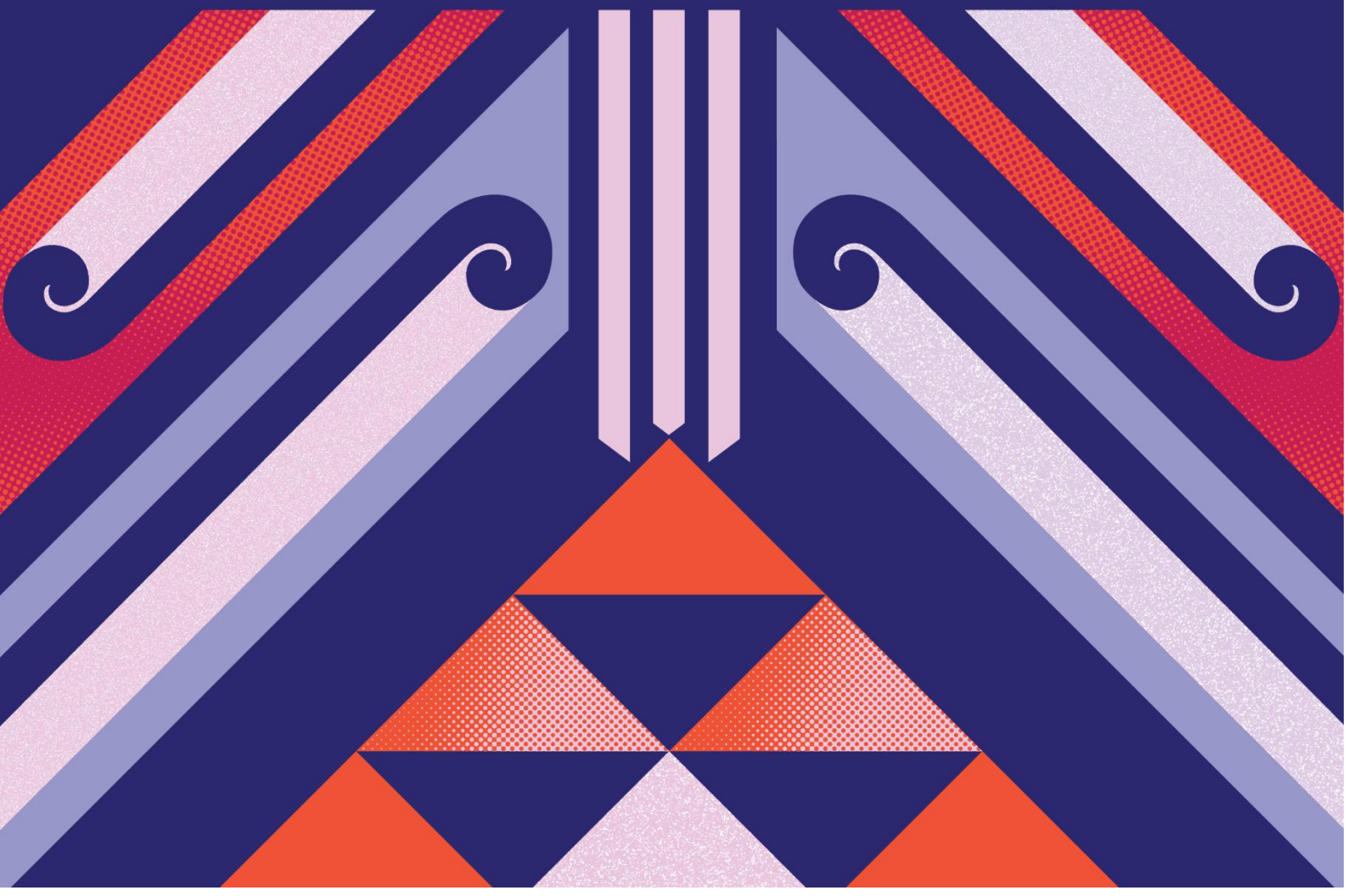
Te Tāhū Hauora
Health Quality & Safety Commission

Assessing system quality and safety: Insights report

November 2024



Background

This is the second report from Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora) providing insights into the quality and safety of the health system.

This report includes updates to the clinical quality and safety monitoring framework (full details in Appendix 2) and insights from consumers and staff in general practice. This has been supplemented with a pharmacist survey and input from aged-residential care quality and safety leads.

These insights are an extension of the findings from our first report that focused on secondary care in the public system. These reports build on each other, as more parts of the system are considered in greater detail.

Summary key findings

1. Like secondary care, primary care clinical governance structures are patchy and insufficient. This especially applies at the interface of general practice, hospital and community-based care, which risks patients "falling down the gaps". The health reforms have exacerbated this situation, with some existing arrangements ceasing before replacements were operational. At a minimum, this creates inefficiencies which exacerbate a mismatch of demand and availability of services; more concerningly, there are some reports of it creating active risks to safety, for example mis-prescription. Information technology is not properly utilised to address these problems.
2. The sustainability and engagement of general practice staff is a concern. Dependence on locums, particularly in rural areas is increasing. Workforce shortages are making it difficult to manage patients in community, reducing morale and engagement of general practice staff.
3. There are major gaps in our ability to measure quality and safety in primary care and respond to issues identified. This represents a risk to patients and the system. Interviews with general practice staff and consumers highlighted a lack of capacity to expend on quality activities, with all available capacity expended on meeting acute demands.
4. Increased difficulties in accessing primary care are reported in the primary care patient experience survey and the national health survey. Nationally, 60 percent of practices are enrolling new patients, but there are wide geographic variations, with only 25 percent taking new enrolments in some parts of the country.
5. Access issues affect patient flow and impact other parts of the health system. For example, lack of access to primary care results in more patients seeking support from community pharmacies. There is evidence of declined referrals to specialist care, which adds demand for primary care practitioners (who must continue to manage the now sicker patient) and this may lead to higher urgency presentations at emergency departments (ED) later. Straightforward substitution, where patients unable to access primary care instead present inappropriately at ED, does not appear to be happening. Some aspects of these pathways are unmeasured (e.g. general practitioners choosing not to refer potentially appropriate patients in the belief that the referral will be declined).

6. In general, patients report a positive experience once care has been accessed. There are consistent and high scores for pressure-sensitive indicators, such a being treated with kindness, having confidence in health professionals and being listened to. A gap in our analysis is the ability to measure outcomes of primary care, except in terms of acute admissions to hospital.
7. Within secondary care, as in primary care, most measures of experience are consistently high. In some locations, responses to specific questions about aspects of care such as communication are worsening. Apart from pressure injuries, most outcome measures have remained consistent. Often seen as a nursing-sensitive indicator, pressure injury rates can be viewed as a marker of system pressure. New data from the perioperative mortality explorer points to improvements in standardised mortality ratio for surgical patients between 2012 to 2023 nationally, with substantial reductions in disparities between Māori, Pacific and non-Māori, non-Pacific people for elective surgeries.

Our findings

Our current assessment of the fifteen leading and lagging quality factors we are tracking, including where we lack sufficient evidence to make a judgement, is summarised in Table 1 and expanded in Appendix 2.

The evidence available to us in making this judgement is collated in Appendix 1.

Table 1 – November 2024: Te Tahu Hauora assessment of system position against the quality framework

Highlighted factors have been updated since our September insights report

Factor type	Factor	Status
Leading/ Structure	1. Are the necessary quality structures (e.g. clinical governance groups, clinical risk reporting pathways) in place?	**CONCERN** **–** not fully in place plus loss of structures at the interface between primary and secondary care
	2. Is near real time data for immediate safe management of services consistently available and used	**PARTIAL CONCERN** **–** not consistently available
	3. Is the necessary clinical workforce in place and engaged	**CONCERN** – not fully in place in either primary or secondary care
	4. Are there any gaps and assets in the safety infrastructure?	**CONCERN** **–** not consistently available
Leading/ Process	5. Are quality structures operating effectively? For example, required information flow as needed and is there authority and accountability to act at the right levels.	**CONCERN** – not fully in place
	6. Is there enough capacity to make discretionary efforts for quality activities? For example, reporting and response to incidents, and collection of data necessary for quality activities?	**CONCERN** **-** not consistently available **UPDATED DATA**
	7. Are workforce being supported in quality activities?	**PARTIAL CONCERN** **–** not consistently available

	8. Is increasing, changing or mismatched demand for services creating risks to available service supply measures: interpreted whole-system patient pathway?	**CONCERN –** mismatches along care pathways across both primary and secondary care systems, interactions between the two exacerbating problems which manifest ultimately as delayed and restricted access to care
	9. Modelling of likely effects of delay on acuity and complexity	**CONCERN –** concerns expressed by clinicians, and emerging data supports the conclusion that access difficulties are creating feedback loops that are making for sicker patients accessing the system. Fuller data and analysis are required to fully understand the effects, risks and potential solutions
	10. Are appropriate pathways for the management of disease consistently available?	**MORE DATA NEEDED**
Lagging/ Process	11. Are there disruptions or other changes to patient flows that raise concerns about safety risks?	**MORE DATA NEEDED**
	12. Is there any evidence of unwarranted variability or risk in prescribing/dispensing practices in hospital or community?	**MORE DATA NEEDED**
Leading/ Outcome	13. Are there any rapid changes in patient experience of care at a local level?	**MONITOR –** these have remained prima facie consistent once people access care
	14. Do ACC treatment injury and other claims data reveal any patterns that point to changes in safety?	**CONCERN –** need ACC support for data & interpretation
Lagging/ Outcome	15. Are there any concerning trends in complications and harms?	**PARTIAL CONCERN** **UPDATED DATA**
	16. Are mortality rates changing?	**PARTIAL CONCERN** – need further analysis **UPDATED DATA**
	17. Qualitative review of HDC complaints and AE investigations to consider common ‘deep’ causes	**MORE DATA NEEDED**

Data from our first report has been supplemented with evidence from the September 2024 Quality Alerts, intelligence from primary care focused clinician and consumer interviews, a more detailed analysis of patient experience surveys, an update of the Commission's REACH[1] analysis, and the perioperative mortality explorer.

