Accuracy of FSA health target reporting

EY Independent Assurance

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1. Executive Summary

1.1. Background

Shorter wait times for First Specialist Assessments (FSA)[1] is one of the five Government health targets aimed at supporting the delivery of better health outcomes and improving the performance of health services across New Zealand. The FSA health target (which is also one of the Elective Services Patient Flow Indicators – ESPI 2) specifies that by 2030, 95% of patients should be waiting less than four months from the date of receipt of a referral for an FSA, with milestone targets for 2024/25 (62%) and 2025/26 (65%). The most recent public reporting (Q3 FY25) identifies the FSA rate sits at 58.2% nationally, with variation in performance across districts and between specialties.

Health New Zealand (Health NZ) asked EY to provide independent assurance over the accuracy of the FSA health target reporting and the district, regional and national monitoring processes for patients waiting 120 days or more. Health NZ has also requested that the independent assurance assesses if patients are being managed in line with the recently agreed National Outpatient Waiting List Management Guidelines (the National Guidelines).

Our work commenced on 13 August 2025 and concluded with this report being finalised and issued on 4 September 2025. Our approach considered key risks across the end-to-end processes and included engagement with eight Health NZ districts and a range of national stakeholders, review of key documentation, and data analytics.

1.2. Summary of findings

We found no evidence of intentional misrepresentation of FSA health target reporting or waitlist management processes intended to improve or inflate performance (e.g. holding or removing patients for inappropriate reasons). However, we did find significant variability in processes that are impacting the comparable performance of the reported FSA health target between districts.

Across the eight districts we visited, and the series of national interviews conducted, we identified several opportunities for error to arise across both waitlist and data reporting processes that could impact the accuracy of reported performance, primarily due to the manual and variable nature of key activities.

Manual steps introduce opportunities for error:

We observed that all districts had some component of manual data entry across their waitlist management processes, in part driven by local referral and patient administrative systems that are not fully integrated within (or between) districts, which introduces opportunities for error to arise. Additionally, FSA health target reporting is still completed via a manual national collection process that involves data submissions into the National Booking Reporting System (NBRS) KPI table via individual district Excel spreadsheets which again, presents opportunities for error across many steps. This is a historic process with known limitations and there is work underway to understand how it can be modernised.

Comparable performance is compromised by variation in processes:

We observed that the comparability of performance between districts and specialties is compromised by variation in key waitlist management processes including acceptance criteria causing variable waitlist composition and size, the use (or not) of suspensions, and which activities are reported as an FSA. Further, it was evident that districts and regions manage their waitlists in different ways (e.g. the use of virtual clinic templates as a management tool for delivery of non-contact FSAs[1]) and do not always prioritise patients in line with the National Guidelines published in April 2025 (e.g. using additional clinical acuity tools to manage clinical risk, and sub-specialty or clinician specific waitlists). Comparable performance is also compromised by variation in the data business rules used by districts to extract their FSA health target data, including inclusion criteria and how activity is mapped to specialties. These variations reflect historic systems and standard ways of working pre the formation of Health NZ as well as local clinical and managerial preferences. They are well known, and we observed a range of initiatives underway at national, regional, and local levels to optimise and standardise data collection processes.

[1] An FSA is a patient's first assessment by a Registered Medical Practitioner at Registrar level or above, a Registered Nurse Practitioner, or an advanced Clinical Practice Physiotherapist for a specific referral and can be delivered in ward, designated outpatient clinic or by telehealth. A non-contact FSA is when a review is undertaken of patient records and any relevant diagnostic test by any of the above and the patient is then discharged back to the referrer with a management plan.

Processes and initiatives to improve accuracy:

All districts had a range of processes and controls in place to manage waitlist accuracy (and performance) but the nature of these arrangements, including the level of automation, varied widely between districts. Additionally, we consistently heard that the biggest barrier to meeting the FSA health target and to ensuring accuracy was capacity and for some, that this challenge is exacerbated further by low digital maturity. With that in mind, districts conveyed the importance of transparency in FSA health target performance challenges, to better inform future investment required to improve access, outcomes, and experience for patients.

Nationally, the establishment and ongoing evolution of the national RAPID dataset is a key step forward in terms of transparency of waitlist management and FSA health target performance, and for regional and national performance monitoring. As the functionality and capability of this dataset continues to evolve, Health NZ should consider how it could enable more automated and mature reporting arrangements (for both operational and reporting purposes) to improve accuracy and reduce administrative burden.

In this context, the creation of the National Guidelines is recognised as a critical enabler to support standardisation and improve comparability of reporting. However, as districts adapt their own more detailed standard operating procedures (SOPs) to align to these National Guidelines, there is a risk that unwarranted variation remains. As implementation progresses, Health NZ should consider how training and change management activities can support standardisation, as well as how to make best use of regional administrative capacity.

1.3. Key observations

Our key observations are summarised below and have been grouped into the following three areas:

- Factors impacting the accuracy of reporting,
- Factors impacting how districts are following the National Guidelines, and
- Observed local and national controls in place to manage accuracy and performance.

1. Factors impacting accuracy of reporting	2. Factors impacting how districts are following the National Guidelines
1.1 Manual and variable approach to FSA health target data extraction and submission by districts	2.1 Variation in local arrangements and processes for booking and scheduling
1.2 Variation in referral acceptance criteria between districts resulting in variable waitlist composition (and potentially size)	2.2 Prioritisation of patients for an FSA being done differently across districts and not always consistent with the National Guidelines
1.3 Manual steps across the end-to-end FSA waitlist management processes introduce opportunities for error	**3. Observed local and national controls in place to manage accuracy and performance**
1.4 Time recorded on the FSA waitlist is not consistent between districts because of variation in local waitlist management processes	3.1 District-specific approaches to maintaining the accuracy of the waitlist and reported performance results in variable confidence in waitlist accuracy
1.5 There was no evidence of intentional misrepresentation of data or of processes intended to improve or inflate performance (e.g. removing patients from the waitlist for non-clinical reasons)	3.2 Nationally, there are a range of controls intended to both monitor (and improve) performance, and manage accuracy

Our key observations are expanded upon in Section Three. Recommendations to support better comparability of waitlists and to improve the control environment supporting accurate reporting are captured in Section Four.

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Disclaimer

This report was prepared at the request of Health NZ (hereafter "the Client") solely for the purposes of independent assurance over the accuracy of the ESPI 2 FSA health target reporting and not for any other purposes.

