Appendix 1: Descriptive results from the June 2025 Insights Report

Introduction

This is the third report from the Health Quality & Safety Commission Te Tāhū Hauora (the Commission) 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 in general practice, secondary services and aged-residential care.

These insights are a continuation of the reports produced in 2024.

Process

The following data sets were assessed for this reporting period:

a. Patient experience surveys published in May 2025
b. All data within the Commission's June 2025 quality alerts
c. Health sector staff across a range of disciplines were invited to take part in a 20-minute interview to share their view of the quality and safety of the health system. Interviews occurred between April and the end of May, 2025 (n=12).

   The participants were a mixture of those who had previously participated in our quarterly reports and new participants. They were from general practice, secondary care and aged-residential care. We included practitioners and safety leads, ensuring representation from local, regional and national level.

   Interviews continued until we reached a point of saturation, where the interviews were traversing topics that had already been covered.
d. Interviews with consumers.

Findings

Where relevant, within this description of the findings, we have referenced the measures listed in the Quality Framework in Appendix 2 and the Heat Map, presented in Appendix 3. This section aligns with those we have presented previously where we first discuss the people, then the infrastructure, and finally our perception of the culture of the health system.

The people

The interaction between staffing and perspective

In our interviews with the health sector workforce and consumers, we start by asking them to describe what is good about their current experiences with the health system. Generally,

their first response references the quality of the staff that they work with or who care for them.

In our June interviews, we also found that workforce participants reported some experiences that suggested the system was beginning to settle after a prolonged period of change. Again, in general, these responses focused on the impact of this settling on staff and the environment in which they work. We have captured these responses in Box 1.

Box 1: Evidence of settling or promise in the health system

"More connected – connected system nationally and linked to regional structures"

"Genuine willingness to collaborate"

"Staff were kind – across the whole hospital – fantastic improvement since previous engagement. Felt like a culture shift"

"Tough few years, but it feels like there is light at the end of the tunnel"

"When you have good staff, everything just feels better…It is nice to come on a ward as an educator at 7am and not have the anxieties of clinical work to deal with on top of the educator role."

"The increase in new grads has reduced the fear and stress associated with coming into work".

"Great initiatives – rural health internship programme – nurses, midwives, physios"

For some workforce participants, there was a sense of relief as the staffing levels had picked up since the beginning of the year. In particular, they referenced new graduate midwives, a second intake of graduate nurses and improved registered nurse availability for aged-residential care. Aged-residential care reported that they were able to recruit additional registered nurses due to low levels of nurse recruitment within secondary services as well as increased funding support for graduate nurses.

We note, however, that these experiences are not universal, and some sectors continue to experience difficulties with staffing. Indeed, while the positive changes listed in Table 1 were greeted with enthusiasm, there continued to be caution as the increases were not sufficient to fill staffing gaps in the majority of areas (see Measure 3, Appendix 2).

Continued pressure

> *"We are constantly fighting fires instead of taking preventative approaches".*

Through our interviews we heard of local, person driven examples of staff going above and beyond to support the provision of clinically safe services, as examples of discretionary effort being maintained. As examples of staff staying on shift longer and missing breaks they described:

> *"Productivity is high, but there is a mismatch of resource to demand".*

> *"Have had to rely on dedicated staff going above and beyond to provide safe care… Getting used to prioritising the care we can give rather than the care that women need and are entitled to".*

"I think we manage to provide safe care because of the amazing staff that go above and beyond".

"Going the extra mile even though they are exhausted and under pressure".

"Dependent on the staff being willing and able to work at 200 percent".

"We use TrendCare for planning. It tells us that we are drastically understaffed".

We anticipate that it is this ongoing expended effort in the face of uncertainty that ensures there are no dramatic shifts in patient outcomes, and positive measures of patient experience are able to be maintained (Measure 13, Appendix 2). However, we also note that these responses are potentially unsustainable and provide evidence of ongoing gaps and unwarranted variation.

Further, we could not identify discretionary effort in the form of addressing needs that became apparent through their work. In particular, we note below that the workforce are reporting they simply don't have the time to take part in quality improvement initiatives.