The next section highlights supporting evidence, including newly available quantitative data and themes that emerged from interviews with general practice staff and the consumer survey. Quotes are used to illustrate the themes.

Leading factors - quality structures and infrastructure (factor 1, 2 and 4)

Clinical governance structures

Our first reported discussed the lack of clinical governance within hospital services and across Te Whatu Ora Health New Zealand (Health New Zealand) more broadly. This is mirrored in primary care, particularly in clinical governance structures which cover the interface between primary and secondary care.

In some districts, the loss of joint clinical councils and alliancing has reduced the ability to raise issues. One example is discharge processes, where general practice staff told us that discharge letters are becoming longer and having multiple versions as information is updated post discharge. This takes longer to review to determine changes to the patient's status, their care plan and subsequently affects productivity.

In locations where governance structures have been retained, general practice liaison and joint clinical committees were seen as a way to maintain relationships and effective communication between primary and secondary care.

> *"We have continued to meet as a group of clinical leaders regionally… primary care clinical leaders and… inviting the clinical integrators and clinical advisers that are being appointed to that group…it's this pragmatic sort of functional response. We're here, we can contribute, but it still isn't clear…built on relationships rather than structures."*

An inconsistent approach to clinical governance and system integration was identified by general practice staff.

Approaches that were seen as facilitating integration include

> *"*[A] *place where we can systematically discuss these* [clinical governance] *issues"*.
>
> *"Clinical advisor and clinical integrator roles across* [the region]."
>
> *"A regional pathology governance group to talk about that with some of the experts to sort of go through and make some recommendations. We don't have that…No consistency in access to blood tests for people who are stuck*

[1] REACH = Rapid Effects Assessment of COVID-19 on healthcare is an analytic tool Te Tāhū Hauora developed to understand changes in patterns of provision in healthcare. It was originally used to understand how COVID-19 affected access to healthcare, but the underpinning model has a broader applicability, particularly in understanding patterns of healthcare during turbulent periods.

at home or rural communities where there is no local phlebotomy service. Need a governance group to manage this."

While some practices have their own clinical governance structures, general practice staff told us these were not adequately supported by funding, indicating a lack of a strategic approach to clinical governance.

> *"Ninety percent very low-cost access, community trust, so we are very clear about the need for quality improvement…Clinical meetings for 90 minutes on a weekly basis…Clinical governance team put into place…Battled to have dedicated time and resource to think about this – sometimes difficult to achieve because of financial pressures, but critical part of developing the clinic…it's the clinical team being very, very clear that that is a critical part of working in the clinic…but it's a constant tension that the practice has to fund itself. If there's no funding for this, it comes out of the baseline."*

Interface with pharmacists

The lack of clinical governance structures that cover the boundaries between care means there is nowhere to raise issues, negatively impacting community pharmacy. Pharmacists report…

> *"No positive changes. Hospital is continuing to discharge patients into rest homes late in the day. This puts pressure on pharmacy at their busiest time of the day. Hospitals still don't use Medi-Map and general practitioners are charting late into the night. Seems to be an inefficient system."*

> *"General practices do not routinely review hospital discharges and follow up. Communication between primary and secondary care is fragmented and fraught with difficulty."*

Pharmacists also expressed concern about errors in prescriptions, possibly due to pressure on general practice.

> *"Risks are to patients with incorrect medications or dangerous prescribing. This is mostly due to increasing pressure and lack of time with doctors. Unfortunately, pharmacy is also under pressure and the risk of a serious incident is real. We catch many errors on a daily basis, which takes extra time and effort."*

There was also concern expressed that the only way to communicate with general practitioners was now by email.

> *"We have many general practices not answering their phones. Email the only way to comment. Not efficient."*

> *"Yes, less interface – general practices don't answer their phones straight away and we remain on hold and some practices only allow interaction by email not phone. Getting hold of hospital doctors is becoming increasingly*

difficult and colleagues taking over shifts from others won't help when we have a query."

Information technology

Information technology (IT) infrastructure to support seamless care is not consistently in place, impacting productivity and creating risks to safety.

Rural general practitioners told us about the lack of IT functionality to support cross boundary referrals.

> *"If I want to refer to the regional genetics service, I still must print off a manual referral letter and get my nurses to fax it and then post it down to Auckland. And there's not the electronic system for us to be able to automatically choose which district health board (DHB) we're coming from, which DHB we're referring into."*

Aged-residential care (ARC) quality and safety leads report concerns about the interface between general practice and ARC IT.

> *"There are issues with general practitioners and nurse practitioners accessing their electronic system in a timely manner, which results in delayed care for their residents (approximately four hours)."*

> *"We are also facing general practices not wanting to utilise the ARC facility's electronic system as they have the same request by multiple facilities."*

> *"The electronic systems are requiring double handling for general practices."*

Leading factors – workforce (factor 3)

As in secondary care, general practice staff and consumers told us about workforce challenges. It is difficult to locate consistent and detailed time-series data on the primary care workforce to enable us to triangulate these responses.

Feedback from both the consumer survey and workforce interviews highlighted the value of the workforce.

> *"If you visit practices today, you will observe outstanding action and outstanding efforts within practices, adapting their care models to address funding constraints, staff shortages and community needs."*

> *"Ongoing understanding of patient and whānau needs".*

However, workforce sustainability risks were raised. Pay disparities and the ownership models for community-owned practices were mentioned as an issue impacting general practice staff retention.

> *"Why would you come* [here]*? You will work twice as hard and get paid half as much."*

> *"…the rest of the health system falls down around general practice. We're the guys carrying holding the risk. We're the guys personally liable and financially paying for this…"*

> *"Big corporate general practices pay $30 more an hour. Can't compete. General practitioners that are staying are there for aroha and the kaupapa."*

Practices are increasingly using locums to address workforce gaps. This was reflected in the consumer survey and noted in the Rural General Practice Stocktake Survey, where 57 percent of respondents reported that their practice had general practitioner vacancies. Of those carrying vacancies, 44 percent were filling the vacancies with locums.[2]

Using large numbers of locums carry risks, as noted by a community pharmacist.

> "*Where there is a revolving door of medical practitioners at the local practice there is a distinct lack of follow up and therefore many things are missed/"fall through the cracks". General practitioners record keeping (particularly with regard to prescribing) is very poor. People suffer because of this. It is only a matter of time before I miss something subtle, but critical, and there is harm caused to a patient."*

Alongside availability of workforce, morale and engagement are important measures of pressure. The Rural Health Network's recent report describes the 'temperature' of rural general practice as 'critically low'.[3] "Temperature" combines goodwill and commitment of staff[4] with 'perceived sustainability'[5].

Comparison of the results between 2023 to 2024 revealed that while there was increased goodwill and commitment, there was a reduction in perceived sustainability.

Unmanageable workloads in general practice were seen as a threat, with staff reporting a need to protect their team and relationships with patients by restricting access.

Pressures elsewhere in the system were seen to be affecting clinical practice and morale. General practice staff spoke of the impact of shortages on their ability to provide the level of care they want to

> *"I can't say it more strongly. You know, we are morally injured every single day from working within the system. We are only there because we care about people, which makes us even more vulnerable to that sort of stuff... I personally have had two of my very close rural colleagues die this year…one of them by suicide. And, and I think we will see more of that…"*

Some staff told us that the "tipping point" is closer to being reached and that continued pressures may prompt an exodus of staff.

[2] Hauora Taiwhenua, Rural Health Network. 2024. Rural General Practice Stocktake Survey. October.
[3] Hauora Taiwhenua, Rural Health Network. 2024.
[4] Measured by respondent's level of agreement with the following statement: "Staff in our practice are energised and motivated".
[5] Measured by respondent's level of agreement with the following statement: "Our practice is sustainable in terms of its overall 'health'".

> *"Workforce is getting to the point where you just put more and more pressure on the ones that are left and then you know, if we're not careful, we'll get to the point where that implodes and you know all those general practitioners that I was talking about that are getting close to retirement would say ****** it. You know, we'll have an en masse sort of retirement of those older general practitioners and then the system won't cope..."*

This concern is supported by the age and retirement intention of general practitioners. The 2022 General Practice New Zealand survey shows that a quarter of active general practitioners were aged 62 years or over and that 37 percent of general practitioners intended to retire within five years.[6]

Leading factors – quality and safety behaviours, activities, and culture (factor 5, 6, 7, 10, 12, 14)

Capacity to use discretionary effort for quality activities

General practice staff told us that discretionary effort was waning.

> *"It's getting harder that discretionary effort because of the pressure we're under in terms of the acute demand. There's not as much space or capacity for that discretionary effort. You know when you're feeling already under the pump and having to put people in then you know… it's quicker just to say no, go to ED… it's stuff that could be dealt with in primary care."*

> *"Put a lot of effort into working groups that never materialise into change for our patients, communities or workforce."*

Quality risks associated directly with pressure

Pressure leads to work done more quickly. When combined with an exhausted workforce, this could lead to mistakes. For example, pharmacists told us about concerns regarding errors in prescriptions.

> *"You get tired and in a hurry. There's a there's always a risk of more mistakes if you're doing it like that."*

General practice staff told us that some pathways of care were breaking down and access to specialist care is becoming more constrained, with integration across sector boundaries deteriorating.