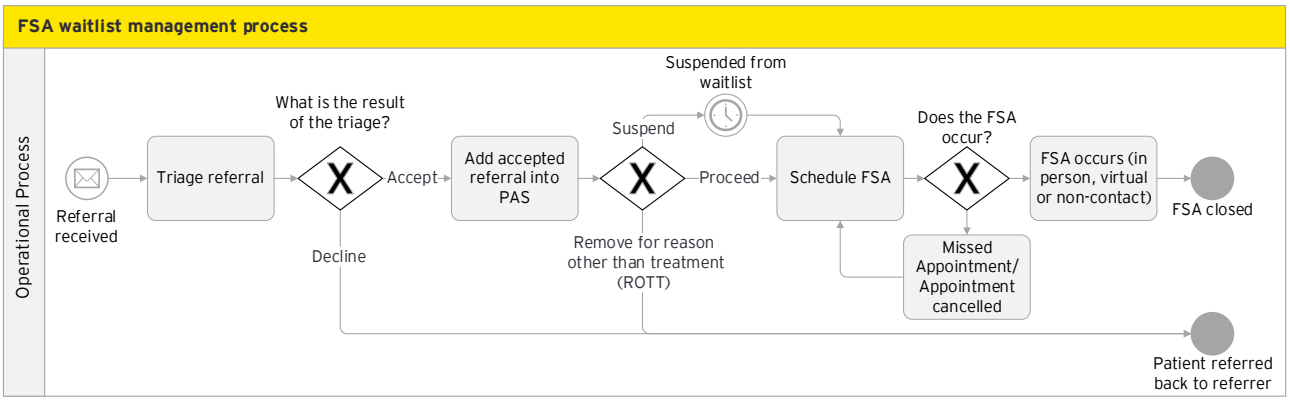
This report may only be provided to the Minister of Health (hereafter "Minister") for the purposes of independent assurance over the accuracy of the ESPI 2 FSA health target reporting. The Minister and any other party other than the Client who access this report shall only do so for their general information only and this report should not be taken as providing specific advice to those parties on any issue, nor may this report be relied upon in any way by any party other than the Client. A party other than the Client accessing this report should exercise its own skill and care with respect to use of this report and obtain independent advice on any specific issues concerning it.

In carrying out our work and preparing this report, EY has worked solely on the Client's instructions and has not taken into account the interests of any other party. The report has been prepared based on information provided by the Client and current as of 4 September 2025. Since this date, material events may have occurred which are not reflected in the report.

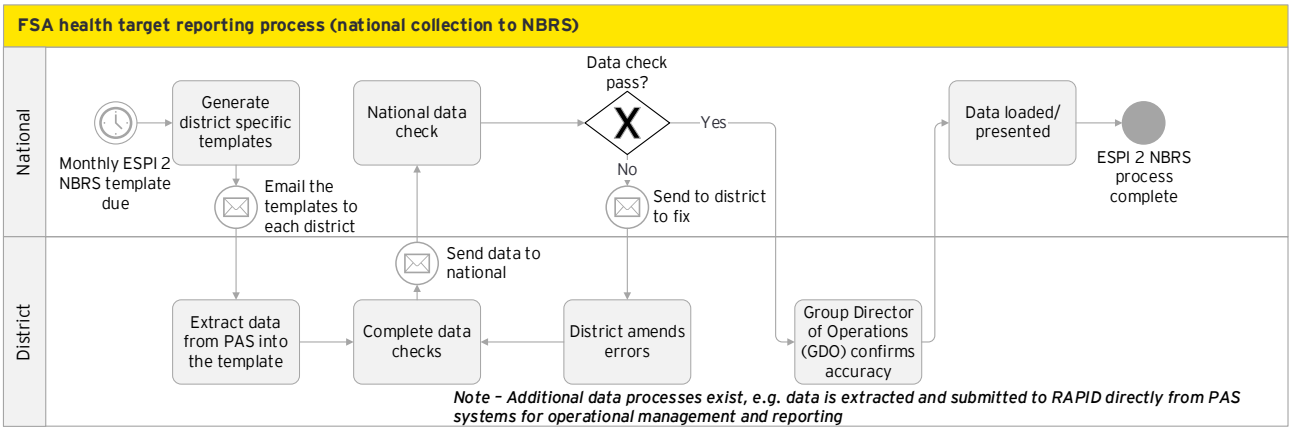
2. Context

Shorter wait times for FSAs is one of the five Government health targets aimed at supporting the delivery of better health outcomes and improving the performance of health services across New Zealand. Improvement of FSA waitlist reporting and performance has been a focus for Health NZ for some time, with recommendations included in the Reset and Restore Plan (published in 2022), and the NZ Health Plan (1 July 2024 – 30 June 2027).

The FSA health target measures the time taken from the point a referral is received by secondary care (for referrals that are accepted by a service) until an FSA occurs (including non-contact FSAs when a patient is discharged back to the referrer with a management plan without being seen by a practitioner). The target is calculated by dividing the number of patients waiting less than four calendar months from the date of referral receipt for an FSA by the total number of patients waiting at the end of the month for an FSA. The diagram below depicts the high-level patient pathway from referral to FSA (the detailed patient pathway will vary between districts and services).



Health NZ publishes reporting on the FSA health target performance monthly, under guidance from the Ministry of Health. Reporting is informed by data that is submitted by each district into the NBRS KPI table. The diagram below depicts the high-level reporting steps (the detailed reporting process will vary between districts).



To support consistency across districts in the waitlist management process, Health NZ released the National Guidelines in April 2025 to provide standard guidance on the process for how waitlists should be managed. Districts are aligning their local SOPs to the National Guidelines, noting that the operating context for each district and specialties/subspecialties means there will always be a level of appropriate variation in waitlist management processes.

In addition to the development of the National Guidelines, additional initiatives are also underway across the whole planned care pathway to remove variation and standardise processes. This includes a range of programmes to address the 101 recommendations from the Planned Care Taskforce as part of the Reset and Restore Plan, which included the introduction of the national RAPID datasets. There is also work underway to consider how the historical national collection process for FSA health target reporting can be modernised.

Health NZ requested EY complete rapid independent assurance over the accuracy of the FSA health target reporting and the district, regional and national monitoring processes for patients with the longest waiting times (see Appendix A for details regarding the scope of this engagement and the approach taken). For the purposes of

this report, accuracy of reporting is defined as both the accuracy and integrity of the reporting process, and also confidence in the accuracy and comparability of the underlying data being submitted.

The independent assurance was completed over a period of approximately three weeks. Our approach included consideration of key risks across the end-to-end patient and data pathways (refer to Appendix B for further information regarding the key risks). Interviews were completed with key stakeholders both nationally and with the respective Group Director of Operations (GDOs), planned care leads (including some clinical leaders), bookers and schedulers and data analysts across the eight in-scope districts. We also received and reviewed a range of relevant documentation from districts and the national teams and undertook a range of data analytics to quantify and support key observations, such as removal for reasons other than treatment (ROTT) rates and waitlist composition.