It is because of these responses that we continue to hold concerns about the gaps in staffing. We note that staff shortages appear particularly problematic in areas where there are a high proportion of patients with complex health needs (Measure 3, Appendix 2). For example, as one of our workforce participants described:

"Poor in particular areas. Capacity is very unbalanced. Insufficient GPs resulting in practices closing their books – have sufficient nurses and paramedics but not enough GPs. [Workforce shortages are] especially problematic in high needs areas (Porirua, Northland, South Taranaki, parts of Hawkes Bay), with latent capacity in some areas such as Auckland…Porirua has all practices closed…High and middle classed practices won't accept patients from high and complex (low SES) areas – every complex patient that signs up to our practice we lose money on".

The infrastructure

As shown in Appendix 2 (Measure 4), we continue to hold concerns about the infrastructure that exists for maintaining the quality and safety of the health system.

Access to services

Pathways for the management of disease unable to be enacted

In our discussions with consumers, there was a view that advocacy was necessary to ensure that health needs were met.

"Had I not actually quoted the Pae Ora legislation in dealing with my koro… to make specific notes on his chart… He's not to be discharged without consultation with his next of kin… he would have been sent home in a taxi,

two hours in the middle of the night, back to his house. That is a safety issue on so many levels".

However, concern was also expressed that *"not everyone has an advocate"*, the implication being that those who don't will miss out on care. Further, where there has been a breakdown in the relationships between primary and secondary care, compounding staff shortages and high workloads, there is the potential for patient safety risks from this lack of advocacy (Measure 11, Appendix 2), as reported by consumers:

"Lost all confidence [in ability to access care]. Has got a lot worse this year. Difficulty getting proper diagnosis and care even when people are strong advocates [for themselves]…Requires a lot of flexibility on the part of the patient…Particular difficulty getting ACC approval for diagnostics (MRI) – quality of life deteriorates while waiting".

Participants in our workforce survey highlighted the need for the Commission to raise systems issues such as the impact of hospital pressures on general practitioners whose workload increase as a direct result. This is a factor of the interconnectedness of the health system. In this section, we raise systems issues as a reflection of health pathways not able to be enacted (Measure 10, Appendix 2).

"Hospital issues are being placed back on general practices. Letters from the hospital provide instructions on patient follow-up, but general practice don't have the capacity. [There are] requirements for follow-up from secondary care [that] do not fit into 15 min GP appointments. [The] clinical responsibility falling to GP, leading to an unsafe system".

General practitioners feel that they are being placed in a context not of their own making, which is out of their control and for which they are carrying the clinical risk. For example:

"Rely a lot on primary care to continue to support people. Regular monitoring for adverse reactions to medicines falls to the GP – no formal shared care arrangements. Pressure in primary care can result in patients being referred back when they could be managed in primary care – need resources and clinical confidence in primary care…Where there is poor continuity of care people will fall through the gaps".

This is further compounded by the inoperability of patient management systems between primary and secondary care, increasing the potential for risk through patient transfers.

Our workforce participants also expressed concern about those who were waiting to be seen in emergency departments and those who were waiting for first specialist appointments. They recommended that there is further consideration given about providing safety nets for patients in these situations:

"Triage system within ED can't cope with the capacity – greatest risk is at triage 2 and 3…Can do some safety netting initially. [Also], first specialist appointments, the clinical grading around these patients can't cope with the volume of patients…Are there sub-groups of patients within broader clinical grading classifications that need to be focused on?"

Clinical governance

In this set of interviews, we were able to document the beginnings of the establishment of structures for clinical governance (Measure 1, Appendix 2), although issues with decision-making authority and feedback loops appeared to continue to exist.

"What is the governance structure? Who is in charge?"

This quote highlights that there remains uncertainty about who holds responsibility for making decisions about actions to take in response to safety concerns that are raised (Measure 5, Appendix 2). Further, while there have been changes in models of service delivery, there is concern that clinical governance is not keeping up with the changes being put in place:

"Clinical governance not keeping up with the development of new initiatives – what are the standards for acute care paramedics in general practice right now? Is there transitional training available for people transferring from ambulances? Is there a minimum standard for people delivering care? - system is not sufficiently adaptable to adjust to changes in how services are delivered".

We were told of regions where regional leadership teams and joined up systems are being established, and there are the foundations of clinical governance structures. In addition, reviews of clinical governance structures were being undertaken with the aim of surfacing good examples.

However, we note that there continue to be problems with clinical governance functions such as robust systems of mortality review within localities, centralised incident management and ineffective complaint resolutions.

General practitioners and aged-residential care workforce members expressed concern that there were not structures in place that allowed shared learnings across organisations at the national level.