Examples of how this has increased primary care workload included undertaking pain management of patients awaiting elective surgery that has been either delayed on declined; patients with complex mental health needs being treated primarily by general practitioners rather than psychiatrists; recurring infections in children, and hospital discharges made with an expectation of general practitioner follow up, but with the patient unable to get access to their general practice.

[6] https://www.rnzcgp.org.nz/resources/workforce-survey/2022-workforce-survey/

Leading/lagging factors – demand for and availability of services, the effects of this (im)balance on quality (factor 8, 9, 11)

Access to primary care services

A mismatch of supply and demand leading to access issues in public hospital services was identified in our previous report. A similar picture is seen in primary care, with the most widespread quality alert this year being reduced access to primary care.

In the patient experience survey, the number of patients reporting difficulty in accessing a general practitioner or nurse in the previous 12 months has increased from about 18 percent to around 25 percent since 2021.

This may understate the size of the problem. Respondents to the patient experience survey are those who have, at some point, been able to access care. This excludes those who are completely unable to access care, including those unable to enrol with a practice at all.

This increase is almost entirely due to an increase in patients unable to find an available appointment within an acceptable period.[7] Some form of reduced access is reported in every part of the country.

The impact of reduced access has been reported by consumers

> *"Inability to get an appointment for literally weeks (three weeks generally); feeling like I should just tough it out, but worrying that I am leaving something that could be serious; having to sit with sick moko in an acute care waiting room for over an hour (chest infection leading to pneumonia and later hospitalisation that night)."*

The most recent New Zealand Health Survey, which surveys the whole population rather than just health service users, reports that over 15 percent of the general population was unable to access care due to cost in 2023/24, with marked inequities for Māori, Pacific, disabled people and women, all of whom are more likely to have access difficulties[8].

This partly reflects "closed books". 60 percent of practices are enrolling new patients, but there are wide geographic variations, particularly in rural areas which typically have only a quarter to a third of practices accepting new patients. As General Practice New Zealand said in its most recent survey.[9]

> *"…there are pockets where you can enrol rather than pockets where you can't enrol."*

General Practice New Zealand have reported that all Primary Health Organisations (PHOs)[10] had at least one practice within their network restricting access to services, with 41 percent of PHOs reporting closed books or ceasing new enrolments by practices. This was done to manage workload and the allocation of rooms available.

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[7] https://reports.hqsc.govt.nz/APC-explorer/?_gl=1*5itcy6*_ga*MTA1NTIyMjE5My4xNzE2NDI5NTEx*_ga_TG4RCRSBWS*MTczMjY2MDIwMS4xMDUuMS4xNzMyNjYwMjEyLjAuMC4w#!/questions

[8] https://minhealthnz.shinyapps.io/nz-health-survey-2023-24-annual-data-explorer/_w_7f2b0973/#!/explore-indicators

[9] General Practice NZ. 2024. Escalating pressures on general practice access: Snapshot survey results. URL: https://gpnz.org.nz/media-releases/escalating-pressures-on-general-practice-access-snapshot-survey-results/

[10] Health New Zealand | Te Whatu Ora contracts Primary Health Organisations (PHOs) to provide primary health services within a certain geographical area. PHOs manage contracts to general practice that provide subsidised health care for people who are enrolled with a general practice team. URL: https://www.tewhatuora.govt.nz/for-health-providers/primary-care-sector/primary-health-organisations Accessed 21 November 2024

Some consumers told us that, having moved to a new location, they were unable to enrol at a local general practice. Instead, they remained enrolled with their original general practitioner and used virtual consultations. This creates a challenge when a public service referral is required, because the technology to support cross boundary referrals is not generally available.

General practice staff reported that there are 'perverse incentives' in the capitation model encouraging high patient to general practitioner ratios. This means that some practices have technically open books with large and unmanageable list sizes for individual general practitioners.

However, the increasing number of high-needs patients need more care, more often.

> *"High needs patients need the best possible care, and the funding formula perversely incentivises the opposite of that."*

Long term sustainability

General practice staff told us they were concerned about the effects of closure of neighbouring practices and retiring general practitioners.

> *"Average age of general practitioners [here] is 72 – about to retire, so* [here] *will be a region without general practitioners."*

> *"Still have open books – feel a keen responsibility to maintain local books… Every consult we do in general practice is losing money at present…If we are asked to take on another 5000 patients* [due to a neighbouring practice closing]*, we simply can't afford to do it."*

Equity and very low-cost access

Restricted access has affected populations differently, with Māori, women and disabled people in particularly having worse access to primary care. Very low-cost access (VLCA) practices are a case study of the complexity of provision, and how funding policy decisions can have perverse effects.

As VLCA practices have a higher proportion of patients with greater health need, they are eligible for higher capitation payments, but have more restrictions on the amount of co-payment by patients.

Overall, more VLCA practices are enrolling new patients (66 percent of practices compared with 60 percent overall), although there are large areas of the country with no VLCA practice enrolling.

Staff in VLCA practices we interviewed, the majority of which were Māori providers, confirmed this trend, reporting that they continued to have open books in keeping with their philosophy. They report taking on

> *"*[patients] *that the other services don't want."*

> *"*[with] *multiple comorbidities and health issues, mental health, alcohol, drug…"*.

However, the maintenance of open books was costly and increasingly financially unsustainable with some practices reporting the *"biggest debt levels"* they had ever had, with patients with multiple comorbidities requiring more contacts than planned for under capitation funding and with limited means to meet the already reduced co-payments.

As a result, some of these practices were no longer offering extended opening hours to manage finances, potentially losing income:

> *"If our patients go to after hours, there is a claw-back. If we can't do extended hours, our capitation will get eaten away by after-hours attendances."*

Whilst VLCA practices could raise the patient co-payment allowed in the recent increase (4 percent) practices were reluctant to do this as many patients already had limited ability to pay.

> *"Attend Iwi provider general practice service, cost is great compared to other general practice services." (consumer).*

Those who worked in VLCA practices told us that the VLCA funding model needed updating to reflect the healthcare needs of enrolled populations.

> *"It never made sense… a practice with 50 percent VLCA got the same funding as a 90% VLCA practice."*

These participants told us that some funding arrangements had ceased (or were about to cease), directly impacting their ability to service high needs patients.

> *"Used to have access to wellness funding – used to be unlimited for wellness consults. Is now capped. Used to claim $50-60,000 per month, now have access to $7,000…have to look at general practitioner to patient ratio as a result of that…Sitting at one general practitioner to 800 patients and still have a 3-4 week wait – reflective of the clinical complexity of the whānau we see – see us for a higher number of consults than other practices…89 percent high needs in Mangere – VLCA model, really struggle financially."*

> *"And thanks too to Te Aka Whai Ora, we were able to get some rongoa contracts that have meant that we have invested a lot in designing our own Māori wellness service. And so that's definitely at risk...because Te Aka Whai Ora obviously is disestablished and so there's no protection around Māori focused contracts."*

Flow on effects of restricted access

Difficulties in accessing primary care mirror and contribute to pressures on access to specialist public hospital services. The following section has examples of how this is happening. The interactions are complex, and to the best of our knowledge not fully modelled or understood anywhere in the system.

Access to Pharmacy

Pharmacy staff told us that people were increasingly seeking their help because of reduced access to general practices.

“As a seven-day pharmacy we are seeing very sick people who refuse to pay to see a doctor and when we tell them that [they need to see a doctor] they either take up more of our time or get angry at us and the health system.”

“The demand is ever increasing. Patients are stressed as they cannot get in to see their doctor. They are coming to pharmacies for help. I feel hamstrung as often I can see solutions to their problems but by law I cannot provide them.”

“Big increase in demand for extra services and for triage by pharmacist - reflecting the long wait times at the doctors.”

“We are very much a triage service for minor ailments especially since our accident and emergency provider closed next door due to a lack of general practitioner availability.”

Access to imaging services

General practice staff report variation in access to imaging services.

“We had a process where there was a bit of discretion about what we could and couldn't order if someone had a community services card… And now this varies across the country. You know, you might be able to order an ultrasound scan in Christchurch, but not in Wellington. I can order scans in Wellington, but I can't order them in the Hutt Valley.”

“Long-term lucky in Canterbury – can do a lot ourselves…Initial x-rays, bone density scans…Modest reduction in diagnostics.”

“In Auckland and Counties…we basically have access to diagnostic scheme. It's not funded enough. So, most people run out of their budget, but you can send somebody to a community radiologist and have a procedure done. Counties don't do any scans in the public sector at all, they all go into the private sector …we are allocated the budget. It's very common that that budget is used up on the first two weeks of the month and then if you get somebody that needs to be investigated at the end of the month…I have told them come back next week and I can give you the voucher and it will be free.”

General practice staff indicated that ultrasounds were difficult to access.