Given the rapid timeframe in which to complete the independent assurance and reporting, we did not undertake a detailed assessment of Health NZ's control environment or conduct detailed testing across all identified controls.

Our experience in completing the engagement was of a willingness of all Health NZ stakeholders nationally and locally to prioritise engagement and share insights and documentation, as well as a collective will to uplift processes to support improved standardisation and ultimately outcomes for patients.

3. Observations

Across the eight districts we visited, and the series of national interviews conducted, we identified several opportunities for error to arise across both waitlist and data reporting processes that could impact the accuracy of reported performance, primarily due to the manual and variable nature of key activities. We found no evidence of intentional misrepresentation of FSA health target reporting or waitlist management processes intended to improve or inflate performance (e.g. holding or removing patients for inappropriate reasons). However, we did find significant variability in processes that are impacting the comparable performance of the reported FSA health target between districts. We have nine key observations, grouped across three themes:

- Factors impacting the accuracy of reporting,
- Factors impacting how districts are following the National Guidelines, and
- Observed local and national controls in place to manage accuracy and performance.

1. Factors impacting the accuracy of reporting

1.1 Manual and variable approach to FSA health target data extraction and submission by districts

The detailed process for data extraction and submission varies between districts but in all cases involves completing a district specific Excel template which is then validated and sent, usually via email, to a single national collections' inbox. This is a historic process with known limitations and there is work underway to understand how it can be modernised. However, by nature of the process requiring manual data entry within the Excel spreadsheet, there is potential for data error that could compromise the accuracy of FSA health target reporting (e.g. incorrect or missing data entries through transposing errors, or inadvertent deletion or changing of formulas).

Additionally, each district's SOP for data extraction and submission varies, including the data business rules used and the submission timing. This is unlikely to impact the accuracy of reporting for an individual district over time (as the process is usually the same month to month) but does impact comparability of reported performance between districts.

In relation to data business rules, the FSA health target reporting file that is sent out is district-specific and has fixed specialties based on prior year inpatient activity. In some cases, these specialties may not be fully reflective of all the services that districts provide (e.g. Maxillofacial), and some mapping may be required. This is not always done consistently (e.g. subspecialties under General Surgery can sometimes be mapped to other specialties). Some districts may also exclude some activity within specialties, for example District C excludes some patients within Endocrinology and Pain Management, but this did not appear to be consistent between districts.

In relation to variation in submission timing, some districts (e.g. District H), submit toward the end of the month (for the prior month) while others (e.g. District C) submit in the first couple of days of the month (for the prior month). Due to the known operational lags in data flowing through (e.g. timeliness of closing appointments and accepting referrals), districts submitting earlier in the month may generate a less accurate view on performance.

In all districts, the GDO confirms the accuracy of the reported performance before it is published and there are also a range of additional data validation process steps in place (see Observation 3.1). However, the nature of these controls varies. Once data is received by the National Collections Team, the file is checked for completeness and accuracy by comparing reported performance to that of previous months. There is also national variance reporting that is done against the RAPID dataset to check (and improve) proximal accuracy overtime. This shows that over the last 11 months, the variance has been ~1.5%.

These controls are useful in terms of identifying any significant variances in performance but wouldn't identify consistently biased information and challenges with the comparability of reported performance between districts remains.

1.2 Variation in referral acceptance criteria between districts resulting in variable waitlist composition (and potentially size)

It is widely understood both nationally and across districts that there is variation in the acceptance criteria for FSA referrals across specialties and districts. All districts reported capacity constraints that made it difficult to meet the FSA health target, but how districts managed this varied with some districts declining routine referrals in most or all specialties (e.g. District F) whereas others (e.g. District H and District C) accept routine patients for nearly all specialties. This was evidenced when we analysed national RAPID data. As at 29 August 2025, the national

waitlist breakdown across Clinical Urgency Categories (CUC) shows that 10% are urgent referrals, 39% semi-urgent and 48% routine (3% low priority/unknown). However, routine referrals made up as little as 16% and up to 72% of a waitlist when looking at a district level.

Districts that are declining routine referrals remained cognisant of the unmet need in the community. They communicated that to manage clinical risk, rather than have patients on the waitlist who they do not have the capacity to see, they instead often decline the referral, with advice back to the referrer on how the patient could best be managed in the community. This could be until they meet the criteria to be accepted onto the waitlist for an FSA or they may be able to be managed in the community on an ongoing basis.

While the acceptance of referrals is not part of the FSA health target it is an important observation because this impacts the accuracy of comparable performance between districts as the more referrals a district accepts, the more patients that need to be seen to meet the health target. Documentation reviewed as part of this independent assurance presented an example of how a change in one district's acceptance criteria for Gynaecology referrals resulted in a 30% reduction in referrals received (as referrer practice changed in line with new acceptance criteria) and markedly improved FSA health target performance to over 90%, even though the number of patients that had an FSA had gone down.

Nationally, there is work underway to look at the harmonisation of acceptance criteria and recognition that setting standardised referral criteria would remove the 'postcode lottery' and provide consistent access for patients to be accepted onto a waitlist. While this work is important to drive improvements and standardisation, this alone will not remove inequities in the timeliness of being *seen (and later treated)* by a specialist because of local variation in referral rates, capacity constraints and access to outsourced capacity for treatment.

1.3 Manual steps across the end-to-end FSA waitlist management processes introduce opportunities for error

In all districts, the end-to-end process for managing the waitlist is delivered across more than one system i.e. the specific patient administration system (PAS) and at least one e-referral system. In most cases, there are also a number of manual, and sometimes paper-based, processes done outside of these systems.

In some districts (e.g. District E), the PAS and e-referral systems are integrated which allows electronic referrals to be automatically loaded into the PAS, but in most districts, there is either partial (e.g. District H, District C) or no integration (e.g. District F, District A) and referrals must be manually entered into the PAS from the referral system. This can create a significant administrative burden and creates opportunities for error through manual data entry.

Across all districts, there were variable degrees and layers of exception reporting, business intelligence reporting, and operational and clinical resource that is focused on identifying and resolving any missing or incorrect referrals or data errors across the end-to-end process. For example:

- For some districts these controls were automated (e.g. District C) showed evidence of automated exception reports, produced daily, for any referrals not able to be automatically loaded from one of their e-referral systems into their PAS system, which their Administrative Team then pick-up and process.
- For other districts (e.g. District F) these controls are manual and resource intensive which can impact the ability to provide confidence in data accuracy due to capacity and resource limitations.
- Within some districts, Operational Managers and the Booking and Scheduling Teams are routinely monitoring referrals without triage outcomes to confirm they are not 'lost'. For some districts this monitoring is manual in nature whereas in others, (e.g. District H), there are exception reports that are auto generated when a triage outcome has not been entered after a certain period.