There is an overlap between clinical governance systems and structures and access to information technology (Measure 2, Appendix 2), as described below:

"Data on its own without narrative is not a lot of use – ensure that the data speaks to staff. Walk people through reports, dig into underlying causation".

"Need to get information back out that is meaningful and helps make improvements to quality and safety (re adverse events)".

"Systems and structures need to be identifying risks and supporting change".

"Closing the loop on alerts – support clinical staff to understand the data so they support driving change".

Our workforce participants reported that time is the greatest impediment to undertaking quality improvement initiatives. Of those who were interviewed, when asked why they didn't participate in more quality improvement initiatives, most reported that they simply didn't have the time to do so (Measure 6, Appendix 2). While we note that regional quality leads have been appointed, there appears to be a continued disconnect between these appointments and the capacity of staff for engaging in quality improvement initiatives, suggesting that quality improvement initiatives are yet to be fully prioritised by senior leaders (Measure 7, Appendix 2).

Information technology

Almost universally, participants in our workforce survey indicated that they were aware data and information to support clinically safe service provision existed, but they didn't have access to capable staff to make the most of this resource (Measure 2 and Measure 4, Appendix 2). This relates specifically to the ability to undertake quality improvement activities, as the staff whose role it was to analyse and make information available to support quality improvement have been disestablished.

"Biggest challenge is enabling services – data analytics, and audits at the district level – project expertise and resource. [There needs to be consideration of how to] support this at the regional level if it isn't going to be available at district level".

"Reforms have disrupted quality, safety and assurance data collections".

"Quality assurance and safety have been on a backslide in the last few years – reforms have disrupted data collection and reporting. Health New Zealand has not had the capability or capacity to pick up the work. Don't have great confidence in reports coming out of Health New Zealand – personnel and expertise that used to reside in Ministry of Health wasn't transferred when the reporting functions were. Quality & safety aspects have been neglected".

Interviewees also noted that while dashboards and other options for accessing data were available, *"dashboards aren't visible on the floor, [and I] have to go searching for what I want"*. This includes going to *"figure out someone who might then be able to go and get the data for me"*. Without this support available, there was concern that services were *"running blind"*.

Interview participants expressed concern about the lack of alignment of data collection systems at the national level, an inability to proactively identify and manage risks, and a

post-code lottery for access to e-vitals and other digital systems. As e-vitals provide health sector staff with the ability to manage multiple patients concurrently, staff raised this as a potential safety issue where access to this technology did not exist.

> *"Electronic vitals provide real time responsiveness to support staff working with patients. [They] can provide an indication of patients drifting in the wrong direction that might not be picked up by one individual looking after 10 patients. Real-time safety system".*

There is an overlap between the difficulties accessing data, lack of capacity for quality improvement activities (as described above) and the dissolution of clinical governance structures that are now being re-established. Engagement with quality and safety data at national, regional, local and ward levels enables safety to be at the forefront of minds in day-to-day operations, as well as supporting safe care, as described in the case of e-vitals. Such systems exist[1] and are an essential component of an effective clinical governance system.

Clinical service planning

Our workforce interviewees also reported positive adaptations that had occurred in response to ongoing difficulties recruiting general practitioners and to ensure continuity in the wider health workforce.

Comprehensive primary care teams were noted as a positive development, supporting the sector to grow alternate responses to the general practitioner led response model. We spoke with workforce members who were prepared to seek solutions to the difficulties that they faced and consumers who were appreciative of the options that were now available:

> *"We are introducing supported discharge home service – includes transitional clinical support provided at home: district nursing and physio care".*

> *"Our clinic open to trying new things, being innovative about improving health. Unique and incredibly solutions-focused".*

> *"An ACC counsellor has started coming to the rural clinic weekly. It is just for the sensitive claims. Originally it was once every two weeks, but demand driven to increase to weekly".*

Roles such as prescribing pharmacists, extended care paramedics and health coaches were increasingly becoming a feature of general practice. In secondary care, initiatives such as Maternity Care Assistants and rural placement programmes were viewed as mechanisms for encouraging graduates to stay in the teams they are placed with during their training.

In response to limited general practitioner support available for aged-residential care, 24/7 nursing support is being trialled by larger providers, which is also providing additional support to internationally qualified nurses and those who don't have English as their first language.