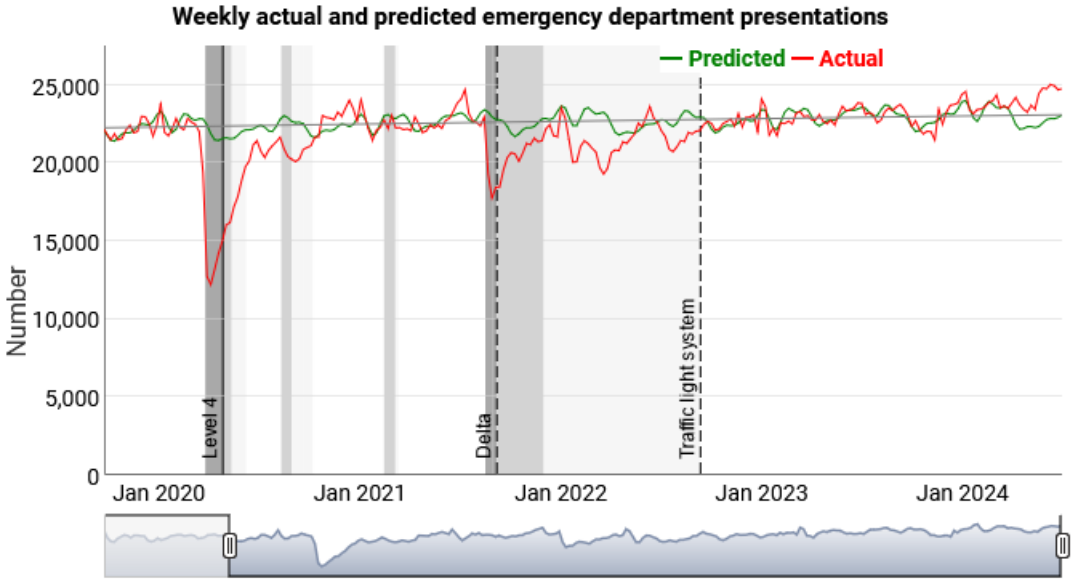
Access to secondary care

The interactions between primary and secondary care driven by restricted access are complex. There is a hypothesis that where general practice care is restricted, there will be an increase in potentially inappropriate presentations at ED. Data does not support this hypothesis.

Whilst for the first time since the pandemic, ED presentations are higher than the long-term trend (see figure 1), this is entirely driven by higher urgency cases.

The lower urgency triage four and five, which might be expected to increase if ED was straightforwardly “substituting” for GP appointments has fallen by 15 percent, while the most urgent triage one and two have increased by 30 percent.

Figure 1: ED presentations



What these figures may reflect is people with long term conditions are becoming sicker while being unable to access primary care and subsequently presenting at ED as a very urgent case.

Other explanations include the general increase in age and sickness of the population and the flow on effects of reduced access to primary care during the pandemic. Further analysis is required to understand this more fully.

General practice staff told us that more referrals for specialist treatment were being declined. In some cases, this led to worse outcomes.

> *“Certainly, we are noticing more referrals being declined and sometimes even genuine ones. So… I mentioned the case of the lady with presumed sarcoma, she's finally been found… the ongoing saga of that was that the sarcoma clinic eventually replied to my third referral and said ‘Oh no, we can't see her. She needs to be worked up at Middlemore’, which is where we sent the first referral to in the first place… it's now four months since the original referral, even longer since the scan and you've done nothing about it…and that's something that is supposed to have an urgent pathway.”*

> *“I know a man that was referred by his general practitioner to get tests in Christchurch which he was refused. The general practitioner apologised and continued to refer him. On the third or fourth referral he finally got the tests and specialist appointment. He now has permanent damage, having to*

permanently rely on crutches, and has to regularly see his general practitioner because of the time it took to get help. He can now only work part time."

Declined referrals also impact general practices, including increased resource requirements to support patients awaiting specialist assessment or definitive treatment.

"While waiting for first specialist appointment we will see them more frequently – pain relief and escalating interventions…If you don't make the referral and wait until the problem escalates before you make the referral, will see them more during that time."

"Capitation works on the basis of an estimate of how many visitations an average patient would make in a year…When we can't access the services that patients need, we are seeing them 2, 3, 4, 5 times more than we are paid for under the utilisation agreement…So it ends up that their general practice who has signed up to look after them ends up holding the risk for the failing public health system. We end up personally paying for that. It's not the managers at the DHB, it's not the senior medical officers at the hospital. It's not the bureaucrats at Te Whatu Ora…the funding formula is beyond broken and we are left holding the risk."

General practice staff also told us that declined referrals alter general practice referral patterns

"There is a learned helplessness around not making the referral. When rejected often it is just that your patient doesn't meet the threshold for care and there is no suggestion as to what else you can do."

As a learned behaviour pattern this carries risks of worse outcomes.

"Sometimes don't refer. Hips are a good example – lingering and come back more often…Colonoscopies are difficult…Feels like there is an inevitability about adverse events."

Declined referrals reflect changing acceptance thresholds in public hospitals. General practice complaints were not necessarily about the threshold change happening, but the lack of communication about changes. One general practitioner reported being uncertain when to refer and that

"Health pathways don't reflect practice."

Primary care adaptations

When asked to describe what was positive about general practice currently, some general practice staff told us about the adaptations they had made to become more efficient and responsive to the needs of their community. Staff told us about the increased use of:

- Information technology to support virtual consultations
- Employing nurse practitioners, with around 800 now employed around the country

- Multidisciplinary teams, including the use of paramedics for acute triage and prescribing pharmacists
- Use of telehealth *"where services have completely fallen over"*
- Extending skills of individual general practitioners
- Point of care testing (although not consistent across the country)
- Rural chest pain pathways
- Relationships with community and iwi health providers
- Nurse prescribing
- Comprehensive primary care teams and integrated clinics.

> *"In some ways it's good for us because we don't actually highly rate the current mental health system or the service that our whānau get and we actually think our own mental health services are better."*

A community pharmacist told us about how they collaborated with other providers in proactive and innovative ways

> *"I am a rarity in that I have been in the same position/role in a small rural community for the past 27 years. This gives my team and I the ability to recognise the significance of various scenarios and take action before harm is caused. The ability to be proactive and grease the wheels by having a positive relationship with the local district nursing staff is also a huge strength.*

Some consumers were supportive of these adaptations, especially where they were perceived to have resulted in improved access to care.

> *"The triaging system works well. Emergency slots are available each day and we have been able to get in on the same day."*

> *"Cost is not an issue (approx. $19). Another factor that I feel contributes to positive health is the amount that the practice integrated into the community, if there is a community event, the team is there. If there is a remote marae, the team is there (in the mobile health hub camper van). The practice comes to the people."*

> *"My health centre has quite a large group of general practitioners, but they are heavily booked and it's sometimes difficult to get a fast appointment. However, they also have a group of nurses on duty and if you need urgent help, you can get either a phone consult or an appointment with a nurse (I think of the nurse team as a triage team). If you are seen by a nurse and they deem your need urgent to see a doctor, they will push open an urgent appointment for you."*

However, these adaptations had limitations or were sometimes seen as a stop-gap measure.

“The services are trying to use telehealth but really we need investment in nurses, better ways of working and a communication strategy to inform ways that communities of need are not disadvantaged.”

While alternate workforces such as extended care paramedics and prescribing pharmacists provided increased capacity, there were limits to how much they could absorb the increased need in the community.

“Very defined scopes of practice. Grey areas get referred back to a general practitioner”.

Some practices implemented a model where a senior general practitioner would support a multidisciplinary team but noted that this additional capacity was not supported by the current funding arrangements.

Lagging factors – patient experience and outcomes Primary Care (factor 13, 15, 16, 17)

Experience

Whilst the primary care survey (with data through to August 2024) shows evidence of reduced access to care, in general, the experience of quality of primary care remains high once accessed.

There are consistently high levels of performance in questions such as being treated with kindness and respect, being listened to, and having confidence in doctors and nurses.

In our consumer survey, effective communication was particularly appreciated by those caring for elderly or disabled family or whānau members.

"Respectful care: The doctors treat my parents with genuine dignity and respect. Their compassionate approach helps create a trusting environment, which is so important for us as a family.

However, some consumers reported examples of reduced consideration being shown

“I have faced challenges with general practice over the last three months. At my general practice, I found it especially difficult due to the general practitioners visible fatigue, irritability, and unprofessionalism, which created an impression of rudeness during our interaction.”

“Wham, bam thank you ma'am attitude. No consideration for age, gender or culture. Too busy.”

“The kaimahi are generally amazing. However, they are over-burdened and over-stretched, and this leads to less capacity for compassion.”

Lagging factors – UPDATED patient experience and outcomes in secondary care (factor 13, 15, 16, 17)

While this report is focused on primary care, there has been a substantial update in quantitative data covering hospital services since our last report. To reflect this, we present an update on outcome and experience in secondary care.

Since our last report we have updated the inpatient experience survey, the quality and safety markers (measuring specific safety outcomes), the quality alerts and the perioperative mortality explorer. Some of these indicators point to increased system pressure.

As with the primary care survey, most measures of experience are keeping consistently high scores (and higher than we saw ten years ago), but there are isolated examples in some locations of worsening responses to questions which could relate to system pressure. These include, ‘nurses always listened’, ‘patients always had confidence in their doctors’, and ‘help to use toilet’.

Most outcome measures that Te Tāhū Hauora routinely monitors have remained consistent (reflecting improvement over 5–10 years ago). The notable exception is pressure injuries, whether acquired inside or outside hospital, which have increased by about 20 percent. This is often seen as a nursing sensitive indicator, so is likely an effective marker of system pressure. Taken in line with new alert data concerning patient experience (factor 13) and quality processes not undertaken (factor 6), this provides evidence of increasing direct negative effects of system pressure on outcomes

New data from the perioperative mortality explorer points to a reduced standardised mortality ratio for surgical patients between 2012 to 2023 nationally, with reductions in disparities between Māori, Pacific and non-Māori, non-Pacific for elective surgeries. In part this reflects an increase in the proportion of higher risk surgical patients, particularly since 2020. There is no evidence of increased perioperative mortality in 2023 (the most recent full year).

There is geographic variation in outcomes. Looking at 2020 to 2023 only, there is a common pattern of higher mortality in mid-sized North Island districts (Lakes, Mid-Central, Northland, Taranaki, Waikato).