This fragmented approach can necessitate resource-intensive safety nets to manage these risks (where not automated). Overall, this impacts the confidence in both referral and waitlist data, complicates performance reporting and demand forecasting and generates operational inefficiencies.

1.4 Time recorded on the FSA waitlist is not consistent between districts because of variation in local waitlist management processes

There was good knowledge of the recently introduced National Guidelines across all the districts. However, districts are still implementing the National Guidelines and there remains variation in local processes and ways of working that mean that the 'time recorded' on the FSA waitlist (i.e. when the time on the waitlist starts, pauses, and stops for an individual patient) varies between services and districts. This includes variation around the use

(or not) of suspensions, treatment of wait times for diagnostics, treatment of the readiness of the patient for an FSA, and timeliness in closing appointments.

For example, District H and District G use the 'suspension' function as per the National Guidelines for patients who are not 'ready' for an FSA either due to clinical or patient-driven factors which 'pauses' the time on the waitlist while they are suspended. Other districts (e.g. District F, District C) do not use the suspend function at all and either retain the patient on the waitlist or discharge them back to the referrer until they are 'ready' for an FSA. Whilst the use of the function is highly variable between districts, our data analysis shows that the impact of use of suspensions is relatively low, with less than 1% of patients being suspended (from available data). Additionally, all districts using the suspend function reported monitoring the use and reasons to ensure they were appropriate. The use of suspensions is not easily comparable across districts as despite suspension reasons being a fixed 'drop down' selection in the PAS system, the options enabled differ across districts.

Variation in the treatment of diagnostics that are a prerequisite for an FSA was another common reason why the 'time recorded' on the waitlist varies between districts. Some districts keep patients on the waitlist while they are waiting for critical diagnostics (e.g. District C), whereas others use the suspend function, and some (e.g. District E) decline these referrals and ask the referring practitioner to re-refer the patient once diagnostics are complete.

Once a referral is accepted, the time on the waitlist should be backdated to the date of referral receipt. There is a risk that districts may not be using the correct date in reporting, although analysis of national FSA waitlist data (from all 19 districts) identified that 97.5% of records had no variance between the referral receipt and waitlist start date indicating a very low variation against this National Guideline.

Timeliness in closing appointments differed across the districts. For most districts, once an FSA is attended, this is recorded within 24 – 48 hours but there are sometimes delays due to paper-based outcome forms (e.g. District A, District C, District F), or staff capacity, especially for remote outpatient services (e.g. District G and District B). Approvals of outcomes from Senior Medical Officers may also be required in some cases which can cause delays as can the waiting for results of a diagnostic completed during the FSA (e.g. District G).

Whilst variation exists, the materiality of the impact on reported FSA health target performance for an individual district is likely to be minimal, however it may make comparable performance between districts difficult.

1.5 There was no evidence of intentional misrepresentation of data or of processes intended to improve or inflate performance (e.g. removing patients from the waitlist for non-clinical reasons)

In any system with targets, there is a risk that data is misrepresented, or procedures used to falsely improve reported performance. However, we did not observe or find any evidence of intentional misrepresentation of FSA health target performance data or processes intended to improve or inflate performance (e.g. removing patients from the waitlist for non-clinical reasons).

Across all districts, key steps that drive the reporting of waitlist performance are done within the respective PAS system. The steps are acceptance of referrals, the use (or not) of suspensions, and recording of the clinical outcomes or other removal (ROTT) reasons. The data feed for the national collection (whilst manually submitted) is extracted from the PAS systems and so health target performance presents what is in the system (ignoring the accuracy of the data business rules applied to the extraction and the opportunities for error identified).

For all districts, a patient is removed from the waitlist[2] once they are assigned a clinical outcome by a clinician, or if they are removed for ROTT. This means that if a patient is booked into a virtual or physical clinic, they appear in waitlist reporting as 'waiting for an FSA.' A clinical outcome can be given as a result of an in-person / telehealth appointment or a non-contact FSA. A non-contact FSA is where a patient needs a management plan but do not need to physically see a specialist, for example a review of diagnostics to determine the next course of action. In some districts a virtual clinic template is used for patients requiring a non-contact FSA, where the nominated clinician reviews patient notes/diagnostic results and writes their management plans (e.g. District A). These patients may then be removed from the waitlist, consistent with the National Guidelines, and discharged back to the referrer with a letter if they do not need to be seen by a specialist.

[2] When a patient is removed from the waitlist (by either receiving a clinical outcome or ROTT) it triggers a letter back to the patient and the referrer outlining the reason and any next steps/ clinical advice where appropriate. Whilst these processes and controls were discussed, and the SOPs reviewed for some districts, time constraints meant we were unable to confirm and test the effectiveness of the controls in place.

ROTT removals can be either patient-driven (e.g. they have sought assessment in private) or hospital-driven (e.g. consistent with a missed appointment or the 'unable to contact' processes within the National Guidelines). Nationally, reporting showed that ROTT rates can range between 2% - 53% across districts (as at end of June 2025). While there is a risk that patients are being removed from the waitlists for inappropriate reasons, this is mitigated to an extent by ROTT removal reasons being fixed via drop downs in the PAS systems and regular national monitoring. Additionally, in some districts (specifically, District C, District H, District F), clinical input and oversight occurs for all hospital-driven ROTT as well as patient-driven ROTT relating to urgent and semi-urgent referrals.

The National Guidelines stipulate that patients should not be booked more than six weeks in the future to minimise the risk of needing to change appointment times. Some PAS systems prevent bookers from doing this. As such, there may be instances of bookers using either system or offline mechanisms to list patients who need to be booked more than 6 weeks in advance. However, until the appointment is closed (or removed for ROTT), they will remain 'waiting for an FSA' in the system and in reporting.

2. Factors impacting how districts are following the National Guidelines

2.1 Variation in local arrangements and processes for booking and scheduling

Each district has its own arrangements and SOPs for managing waitlists and booking and scheduling FSAs. These largely reflect the historical arrangements which existed prior to the creation of Health NZ. All districts reported being aware of the recently introduced National Guidelines and were in the process of aligning local SOPs to these. As this was still in progress, and given it was being completed at a district and/or regional level, variation may remain. The operating context for each district and their specialties/subspecialties does mean there will always be a level of warranted variation in waitlist management processes. Notwithstanding that, some of the current variation does impact on the comparability of waitlist reporting. For example, between districts, there is variation in whether activities like skin "see and treat" is included in the FSA health target reporting.