Resourcing that doesn't equate with demand

[1] For example, see: https://visualsystemshealthcare.co.uk/boards/quality-and-safety-boards/ (accessed 11 September 2025)

As an explanation of the continued pressure on staff, the participants in our workforce interviews noted that, as well as needing additional people, there was a need to ensure that capacity, capability and equity was considered when planning for service continuity (Measure 8 and Measure 9, Appendix 2). For example, a general practitioner from Porirua described to us:

> *"Current wait list of 400 people. We have people on the phone crying every day".*

Rural general practitioners reported an increase in the use of locums to provide coverage for staff shortages. However, due to an increase in the price for locums, there was increased financial pressure on those practices. They also reported that use of locums reduced the continuity of care for patients and, where locums chose to only be involved in telehealth, reduced physical access to services. Further, increased use of locums increased the supervision burden for senior practitioners and reduced their ability to engage staff in quality improvement and clinical governance.

> *"More difficult for PHOs to apply clinical governance to a transient workforce. [This] creates risks".*

Staff shortages in secondary care continue to have flow-on effects on general practice. There are concerns that there is a lack of understanding of the complexity of needs that present to general practice, and insufficient resourcing to support the additional effort that is required (Measure 11, Appendix 2). To address this, general practitioners recommend the development of shared care arrangements, regular monitoring of adverse events and resourcing to support their efforts. We note the overlap between the quote below, which discusses increased scope of general practice and shifts in approaches to delivering services, highlighted in the clinical governance section above. Both highlight the need for robust, permanent clinical governance structures that are responsive to the changing health care environment.

> *"[It is] not just about capacity, also about capability. We need people who can work at the top of their scope and manage the complexities faced…Two registrars came in, but both left because they couldn't deal with the complexity of what they were seeing on a daily basis. Need to be able to deal with advanced medical issues on a regular basis… Complexity not well understood by the system".*

Aged-residential care also described mismatches in skill mix of staffing in response to a cohort who are increasingly frail. Combined with difficulties accessing after-hours general practitioners in some areas, and an increasing reliance on paramedics and emergency departments, there was a concern of increased risk of delirium and pressure injuries for their residents (see also Measure 15, Appendix 2 and Quality Alert Issue 3, Appendix 3).

At present we have insufficient data to fully describe the impact of the lack of integration between primary and secondary care. We anticipate being able to report on this more fully in subsequent reports.

Culture

On-going frustration

As noted above, there are green shoots and pockets of optimism amongst the workforce. However, there remains a continued sense of frustration at the changes, the length of time these are taking to be embedded from both staff and consumers, and a failure to understand local context when making decisions.

> *"Health New Zealand is in a state of paralysis following the restructuring. Extremely centralised decision-making compounding this".*
>
> *"Normalisation of low staffing".*
>
> *"Parts of the health system don't recognise that it is very difficult to access staff".*
>
> *"ED overflowing with people with health needs that should have been seen in primary care, but they can't get to a GP".*
>
> *"Detached from reality: Women from South Auckland needing to travel to West Auckland to get a scan [can be over an hour each way] – not easy to achieve if the resources aren't available for this. Eg Taxi vouchers don't address the need to look after other children".*
>
> *"How do you get across the hill if NTA decline you? Rural areas historically underfunded and no one really cares. No public transport options. Provincial NZ really hurting".*
>
> *"Can't get [health staff] to work in the area because of lack of available housing".*

There is also a perception from primary care staff of inequities within the system, such as hospital specialists being paid to attend meetings while general practitioners need to fund their own way.

> *"I think there's a problem and we see this all the time in terms of what goes on… we need equivalence. But then you get the situation that arises, those specialists that come out of the tertiary or secondary sector are paid for their time. So, if they go to one of the meetings, they are paid for that…The GPs are expected to do it for free. Unacceptable and something the system does not acknowledge…End up with inequitable representation, which results in problems with validity".*

While it is important to test the veracity of such comments,[2] the perceptions of differential treatments can lead to distrust, grievance and an unwillingness to engage with new structures as they are developed.[3]

While there is the potential for improvements to be occurring, change fatigue and reduced tolerance for ongoing change remain a feature of the culture of the health sector.

> *"Staff in general not in a good place. Significantly protracted health reform process and the multiple change processes and uncertainty around all that. Adds to the stress of their job".*

[2] We note that payment for attendance at bodies for which the Crown has an interest is guided by the Cabinet Fees Framework. To attend such meetings, GPs may need to arrange locum cover for their practice. The Fees Framework sets fees at a "fair but conservative basis" (page 13) and will therefore not fully cover the costs incurred to attend meetings.

[3] We have made minor changes to this section to improve clarity of the information presented.