Appendix 1: Our approach

Quantitative measures

Patient experience surveys

We conduct national patient experience surveys to regularly collect, measure and use patient experience feedback for quality improvement. Every three months, a national selection of adult hospital and primary care patients are invited to participate. Children under 15 years are not surveyed. Participation is voluntary and anonymous.

We conduct three national surveys: the adult primary care patient experience survey, the adult hospital inpatient experience survey, and the adult hospital outpatient experience survey.

This report uses data from the primary care survey and the adult hospital inpatient experience survey.

Quality safety markers as reported to Te Tāhū Hauora

We collate a series of quality and safety markers to evaluate the success of quality improvement programmes that have been implemented and whether these result in the desired changes in practice and reduction in harm.

Quality measures are dependent on district reporting and there is varying level of engagement with quality alerts across different regions of the country.

Perioperative mortality data

As part of the national mortality review function, Te Tāhū Hauora publishes the perioperative mortality explorer. This online dashboard provides information on surgical mortality rates for elective and emergency surgeries.

Perioperative mortality refers to deaths that occur during the hospital admission for the index surgery or within 30 days of the surgery.

Differences in perioperative mortality by age, ethnicity, gender, and deprivation level, as well as between surgical specialties and groups of surgical procedures can be viewed in the explorer.

Health New Zealand measures

We obtain quality and safety indicators from Health New Zealand (released 30 August 2024). Included in this report are the following measures:

a) System flow: 28-day unplanned readmission rate.

b) Clinical workforce.

c) Vacant FTE (as at 31 March 2024).

d) Medical locum spend (June 2024).

Qualitative information

Consumer survey

To supplement the information from patient experience surveys, an email invitation was sent to members of Te Tāhū Hauora consumer groups to participate in a short questionnaire: Te Kāhui Mahi Ngātahi Consumer Advisory Group, Kōtuinga Kiritaki Consumer Network and Ngā Kōrero Māhuri Young Voices Group.

We received 37 responses to the survey. The geographical distribution of responses is presented in Table 1.

Table 1: Geographical representation of consumer survey responses

District	Number
Manawatu	10
Auckland	5
West Coast	4
Wairarapa	3
Capital & Coast/Hutt Valley	3
Tairāwhiti	3
Southern	3
Nelson Marlborough	2
Otago	2
Canterbury	1
Te Manawa Taki	1

Consumers were asked to respond to two questions:

1. In your experience, what has worked well in general practice over the last three months?
2. Have you or someone you know experienced challenges with general practice in the past three months? If yes, please describe.

Health workforce interviews

Thirty general practice staff members were invited to take part in a 30-minute interview. A snowball recruitment technique was used, whereby participants were invited to nominate colleagues who might also be interested in participating.

Of those invited, 28 were available to participate in an interview. Table 2 provides an overview of the districts represented, while Table 3 outlines the roles represented. Note: we have not provided a description of roles by district to maintain the confidentiality of participants.

Table 2: Distribution of workforce respondent districts

District	Number
Capital & Coast/Hutt Valley	4
Northland	3
Auckland	3
Bay of Plenty	2
Southern	2
Taranaki	1
Nelson Marlborough	1
Counties Manukau	1
National – General Practice Owners Association	1
Waikato	1
Tairāwhiti	1

Table 3: Distribution of roles represented

Role	Number
General practitioner	8
Clinical director, PHO	2
Practice manager	2
RNZCGP	2
Nurse practitioner	1
PHO Chief Executive	1
Primary care HNZ	1
General practice owners association	1
Community rheumatologist	1
District manager, PHO	1

Interview participants were asked six questions:

1) What is working well in the health system at the current time?
2) What is your capacity to manage new patients from within your community?
3) What changes have you seen regarding the interface between hospital and general practice as a result of the dissolution of DHBs and ongoing changes in Health New Zealand?

4) Has anything changed recently to impact on your ability to manage patients in the community, for example accessing community diagnostics?
5) Have you experienced reduced access to specialist services? If so, what has been the impact and do you have any specific examples of worse outcomes as a result?
6) From a general practice perspective, what are the biggest safety risks you see in the system as a result of the recent changes within Health New Zealand?

Participants were also invited to provide additional comments at the conclusion of the interview.

Pharmacy survey

We also include responses to a survey of community pharmacists in this insights report.

The survey was distributed to all members of the Pharmaceutical Society of New Zealand. Approximately 70 percent of the membership list are registered pharmacists working in community pharmacies.

Participants were asked to respond to five questions:

1) What has been working well in community pharmacy in the past three months?
2) Have you noticed changes in the demand for community pharmacy services in the past three months?
3) Have there been any changes in the interface between hospitals, general practice and community pharmacies as a result of the recent health reforms?
4) From a community pharmacy perspective, what are the most significant safety risks you see in the system as a result of the recent health reforms and pressures on general practice?
5) Is there anything else you would like to share with us about working in community pharmacy at this time?

We received 16 responses to the survey. Geographical distribution of the respondents is presented in Table 4.

Table 4: Distribution of community pharmacy respondents

District	Number
Southern	4
Capital and Coast	4
Auckland	3
Central North Island	2
West Coast	1
Nelson	1
Northland	1

Appendix 2: Clinical quality and safety monitoring framework (expanded) updated January 2025

New data from the Dec 2024 Quality Alerts, Nov 2024 hospital and primary care survey, and soft intelligence have been highlighted in yellow)

Te Tāhū Hauora
Health Quality & Safety Commission

Leading/Lagging (Structure/Process/ Outcome)	**Factor**	**Status**	**Evidence:** 1 - Health NZ evidence assessment from expert group 2 - Te Tāhū Hauora analysis of workforce and consumer evidence 3 - Measurement	**Synthesis and direction of travel including expert panel insights**

Leading/Structure	1. Are the necessary quality structures (e.g. clinical governance groups, clinical risk reporting pathways) in place?	**CONCERN** – not fully in place plus loss of structures at the interface between primary and secondary care	**1 – Health NZ evidence**
			Clinical governance groups and reporting pathways:
			• Clinical governance structure available August 2024.
			• Regional structures a priority – not fully established.
			• Regional clinical governance groups established in two regions (not Northern, Te Waipounamu). Groups need alignment (for example standard terms of reference).
			• National structures in place:
			  ○ Cross-sector National Quality Forum established (meets every 3 months). Forum to escalate national issues/concerns
			  ○ Newly established ELT Quality & Safety Committee replacing Board committee (CQAC)
			  ○ National Clinical Governance Group (NCGG) well-established.
			Clinical risk reporting:
			• Updated organisation risk policy due to be published.
			• National Chief Quality & Safety is developing an - issues escalation protocol and strengthening clinical risk reporting.
			
			2 – Te Tāhū Hauora
			• A mixed level of engagement from different parts of the country around quality alerts – pointing to flows between local and central not being in place yet.
			• Clinicians identify reduced layers of safety as a particular risk.
			
			Clinician interviews: General Practice Oct 2024
			• Shared clinical governance structures between primary and secondary care disrupted.
			• Clinical governance within general practice not funded and hard to support without this.
			• These issues are exacerbating the integration/ boundary issues noted elsewhere in the evidence.
				The structures that enable quality are not fully in place, but this is not just a matter of establishing structures and procedures but also reestablishing relationships
				
				There is a wide sense that existing quality structures were degraded (and in some cases removed) with the creation of Health NZ and that the needed multi-level structures have not been created to replace them. This particularly applies to being able to act as locally as possible but having the necessary escalation and capability support routes.
				
				Some concern of waiting for "new and improved" (i.e. waiting for a new clinical governance framework) infrastructure rather than using the current, perfectly serviceable (2017) one.

Leading/Structure	2. Is near real time data for immediate safe management of services consistently available and used	**PARTIAL CONCERN** – not consistently available	**1 – Health NZ evidence** • Many districts still using paper eg do not have electronic vitals, eLab orders & results, ePrescribing, e-referrals. • Lack of information about status in community & primary care. **2 – Te Tāhū Hauora** • Issues with the referral interface between primary and secondary care (even with e-referrals). • More difficulties with access to specialist, non-urgent, services. Reported by consumers, general practitioners (more referrals being refused), and secondary workforce (less able to attend to elective surgery). • Pressure of work causing people to be less responsive than they might have been previously. • Concern about the reduction in non-clinical roles impacting on data collection. • Auckland district report unable to participate in next survey because new IT system unable to provide an inpatient list. IT issues picked up in Herald story. Potential implications of this on data to support safe care appear significant.	Concern about the inconsistency of digital supports to quality (especially lack of forcing functions which then required the right individual clinician behavioural choices when these are more tenuous in a pressured system). There is a widespread concern that disinvestment in digital is likely as a result of current fiscal restraints. As well as a direct effect on safety, this also reduces the opportunity to use technology enabled alternative care pathways to address supply demand mismatches.