We also observed some variation in how waitlists are managed across districts, even for the same specialties within districts, some of which reflects the variation in booking and scheduling operating models and level of clinical engagement and oversight into waitlist management. In some districts, booking and scheduling is managed centrally, whereas in others it is managed within specialties, or a mixture of both. For districts with highly decentralised booking services (e.g. District F), they reported that it can be hard to have sufficient operational visibility and oversight to drive consistency in practice across the district. Again, this impacts the comparability of waitlist reporting.

All districts reported capacity constraints across Booking and Scheduling Team(s). Some districts (e.g. District D) are working with other districts in the region toward making best use of regional capacity where this is appropriate. Others (e.g. District B and District H), are currently in (or have recently completed) the process of centralising of their teams in order to build capability and drive consistency in how processes are followed and therefore how they are reported.

2.2 Prioritisation of patients for an FSA being done differently across districts and not always consistent with the National Guidelines

The National Guidelines outline that patients should be prioritised for their FSA based on their CUC and then longest wait (i.e. 'book in turn'). National reporting shows that this is not always the case, with recommendations made to districts to focus on ensuring routine patients are booked in turn, especially across pressured services.

Some of this is explainable by clinician sub-specialties i.e. the need for certain patients to see a particular clinician with a sub-specialisation may mean they wait longer than others due to limited availability within sub-specialties. Further, there are also a range of other reasons why districts are not always following this guidance e.g. because of relative clinical acuity, limitations in the patients that can be outsourced, or bespoke triage arrangements. For example, District G uses a clinical acuity tool to overlay waiting time with clinical risk within CUCs and then uses the resulting acuity score to prioritise bookings meaning that sometimes patients are (appropriately) booked 'out of turn' in order to manage clinical risk. For most districts, clinicians provided guidance on patients that should be seen sooner to manage clinical risk which resulted in patients not being booked in turn. Many districts described varying levels of 'pooling' of waitlists for non-sub-specialist referrals. However, in some districts (e.g. District G), their local policy is that accepted patients are by default added to the waitlist of the clinician who triaged them, which also impacts prioritisation.

Within some regions, districts have visibility of waitlists across the region and performance of the waitlist is managed regionally. Some districts (e.g. District G and District A) discussed opportunities to pool waitlists across the region to improve consistency in prioritisation and make best use of capacity. However, this has not yet occurred.

3. Observed local and national controls in place to manage accuracy and performance

3.1 District-specific approaches to maintaining the accuracy of the waitlist and reported performance results in variable confidence in waitlist accuracy

In a well-controlled system, we would expect to see a range of key controls across waitlist management and data reporting processes including integration of systems, clearly defined and consistently applied operating procedures, appropriate segregation of duties throughout the process, routine exception reporting, training on roles and responsibilities around implementing the National Guidelines, and quality assurance to support data accuracy and process integrity. We would also expect to see additional checks on any manual processes to minimise the risk of errors which could include two-person data checks or regular exceptions reporting.

Whilst we observed various elements and maturity of these controls throughout the waitlist management process, these were not consistently in-place, and all districts cited opportunities for improvement including automation of manual processes that underpinned active management of the waitlist. The observed processes and controls included: the use of exception and variance reports looking at duplicates or open referrals; data quality checks on data extracted for the national collection; real-time or retrospective monitoring of waitlist management practices such as suspensions and removals; and clinical / managerial oversight.

As highlighted in Observation 1.3, in some districts (e.g. District G, District H), the processes and controls for waitlist management were highly automated with continuous monitoring of data accuracy and automated push exception reporting (for example, scripted data checks looking for common errors such as. treat by date before the referral received date, exception reports for duplicate referrals or open referrals 48 hours after an 'attended' appointment). Other districts (e.g. District F) reported a range of more manual data-checking and controls requiring a higher administrative workload. In some regions, there were also regional data governance dashboards to review and manage regional data quality and identify potential errors.

We did observe that some activities to actively manage the accuracy of waitlists can result in temporary spikes in FSA health target reporting. For example, in District D, a recent data validation project was conducted for a range of reasons including a PAS system upgrade, leading to a temporary spike in ROTT rates as the waitlist validation actions were delivered.

The arrangements for managing the accuracy of the reported FSA health target performance are also district specific. For example, in District H and District C the person extracting the data also submits it, whereas District E and District F have a two-step process that includes the Planned Care Lead which, theoretically, should reduce the opportunity for error. However, as highlighted in Observation 1.1, in all districts the GDO confirms the accuracy of the reported performance before it is published, and national variance reporting against the RAPID dataset checks (and improves) proximal accuracy overtime.

All districts reported capacity constraints, and for districts with highly manual processes and controls, the associated administrative burden may exceed available administrative capacity, potentially constraining their ability to support data accuracy. Within this context, automation is an important and valuable tool. In some instances, automation outcomes are still being bedded-in and in some instances, for example in District C, the automation between e-referral and PAS is generating additional duplicate referrals that have to be controlled through daily exception reporting, (which creates a high ROTT rate).

The variability in the arrangements for active management limit the confidence that all districts have effective and efficient controls in place to maintain an accurate waitlist that is informing FSA health target performance.

3.2 Nationally, there are a range of controls intended to both monitor (and improve) performance, and manage accuracy

Nationally, there are a range of controls in place intended to both monitor (and improve) performance and manage accuracy (e.g. Final Weekly Data Validation Report for Planned Care Steering Group, monthly performance packs). We did not test the effectiveness of these controls as part of this independent assurance, however the introduction of increased operational reporting using the RAPID dataset (which automatically extracts relevant data from

respective district PAS systems) is a positive step toward transparency of both the performance and accuracy of the waitlists. It is also providing the opportunity for increased performance management to support improvement in FSA health target performance.

The national team use the RAPID dashboard to not only have a 'live' view of the waitlist (recognising that there is an operational lag (circa 3 weeks) to get an accurate view of performance), but they also produce a range of reports to monitor district waitlists, identify unusual activity or trends, and spot potential errors such as duplicate referrals which they then work with districts to resolve.

Nationally, the RAPID dataset is regularly compared to the NBRS submissions at an aggregate level for FSA health target performance to identify any variance and the national team are working with districts to improve the accuracy of both data sources over time. For example, districts reported changing how they are coding specialties in order to better align RAPID and NBRS submissions (and therefore improve consistency).

While the RAPID dataset is a key enabler of improved accuracy, having more than one data source for FSA health target reporting can make it challenging to get a single source of truth on performance. This is also creating additional validation and administrative tasks for local operational teams within districts to identify, understand, and then manage variations.