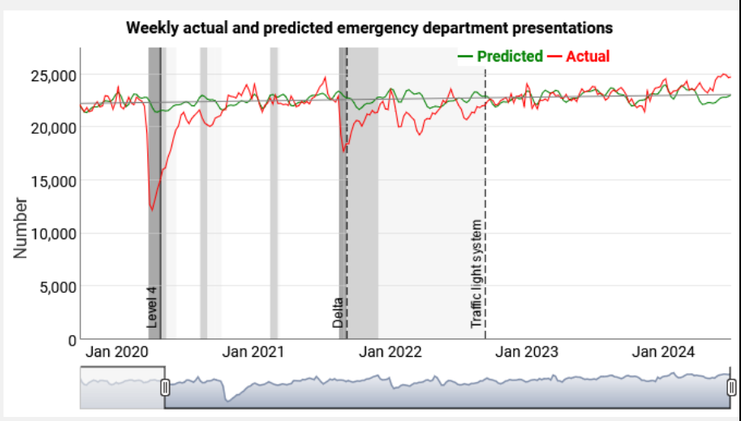
Leading/Structure	3. Is the necessary clinical workforce in place and engaged	**CONCERN** – not fully in place in either primary or secondary care	**1 – Health NZ evidence** • Workforce shortages in particular professional groups of concern: midwifery, mental health, MITs, anesthetic technicians. • Workforce shortages in particular locations – rural hospitals Northland and West Coast.	Available data and gathered intelligence triangulate to that pressures on availability of staff are real and a risk. There are particular hotspots in terms of professions and locations While clinicians interviewed by HQSC suggested that engagement

			• Increase in locum expenditure year on year.
			
			2 – Te Tāhū Hauora
			
			Clinician interviews
			• Highlighted staff shortages and a sense of constant pressure resulting from these.
			  ○ Safety concerns raised due to lack of workforce include
			  ○ Increased relying on locums.
			  ○ Loss of surgical lists.
			  ○ Patients not being adequately reviewed.
			  ○ Jobs done quickly not thoroughly.
			  ○ Operating on minimum standards.
			  ○ No slack in the system or reserve when things go wrong.
			• Clinician interviews suggest that engagement remains relatively high (although there were concerns that this may decline).
			  ○ Good people working very hard delivering great care for patients
			  ○ Well trained, passionate, committed to providing good care.
			  ○ Skill level of senior providers and registrars.
			  ○ Motivated – people wanting to see improvement and be engaged – though this might not continue (spread thin, trying to do the work of two people), all of the indicators are that things are going to get worse instead of better.
			  ○ Goodwill, dedicated staff.
			  ○ Good service when people are really unwell and need the health system
			  ○ Teamwork – collaborative, doing the best they can with what they have.
			  ○ Clinical supervision – though missing continuing education (junior staff) due to sickness or busyness.
			• Concerns were expressed about what was seen as the impact of rhetoric that only clinical roles matter.
			  ○ Simplistic view.
			  ○ Cannot function without administrative and back-up staff.
			  ○ Undermines the value of enabling functions.
			  ○ Key to system flow.
			
			Clinician interviews General Practice Oct 2024
			• Pay disparities impacting on financial sustainability of VCLA practices
			• Dependence on locums in some areas
			• Instability effects on developing trusting relationships
			• Rural Health Network reports increase in goodwill in commitment but reduction in perceived sustainability
			• Workforce shortages elsewhere impact on ability to manage patients in community
			
			• Restructuring of PFO announced prior to Christmas 2024 includes marked reductions in consumer experience and quality improvement staff – potential concerns about the effects of this on the ability to respond and improve
			
			• Against this appointment of national clinical governance manager points to key positions starting to be filled
			
			3 – Measurement
			• Health NZ data shows 4000 clinical vacancies including 670 SMO and 190 RMO (March 24) It is unclear what the baseline this is being measured against, i.e. were long term unfilled vacancies excluded? what are the baseline workforce numbers?
			• Medical locum costs increased 28 percent from July 2023 to 2024.
				remains high, there were less clear how much longer this may last. This is particularly relevant with regard to capacity for discretionary efforts around quality (see 6 below).

Leading/Lagging (Structure/Process/ Outcome)	**Factor**	**Status**	**Evidence:** 1 - Health NZ evidence assessment from expert group 2 - Te Tāhū Hauora analysis of workforce and consumer evidence 3 - Measurement	**Synthesis and direction of travel including expert panel insights**
Leading/Structure	4. Are there any gaps and assets in the safety infrastructure?	**CONCERN** – not consistently available	**1 – Health NZ evidence** • Infrastructure gaps as above - many districts do not have electronic systems (eVitals, ePrescribing, eOrders, eNotes, eForms). • Do not have a national incident management system (cannot collate adverse events, complaints & risk data nationally). • Te Tāhū Hauora patient experience survey reports hospital cleanliness has remained broadly consistent. **2 – Te Tāhū Hauora** • Any CapEx projects are now on hold and cannot progress even if they have already been started. • Future looking projects for IT on hold – data and digital is a big challenge. • Having to employ retired staff because there is no longer training on the systems we are using. *Clinician interviews:* "Auckland districts, they, you know, they've got e-referrals, they've got e-prescribing, they've got e-vitals, and these aren't fancy things. They're core essential data solutions, but it enables them to be safer, be timelier, help deliver good things and a good, timely way, whereas we just don't have any of that."	CF 2 above – Variability between different parts of country in terms of available safety infrastructure. Fears that fiscal restraint will exacerbate this inequity.

Leading/Process	5. Are quality structures operating effectively? For example, required information flow as needed and is there authority and accountability to act at the right levels.	**CONCERN** – not fully in place	**1 – Health NZ evidence**
			• Gaps in quality and safety data submission (June 2024 Quality Alerts; HRT) due in part to vacancies in district quality and patient safety teams and increasing workload (reflected in increasing numbers of adverse events and patient complaints).
			• Uncertainty among some staff about how and where to report safety concerns. National Chief Quality & Safety is developing an issues escalation protocol.
			• Per Te Tāhū Hauora: our interactions with Health NZ around quality alerts take place with several overlapping groups and we have had a mixed level of engagement from different parts of the country – pointing to flows between local and central not being in place yet.
			• Te Tāhū Hauora: reports of lack of local decision-making capacity stymieing improvement efforts.
			
			2 – Te Tāhū Hauora
			Clinician interviews:
			"Fundamentally flawed and under-valued by Te Whatu Ora"
			
			• Reporting up but no feedback loop.
			• Clinical Director positions dissolved.
			• Decision-making appears to have stalled:
			  ○ Who has the authority to make a call?
			  ○ Who is making the decisions?
			  ○ No strategic planning
			  ○ Lost the power and autonomy to progress things quickly.
			• Current situation:
				CF 1 above loss of relationships and clear lines of accountability, support and information flow. It is not just a matter of structures and collateral (policies etc) not being place, but a loss of relationships, and work routines with the loss of positions and structures.

Leading/Lagging (Structure/Process/ Outcome)	**Factor**	**Status**	**Evidence:** 1 - Health NZ evidence assessment from expert group 2 - Te Tāhū Hauora analysis of workforce and consumer evidence 3 - Measurement	**Synthesis and direction of travel including expert panel insights**
			○ Feels chaotic ○ Systems and processes have broken down ○ Staff are reactive ○ No redundancy in the system (allows for standardisation and flexibility) ○ Constantly at the red line ○ Working against protocols and feeling unsafe. "We almost know that we will have an increase in harm as a result of some of these decisions that are being urgently pushed out and we don't know if there's been due diligence around that process." • Progress on quality reporting being made (e.g. mortality and maternity)	
Leading/Process	6. Is there enough capacity to make discretionary efforts for quality activities? For example, reporting and response to incidents, and collection of data necessary for quality activities?	**CONCERN** - not consistently available **UPDATED DATA**	**1 – Health NZ evidence** • High vacancy rate in quality and patient safety teams in districts contributing to inability to respond to adverse events and patient complaints in required timeframes. • Lack of national data on complaint and adverse event reporting (timeliness, close out). • Consistent pattern of a few districts struggling to report QSM data due to staff vacancies. • Lack of resource funded by HQSC for child and youth mortality reviews has resulted in reduced reviews occurring numerous parts of the country. • Growing disparity between adverse event reporting and ACC claims reporting for always report events. • Labs and MH data has been unreliable. **2 – Te Tāhū Hauora** *Clinician interviews:* • Discretionary effort waning – this includes the capacity to do required reporting, but also capacity to take up additional roles and support the sustainability of the system by mentoring and supervising junior staff. • Lack of recruitment to non-clinical roles has a real impact on clinical governance. **3 – Measurement – UPDATED DEC 2025 DATA QUALITY ALERTS** • Increasing evidence of failure to follow quality processes and report quality data – hotspots for this type of alert Bay of Plenty, Taranaki, Southern and West Coast ◦ Observed hand hygiene compliance has fallen significantly in six districts ◦ While in hospital cardiac arrest remain low, failure to consistently follow correct approaches to managing deteriorating patients are becoming more prominent ◦ Likewise there has been a marked reduction in pressure injury risk assessment and care planning in six districts (at the same time that pressure injury rates have increased). ◦ Six districts failed to collect audit data for one or more quality marker this quarter – with more reporting being missed	There is a reduced ability for the system to identify and respond to risks in a timely manner as well as a reduction in the system to learn, adapt and respond to future challenges. This is evidenced by a deterioration in following good safety practice mandated by quality and safety markers and reporting of safety metrics in the most recent quarter The health workforce draws a direct association between the reduction in non-clinical roles and the ability to collect and report on quality and safety.

Leading/Process	7. Are workforce being supported in quality activities?	**PARTIAL CONCERN** – not consistently available	• Insufficient and inequitable distribution of quality improvement resource in regions and districts. • Restructuring of PFO announced prior to Christmas 2024 includes marked reductions in consumer experience and quality improvement staff – potential concerns about the effects of this on the ability to respond and improve •	See factor (5)
Leading/Lagging (Structure/Process/ Outcome)	**Factor**	**Status**	**Evidence:** 1 - Health NZ evidence assessment from expert group 2 - Te Tāhū Hauora analysis of workforce and consumer evidence 3 - Measurement	**Synthesis and direction of travel including expert panel insights**
Leading/Process	8. Is increasing, changing or mismatched demand for services creating risks to available service supply measures: interpreted whole-system patient pathway?	**CONCERN – mismatches along care pathways across both primary and secondary care systems, interactions between the two exacerbating problems which manifest ultimately as delayed and restricted access to care**	**2 – Te Tāhū Hauora** *Clinician interviews:* "We have reasonable triage systems in our GP practice, but patients don't always hear that and when they are experiencing barriers anyway…they just stop ringing…and then they get so sick that they have to go to hospital, or they suffer…and that is happening a lot more for Pacific and Māori than it does for other patients." "We are seeing more referrals declined…planned care where people are left waiting…people on the waiting lists are using primary care so much more than anyone else. Waiting is placing demand on community and primary sector…adds to the burden when we are trying to reduce the number of contacts." "Lost a list last week because there was no staff – regular loss of surgical lists, not able to do what are contracted to do because of staffing issues and the acuity of those who need a response." *Consumer survey responses:* "I have waited six weeks for my last GP practice consult, and regular consult times have been reduced by 33 percent. I have had to rattle off all my issues in a very short period, which has meant my GP has not captured everything as there were too many points to cover off." "From recent experience, with the harsher cost-saving and resource-tight measures I've had two specialist referrals rejected where I believe, otherwise, I would have been seen. Told not worth investigating and so nothing can be done. I wouldn't be able to be seen in the time-windows expected, so not being seen at all or cut out due to stricter requirements."	Primary care access seems as perfect storm of increased closed books (thus likely growing numbers of non-enrolled patients), increased activity (reflecting growing demand) and greater barriers even for those who can access care (largely associated with longer waits to access care). However the precise nature of increased pressure in GP (i.e. increase in higher urgency – less "substitutable" cases) suggests no simple linear links between pressure in different parts of the system Figures showing restricting access to care which triangulate with consumer and clinician intelligence. There is evidence that the nature of demand (more than the total quantum) is changing and becoming more complex and urgent. However, more data is needed to fully understand the risks associated with restricted access. This includes understanding whole patient pathways including discharge into ongoing care, acute admissions of patients already on the waiting list. Cancer Control Agency data is likely to be particularly important here. There appears to be a pattern of more and more urgent patients appearing at EDs that has developed over the last six months. Previously there was pressure associated with more urgent patients, now there appear to be greater numbers of patients also. 

Leading/Lagging (Structure/Process/ Outcome)	**Factor**	**Status**	**Evidence:** 1 - Health NZ evidence assessment from expert group 2 - Te Tāhū Hauora analysis of workforce and consumer evidence 3 - Measurement	**Synthesis and direction of travel including expert panel insights**

Leading/Process	8. Is increasing, changing or mismatched demand for services creating risks to available service supply measures: interpreted whole-system patient pathway?	**CONCERN - mismatches along care pathways across both primary and secondary care systems, interactions between the two exacerbating problems which manifest ultimately as delayed and restricted access to care**	*Clinician interviews General Practice Oct 2024*
			• Workforce shortages elsewhere impact on ability to manage patients in community – long range system impacts on secondary presentations (vicious cycle)
			• IN CONTRAST A POSITIVE is the development of adaptations to address changes in supply and demand match such as telehealth, Nurse Practitioners (800 in the country), MDTs in primary care etc – however sustainability of this without the funding model aligning with this.
			• Access to primary care services limited (recognised by clinician and consumer interviews) this includes long wait times and inability to enroll (implying a cohort who cannot access general practice at all)
			• Ageing workforce in pockets (72 average age claimed in Northland)
			• Financial structures create perversities:
			  ○ Disincentives to open books – equity issues around VLCA.
			  ○ Open books even though unable to actually provide services (e.g. 1 GP with 5000+ patients)
			  ○ Capitation funding not covering actual activity
			  ○ Insufficient funding for community-based diagnostics
			• Changing in referral practice noted (less likely to refer) against a perception of greater likelihood of referrals being declined
			
			3 – Measurement – UPDATED DATA QUALITY ALERTS AND PATIENT EXPERIENCE SURVEYS
			• GP QED data suggest an increase in primary contacts of 9 percent in 2024 compared with a year earlier.
			• In the last quarter there has been an increase 24 per cent of respondents nationally who have been unable to access primary Some form of increased difficulty in accessing general practice is reported in nearly all parts of the country.
			• Among patients who can access care, increased barriers seem to be affecting all groups
			• 40 percent of practices have closed books nationally, with variations:
			  ○ Auckland in general is around 25 percent,
			  ○ Canterbury around 50 percent
			  ○ Wellington more than 50 percent
			  ○ In more rural parts of the country only a quarter to a third of books are open.
			• Increase in self-discharges from ED since before COVID-19 and mortality rate within 30 days among this cohort with 3 hotspots.
			• The most recent analysis of ED presentations using REACH shows a renewed increase in presentations in the six months to June 2024, of about 1500-200 extra attendances a week. This is the first time since COVID that actual presentations have exceeded the historic trend-based predictions.
			• The switch from lower to higher urgency presentations has accelerated. Comparing 2023 onwards with the pre-pandemic average Weekly Triage 1-2 presentations have increased by around 29 percent, and triage 3 by 13 percent while triage 4-5 have fallen by 15 percent.
			• Increases in child ASH admissions compared with the pre-COVID-19 period. Inequitable impacts – an increase in the disparity in ASH rates between Māori and non-Māori in 12 districts. Health NZ data from RAPID suggests that Child ASH this may have stabilised in the last year, but this points to a “new normal” which is more inequitable and putting more pressure on hospitals	

			• Provisional peri-operative mortality calculations suggest a long-range and broadly linear increase in risk of the patients operated upon (supporting the hypothesis that patients are becoming more complex over time). • Acute admissions as a percentage of all admissions have increased slightly since before COVID-19 (while W/L admissions are slightly lower, but the changes are not dramatic at an overall national level). However, local pressure points exist: there are substantial “swings” from elective to acute admissions in Canterbury, Nelson Marlborough, Counties Manukau and Auckland districts.	

Leading/Lagging (Structure/Process/ Outcome)	**Factor**	**Status**	**Evidence:** 1 - Health NZ evidence assessment from expert group 2 - Te Tāhū Hauora analysis of workforce and consumer evidence 3 - Measurement	**Synthesis and direction of travel including expert panel insights**
Leading/Process	9. Modelling of likely effects of delay on acuity and complexity	**CONCERN** – concerns expressed by clinicians, and emerging data supports the conclusion that access difficulties are creating feedback loops that are making for sicker patients accessing the system. Fuller data and analysis are required to fully understand the effects, risks and potential solutions	**2 – Te Tāhū Hauora** *Clinician interviews:* • Acute work going up, limited capacity, elective work being delayed leading to compounding problems. • People who should have had a simple procedure are becoming more complex and likely costing the health sector more. • Transfer to other centres for diagnostic procedures enhances the likelihood that they will be lost to the system and not receive the care they require. **3 – Modelling/ measurement** • Early analysis suggests that there has **NOT** been an increase in the proportion of patients admitting acutely with long term conditions who have not been able to access primary care in the period around their acute admission. This requires more work but suggests one of the obvious feedback loops between primary and secondary care access has not been occurring.	Additional work is required for a more robust model, but there is common thread of evidence from clinician interviews that the effects are being seen.
Leading/Process	10. Are appropriate pathways for the management of disease consistently available?	**MORE DATA NEEDED**	**2 – Te Tāhū Hauora** *Consumer survey:* "An ongoing issue for our rural community is delays in prescriptions from our one and only pharmacist – waiting for hours (days) for prescriptions, even after calling the day before to ensure the pharmacy has received the prescription order from their doctor… many of our community live rurally. They travel long distances to their doctor's appointments and to the pharmacy, so there is a cost in time and dollars that is distressing for our small, rural, low socio-economic town. Another concern is that many of our community are elderly and some live by themselves. Getting their meds is challenging enough, without the added risk of taking the wrong pills." **3 – Measurement** • New diabetes atlas shows a small increase in appropriate medication being dispensed since 2018 but some hotspots of low dispensing and reasonably consistent inter-ethnic disparities. Admissions for diabetic complications are low.	This approach is likely to be valuable for addressing specific conditions and patient groups where risks may manifest. This is work that needs to be developed over time – including e.g. ANZICS-QI data and Atlas updates.

Lagging/Process	11. Are there disruptions or other changes to patient flows that raise concerns about safety risks?	**MORE DATA NEEDED**	**2 – Te Tāhū Hauora**
			
			Clinician interviews:
			• Concerns about:
			  ○ Safety of hospitals overnight
			  ○ Rushing people out the door
			  ○ Discharge from hospital to aged residential care with high and complex needs
			  ○ Daily risk of being unable to staff ED
			  ○ Lack of continuity of care (primary care shortages).
			
			"A large number of undifferentiated patients who may or may not be high risk. The normal systems of waiting times have blown out. We need to think about how we put a safety net around those people."
				A clear view of concern expressed by clinicians about processes through hospital not operating optimally with safety implications. Current data inadequate to triangulate with this. Ambulance ramping and corridor use likely useful as measures to explore this (seeking available data now for next. Mental health KPIs.