4. Recommendations

Given our key observations above, we have developed a set of recommendations to support Health NZ to continue its work to improve the comparability and accuracy of the FSA health target reporting. We have segmented the recommendations into those that can be done in the short, medium, or longer-term based on our understanding of your current operating context (incl. funding, resources, and necessary enablers in place). Health NZ will need to consider and prioritise these against its overall work programme, commitments, and resourcing.

#	Recommendation	Observation
Short term: prioritise and build into existing programmes of work		
1	**Managing assurance over the accuracy of the FSA health target reporting** Ongoing assurance around the accuracy of FSA health target reporting for all districts is necessary to support confidence in the reported progress towards targets and for comparability across districts and regions. The following are some testing and verification activities that could be taken forward as part of an ongoing programme to support assurance in addition to those which are already in place. We would recommend that a representative and rotating sample driven approach is taken overtime to manage the effort required: o Confirm and test any standardised exception/variance reporting and reconciliations implemented as part of Recommendation Two across a rotating sample of districts to confirm errors are identified and remediated in a timely manner consistent with expectations. Reporting could include reporting covering suspension reasons, removal reasons, referral dates and waitlist acceptance, duplicate referrals and FSAs, triage outcomes, priority rating assigned, and patients transferred from other districts. o Confirm and test appropriate segregation of duties exist throughout the waitlist management process (e.g. consistent clinical sign-off of all ROTT removals) o Sample test how data is checked and validated after it is manually entered into or extracted from systems. o Review the sign-off controls in place throughout every step of the waitlist management process to confirm they are being executed in accordance with expectations. o Test on an ongoing basis the data business rules, and inclusion/exclusion criteria used for ESPI 2 reporting at each site as this has an impact on the accuracy and comparability of reporting. o Periodically test access rights to the systems used at each district to confirm access is appropriate.	1.1 - 1.5
2	**Update the National Guidelines to be more explicit about the minimum expectations for local processes and controls to manage the accuracy of waitlists** Whilst there are standard national processes and controls to improve the accuracy of reporting, local processes and controls are variable and, in some cases, are resource intensive. The National Guidelines include broad guidance around the need for local quality assurance processes, but do not provide detail on the expected controls districts should have in place. We recommend that the National Guidelines incorporate additional guidance over how districts should be managing their waitlist with a minimum set of exception reporting and local monitoring processes to support waitlist accuracy (e.g. monitoring of duplicate referrals, FSA appointments with no outcomes within 48 hours, urgent priority Missed Appointments and referrals with no triage outcome). Further, the National Guidelines refer to how districts can achieve improved quality assurance through a validation programme; however, the guidelines do not explicitly describe what this should look like in terms of approach, and frequency. These additional guidelines should be designed in consultation with districts and provide for the variation in current technological capability (see Recommendation One for details regarding potential guidance).	1.3, 3.1

#	Recommendation	Observation
3	**Review the local SOPs that are being refreshed in line with the National Guidelines to ensure alignment, and support districts with the necessary change management activities to enable standardisation of practice** The National Guidelines outline a standardised process and include an expectation for districts to update their local SOPs accordingly. As this occurs, we recommend that SOPs are reviewed for consistency across districts and regions. As part of this review, the differences in how different e-referral and PAS systems are used by bookers, schedulers and clinicians should be considered, with a view to strengthening consistency of processes, data capture and reporting from all systems. As there is variation in how bookers and schedulers are organised and trained, and in the processes used to book and schedule patients, successful implementation of any new/refreshed SOPs will require dedicated change management effort, including additional training. We recommend this activity be standardised and co-ordinated where possible so that there is common training that drives consistency between districts, and to reduce the administrative burden of implementing it.	1.4, 2.1, 2.2
Medium term: accelerate once short-term recommendations are underway		
4	**Advance automation for data extraction and reporting of the FSA health target based on standardised data specifications** As observed, the published reporting on FSA health target performance is driven by district submissions to the NBRS KPI table. We understand that efforts are already underway to explore more automated and standardised processes supporting districts data extraction and submission. This is a key improvement initiative, as it will deliver multiple benefits and address several observations in this report. In particular, it will improve confidence in the accuracy of the published reporting, reduce the risk of error associated with data extraction and data processing, and reduce the administrative burden and manual processes across both district and national teams associated with the current processes. As part of automating this process, we recommend that Health NZ drive and obtain consistency in the business rules used including the submission timing (e.g. specify districts should not extract data prior to the 18th of the month) and inclusion/exclusion criteria to support more accurate and comparable reporting in the immediate term. These steps can also occur ahead of automation.	1.1, 3.2

#	Recommendation	Observation
Longer term: work towards (balancing funding, resourcing and delivery commitments already made)		
5	**Uplift the baseline digital maturity of all district PAS and e-referral systems to allow for integration and automation** There is variation in the maturity of PAS and e-referral systems across districts, with some districts still highly reliant on paper and manual processes. While the National Guidelines will support process standardisation, their impact may be limited by district's digital maturity, especially if systems do not support basic integration or automation. Additionally, improving the technology foundations for all districts is a critical enabler of a more sustainable and efficient future-state operating model for booking and scheduling. Overtime, districts and regions should work toward a common level of digital maturity that supports: o Automated referral loading from e-referral to PAS systems. o Automated exception reporting. o Automate standard workflows to reduce manual and paper-based processes. o Common and mature regional PAS and e-referral systems and instances that supports regional monitoring and waitlist management. o AI-enabled scheduling tools to optimise clinic utilisation. o Patient-facing portals for referral tracking, self-service booking (where appropriate) and appointment management.	1.3, 2.1, 3.1
6	**Improve regional consistency in acceptance criteria, clinical pathways, and triage models** There is ongoing work within Health NZ to strengthen regional working arrangements, devolve accountability, and make best use of resources. Given this context and our observations about the variation in FSA waitlist management practices, we recommend that Health NZ: o Harmonise referral acceptance criteria across districts to standardise clinical triage approaches and gain consistency around acceptance onto the FSA waitlist. o Standardise high-volume clinical pathways for to improve consistency, optimise capacity and enable more streamlined booking and scheduling. o Look to establish centralised clinical triage functions within districts and regions (for appropriate services), enabling better use of clinical workforce and more consistent prioritisation. o Employ assistive tech (e.g. e-triage tools, AI-supported referral screening, dynamic referral allocation based on real-time capacity) to streamline triage, reduce manual effort, and make best use of capacity. This will help to reduce unwarranted variation, improve equity of access to FSAs, support more effective and efficient use of regional capacity, and ultimately give greater confidence in the accuracy of FSA health target performance.	1.2, 2.2

Appendix A Scope and approach

Scope

The scope of this independent assurance included:

- Assessment of the FSA health target reporting and evaluation of the accuracy of content.
- Analysis of sample data to determine compliance with the FSA health target.
- Examination of the processes for identifying, monitoring, and managing long-waiting patients, in relation to the requirements of the National Guidelines.
- Understanding district accountabilities for the delivery, audit and reporting against the FSA health target and the National Guidelines.
- Interviews with key stakeholders, including healthcare providers, administrators (including bookers and schedulers) at a district, regional and national level (identification of key stakeholders was completed by Health NZ).
- Assessment of relevant documentation, including guidelines, procedures, and performance reports relating to the FSA health target including the National Guidelines.

The independent assurance services did not include the following:

- Any evaluation of the appropriateness or other focus of the FSA health target.
- Any other health targets other than the FSA health target.
- Any other guidelines other than the National Guidelines.
- FSAs not included within ESPI 2 definitions and not counted as part of the FSA health target.
- The independent assurance only considered the controls around accuracy, completeness, validity and restricted access relating to the identification, capture and reporting process that are controlled by Health NZ.
- Full reconciliation and assessment services, all activities were completed on a sample basis only.
- Validation of any underlying data provided to EY by Health NZ.
- Detailed testing across all identified controls.
- Assurance over the appropriateness of the patients on the FSA waitlist.
- Referral process pre acceptance into services.
- Validation or assurance over referral data or the process prior to referral acceptance.
- Anything not specifically included within the scope of the independent assurance above.

Approach

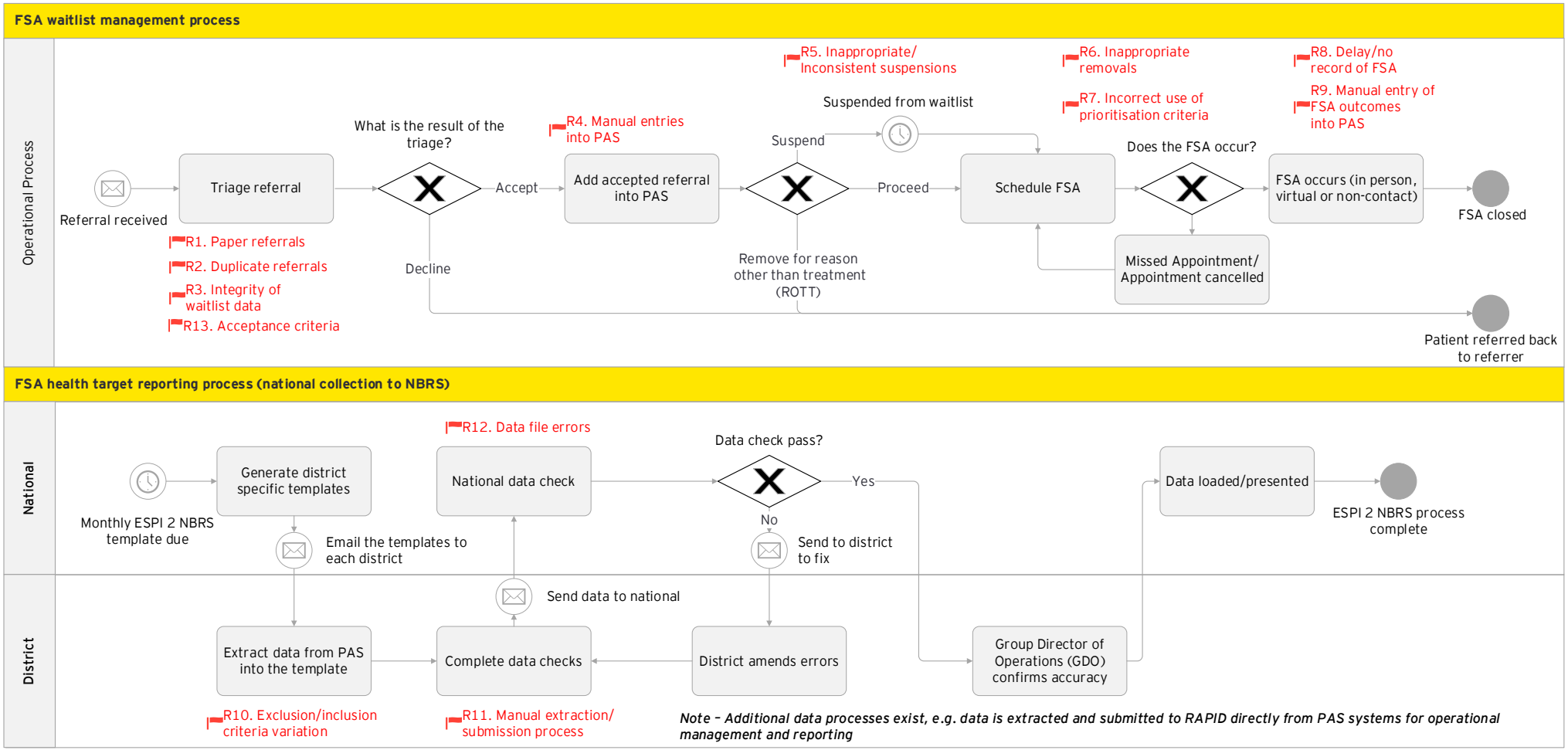
Our approach to providing independent assurance involved:

- Identifying risks across the end-to-end waitlist process by mapping the operational and reporting processes at a high level and identifying potential key risks (see Appendix B).
- Interviews with the National Collections Team and other national stakeholders across Health NZ covering: FSA health target reporting process flows and requirements, national reporting processes and data, long-wait patient reporting process flows and requirements, the National Guidelines, defined data standards and definitions, key risks and issues, and data integrity processes.
- Interviews with regional and district stakeholders (including GDOs, bookers and schedulers, analysts, operational and clinical leadership) covering: FSA health target reporting process flows and requirements, national reporting processes and data, long-wait patient reporting process flows and requirements, the National Guidelines, defined data standards and definitions, key risks and issues, management of referrals, FSA scheduling, specialist assessment processes and district and regional reporting.
- Site visits to eight districts (Northland, Auckland, Waikato, Taranaki, MidCentral, Capital and Coast and Hutt Valley, Nelson Marlborough and Southern).
- Data and document collection and analysis including review of documentation and the completion of high-level analysis of national RAPID data.
- Summarising our observations and determining key recommendations.

Given the rapid timeframe in which to complete the independent assurance and reporting, we did not undertake a detailed assessment of Health NZ's control environment or conduct detailed testing across all identified controls.