Leading/Lagging (Structure/Process/ Outcome)	**Factor**	**Status**	**Evidence:** 1 - Health NZ evidence assessment from expert group 2 - Te Tāhū Hauora analysis of workforce and consumer evidence 3 - Measurement	**Synthesis and direction of travel including expert panel insights**
			3 – Measurement • Health NZ data 28-day readmission rates are essentially flat over the last year, at around 8 percent. • The reported experience of discharge from hospital in patient experience surveys in terms of information and support available remains stable (even showing slight improvement since before COVID-19).	
Lagging/Process	12. Is there any evidence of unwarranted variability or risk in prescribing/dispensing practices in hospital or community?	MORE DATA NEEDED	**2 – Te Tāhū Hauora** *Clinician interviews:* • Aged residential care experiences: ○ closure of primary care resulting in delays and barriers in appropriate care and barriers in transferring residents to definitive care ○ Precipitous discharges from secondary care with poor discharge processes, not having the right prescriptions, not having their medications by 5pm on Friday.	
Leading/Outcome	13. Are there any rapid changes in patient experience of care at a local level?	MONITOR	**2 – Te Tāhū Hauora** *Consumer survey responses:* "Incredible, versatile staff." "Opotiki after hours - can't stay there even though they have beds there." "Dialysis: waiting list, long travel to access it, stressful." "If you get an ambulance in, then the hospital service is great, but any other way to get seen in the hospital, just forget it." *Consumer survey responses: General practice Oct 2024* Some reports of pressure leading to unprofessional/ rude behaviour Lack of continuity of care (different doctor each visit) **3 – Measurement - UPDATED DATA HOSPITAL SURVEY/QUALITY ALERTS** • Most aspects of hospital patient experience are stable with no significant changes since 2020. However, at a national level there are shifts down over the last 18 months for several measures which include "nurses always listened", "nurses treated with kindness and respect", "Trust and confidence in nurses", "help to use toilet", "pain relief as needed", "cultural, spiritual and individual needs met". Against this involvement in patients and patient family and whanau in care is reported to have improved, as has communication about medication. • In all cases these changes are relatively small (a few percentage points) but occurring with enough consistency to achieve statistical significance under SPC rules. • One hypothesis to explain this dichotomy may be that the improving measures can be affected by better clinical governance practice while the deteriorating ones are more affected by system pressure reducing time for ward staff. • • Primary care patient experience survey: Ability to access healthcare and time spent waiting at the surgery for a walk in appointment are worse than 2021 baseline, otherwise reported experience is stable with an increasing number of questions	Patient experience of care once they have accessed services remains broadly consistent. However, there is strong evidence of increased barriers for accessing services in primary care and examples of worsening responses to specific survey questions which plausibly relate to system pressures within hospitals. Decommissioning of local consumer groups and consumer councils will impact on the ability to identify rapid changes in patient experience of care at the local level.

			including those around non-discriminatory treatment trending towards improvement. Once primary care is accessed, patients are tending to report a good experience.	
Leading/Outcome	14. Do ACC treatment injury and other claims data reveal any patterns that point to changes in safety?	**CONCERN –** need ACC support for data & interpretation	**3 – Measurement** • Long term general trend of increase in claiming for treatment injuries – these are generally consistent with events reported in 15 (e.g. Pressure Injury Increase). • But interpreting is complex – changes in claiming behaviour points to not just than change in events but also underpinning safety cultures and pressures.	Conversations started with ACC to consider how these data can be included and interpreted. Data necessarily are lagging (as a claim has to be made after the event) but changes in patterns and how these triangulate with forms of discretionary reporting can be revealing of safety cultures and pressures.
Leading/Lagging (Structure/Process/ Outcome)	**Factor**	**Status**	**Evidence:** 1 - Health NZ evidence assessment from expert group 2 - Te Tāhū Hauora analysis of workforce and consumer evidence 3 - Measurement	**Synthesis and direction of travel including expert panel insights**
Lagging/Outcome	15. Are there any concerning trends in complications and harms?	**PARTIAL CONCERN** **UPDATED DATA**	**3 – Measurement - UPDATED DATA QUALITY ALERTS** • Updated data until September 2024 in the most recent Te Tāhū Hauora Quality Alert (released December 2024) safety outcomes shows the following developments ○ Pressure Injuries both in and out of hospital onset are alerting more frequently (now in 14 districts with broad spread across region, urban/rural, size and deprivation). ○ The increase seen in Post-operative DVT/PE is becoming less widespread – now seen in the Central region almost exclusively ○ Other outcomes remain stable including in hospital falls with a FNOF ○ There remain local hotspots with 3 or more safety outcomes deteriorating – most notable MidCentral, Auckland, with Canterbury and Southern newly alerting this quarter •	Workforce interviews and responses to the consumer survey (see indicator 6) indicate that there is the potential for concerning future trends in complications and harms to emerge. These relate to current barriers in accessing preventative or early response treatment and care, and the impact this has on patient health seeking behaviour, and subsequent impacts on complexity and risk of patients entering secondary care. The most recent quality alerts point to increased pressure injuries becoming a more widespread problem both in terms of in and out of hospital in. This is often seen as a nursing sensitive indicator so is likely an effective marker of system pressure. Taken in line with new alert data concerning patient experience (factor 13) and quality processes not undertaken (factor 6), this provides evidence of increasing direct negative effects of system pressure on outcomes.
Lagging/Outcome	16. Are mortality rates changing?	**PARTIAL CONCERN** – need further analysis	**3 – Measurement - UPDATED PERI-OPERATIVE MORTALITY EXPLORER** • NZ HDXSMR [redacted] appears to be higher than a year ago. [redacted] • North Shore Hospital and Waitakere HDxSMR April 2023 -March 2024 needs further investigation - data anomaly. • [redacted] HDxSMRs show some variance between districts with degree of triangulation between in hospital mortality and other safety markers. • New data from the peri-operative mortality explorer points to a reduced standardized mortality ratio between 2012 and 2023	Early review of new peri-operative mortality reveals no significant increases in risk adjusted mortality rate, but: • widespread variation with Waikato, Mid Central, Lakes and Counties Manukau appearing to have higher SMR than elsewhere • a marked increase in the proportion of higher risk surgical patients particularly since 2020, in part reflecting an increase in acutely admitted patients. Release of the full explorer later this month, a wealth of information for further investigation available through this.

			nationally, with reductions in disparities between Maori, Pacific and non-Maori, non-Pacific for elective surgeries. • No evidence of increased peri-operative mortality in 2023 (the most recent full year) • Looking at 2020 to 2023 only, there is a common pattern of SMRs greater than 1 (i.e. more deaths than expected) in mid-sized North Island districts (Lakes, Mid Central, Northland, Taranaki, Waikato) and also Counties Manukau. • A new alert this quarter is a raised in hospital mortality ratio for patients with pneumonia at Waikato – this is a long standing trend but is notably inconsistent with the country as a whole where SMR for patients has fallen over the last three years in particular	
Lagging/Outcome	17. Qualitative review of HDC complaints and AE investigations to consider common 'deep' causes	**MORE DATA NEEDED**	*This work is to follow.*	

Quality alert heatmap – this shows the districts and alert subjects that are widespread in this quarter's alert release (numbers in cells are number of individual alerts within an issue) – yellow highlights are hotspots (many alerts this quarter). There are four issues widespread across the country, and 7 districts where at least 5 issues apply.

	Issue 1 - access/flow		Issue 2	Issue 3	Issue 4	Issue 5	Issue 6	Issue 7	Issue 8	Isolated issues					
District	Access primary care	Child ASH – not updated	ED self-discharge – not updated	Post-Op DVT/PE	Press. Injury	SAB	Missed reporting	Equity – not updated	Hand hygiene	Patient deterioration	SSI Orth	SSI Cardiac	Pneumonia mortality	N updated issues apply	**Total update flags**
New Zealand	3	1	1	1	2	0	0	8	0	0	0	0	0	3	**6**
Auckland	3	0	0	0	2	0	0	3	0	0	0	1	0	3	**6**
Bay of Plenty	3	2	0	0	5	0	8	3	1	0	0	0	0	4	**17**
Canterbury	4	0	0	1	4	1	0	2	0	0	0	0	0	4	**10**
Capital&Coast/Hutt Valley	0	0	0	1	0	0	0	2	0	0	0	0	0	1	**1**
Capital & Coast	3	0	0	1	1	0	0	0	0	0	0	0	0	3	**5**
Hutt Valley	3	0	0	1	0	0	0	1	0	0	0	0	0	2	**4**
Counties Manukau	2	1	0	0	1	0	0	3	0	0	0	0	0	3	**8**
Hawke's Bay	1	3	0	1	3	0	0	2	0	0	0	0	0	3	**5**
Lakes	2	1	0	0	0	0	0	4	1	1	0	0	0	3	**4**
MidCentral	2	1	1	0	0	0	0	2	1	0	0	0	0	2	**3**
Nelson Marlborough	2	0	0	0	2	0	0	0	0	0	0	0	0	2	**4**
Northland	0	2	1	0	1	0	0	3	1	0	0	0	0	2	**2**
South Canterbury	2	0	0	0	0	0	0	0	0	1	0	0	0	3	**3**
Southern	2	0	0	0	3	0	3	2	1	0	1	1	0	6	**8**
Tairawhiti	1	0	0	0	0	0	2	1	0	0	0	0	0	2	**3**
Taranaki	2	0	0	0	1	0	8	0	0	0	0	0	0	3	**11**
Waikato	3	1	0	0	1	0	0	2	0	1	0	0	1	4	**5**
Wairarapa	1	0	0	0	6	0	0	0	0	0	0	0	0	2	**7**
Waitemata	3	2	0	0	4	0	0	3	0	1	0	0	0	3	**8**
West Coast	1	0	0	0	0	0	4	0	1	1	0	0	0	3	**7**
Whanganui	2	0	0	0	1	0	0	2	0	1	0	0	0	3	**4**
N districts present in	**20**	**9**	**3**	**6**	**15**	**1**	**5**	**16**	**6**	**6**	**1**	**2**	**1**		**131**