Appendix B Key risks across the waitlist management and performance reporting process

The overarching process for managing the FSA waitlist as well as performance reporting is set out below. These processes, alongside the mapped key risks identified, were used to inform the independent assurance activities.



Description of the key risks identified across the overarching process

Risk	Description
R1. Paper referrals	Non-electronic referrals may not be accurately recorded in referral systems which may lead to referrals being missed or inaccurate reporting.
R2. Duplicate referrals	Duplicate referrals (where the same referral may be added to the waitlist more than once in error) may result in double counting on the waitlist compromising the integrity of the waitlist data.
R3. Integrity of waitlist data	Manual entry of triage outcome into PAS systems following clinical triage (that occurs either on paper or within e-referral system) may result in data entry errors, (including triage outcome date) leading to referrals not being correctly added to the waitlist (at all or accurately) which could compromise the integrity of waitlist data.
R4. Manual entries into PAS	Manual addition of all referral information to PAS systems may result in data entry errors, leading to referrals not being correctly added to the waitlist (at all or accurately) which could compromise the integrity of waitlist data.
R5. Inappropriate/inconsistent suspensions	Suspensions from the waitlist for reasons that do not comply with the National Guidelines which may make a patient's reported waiting time inappropriately shorter compromising the integrity of the waitlist data. Inconsistent use of the suspension function between specialties and districts may make it difficult to accurately compare waitlists.
R6. Inappropriate removals	Removals from the waitlist for reasons that do not comply with the National Guidelines may inappropriately remove a patient from the waitlist compromising the integrity of the waitlist data.
R7. Incorrect use of prioritisation criteria	Prioritisation of patients for an FSA are not made according to clinical urgency and see in turn requirements as described by the National Guidelines.
R8. Delay/no record of FSA	FSA occurs but there is a delay or no record of the appointment within the PAS system impacting the integrity of the waitlist data.
R9. Manual entry of FSA outcomes into PAS	Paper clinical outcome forms are manually entered into the PAS system that can lead to data entry errors and delays in entering the data if the form is lost or it takes time to be received.
R10. Exclusion/inclusion criteria variation	Various inclusion and exclusion criteria for data extraction across districts may lead to inconsistencies in reported data, making it difficult to compare and potentially impact the accuracy of reporting.
R11. Manual extraction/submission processes	Manual processes to extract and submit data to the national collection may lead to data errors compromising the integrity of the waitlist reporting.
R12. Data file errors	Data files received contain errors that compromise the integrity of waitlist reporting.
R13. Acceptance criteria	Variation in acceptance criteria across districts impacting 'performance' of FSA target (fewer accepted referrals results in fewer bookings and fewer on the waitlist).

Appendix C Stakeholders engaged

EY engaged with a range of national, regional and district level stakeholders, either in individual meetings or as a group:

Role title	Role title
National stakeholders	**Taranaki**
Chief Clinical Officer	Acting Group Director Operations, Director Allied Health
Acting National Director Planning, Funding and Outcomes	Interim Surgical Service Lead
Regional Deputy Chief Executive, Midland	Planned Care Manager
Head of Analytics	Information Analyst
Director, Health Targets (Acting Director of Hospital Performance), Planning, Funding and Outcomes	Surgical Referrals & Booking Lead
Programme Director, Planned Care and Cancer	Bookers/Schedulers from multiple specialties
Manager, Performance Measures	**MidCentral**
Data Controls Representative	Group Director Operations
Business Analyst, National Collections Team	Chief Medical Officer
Group Managers, National Collections Team	Clinical Director, Planned Care
Manager, Performance Monitoring and Analytics, Ministry of Health	General Manager, Planned Care
Regional stakeholders	District Analytics, Planned Care Data
Group Manager Health Analytics, Northern Region	Planned Care & Admin Manager
Regional Provider Group - ~25 Planned care leads from across all districts in the Northern Region	Acting Operations Lead, Planned Care
Health Target Lead, Central Region	Bookers/Schedulers from multiple specialties
Interim Group Manager – Health Analytics, Central Region	**Capital and Coast and Hutt Valley**
Auckland	Group Director Operations
Planned Care General Manager	Chief Medical Officer
Booking Team Leader	Clinical Directors (Surgery and Women
Northland	District Operations Manager, Elective Surgery and Outpatients
General Manager, Surgical and Perioperative Services	Operations Manager, Patient Administration Services (PAS)
Team Lead, Data Engineer	Team Leader, PAS
Service Manager, Surgical Services	Health Analytics Manager (Capital & Coast)
Patient Scheduling Improvement Lead	Senior Administrator - Outpatients
Head of Data and Analytics	Bookers/Schedulers from multiple specialties
Clinical Nurse Manager, Medical Outpatients Department	**Nelson Marlborough**
Team Leader, Booking Clerks	Group Director Operations
Waikato	Service Delivery Manager, Planned Care
Operations Director, Clinical and Operational	Data & Analytics Manager
Operations Director, Cancer / Chronic and Radiology	Data & Analytics Analyst
Planned Care Manager	General Manager, Clinical Services
Operations Manager, Southern Rural Hospitals & Community	Bookers/Schedulers from multiple specialties
Operations Manager, Waikato Hospital Administration	**Southern**
Charge Nurse Manager – MCC Nursing Operations	Interim Group Director of Operations
Senior Nurse, Surgery and Anaesthesia Clinical Lead	Planned Care District Manager
Project Lead, Planned Care	Planned Care Co-ordinator
Data Analyst	Health Analytics Manager
Women Health Admin Team Leader	Charge Nurse Manager (Ward 4B)
Paediatrics Services, Admin Team Leader	Clinical Administration Manager
Endocrine Booking Clerk	Supervisor ENT
	Booking Administrator from multiple specialties

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Inherent limitations

The procedures that we performed do not constitute an audit. We performed no procedures to evaluate the reliability or completeness of the information obtained. Accordingly, we express no opinion or any other form of assurance.

In performing our procedures, we have accumulated data, written various memoranda for our own use, and have had various meetings with representatives of Health NZ.

The views expressed in our report are strictly limited to Ernst and Young Limited's area of professional expertise and your instructions as stated in the scope and approach section above. Our report is strictly limited by the matters stated in it and is not to be applied by implication to any other matters.

Our fieldwork was completed prior to the report being finalised on the 4 September 2025. Our findings are expressed as at that date. We have no responsibility to update this report for events or circumstances occurring after that date.

Third party reliance

This report has been prepared at the request of Health NZ in connection with our engagement to perform independent assurance services. This report is solely for the benefit of Health NZ for the purpose set out in this report and is not to be used for any other purpose or distributed to any other party or relied upon by any other party without Ernst & Young Limited's prior written consent.

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