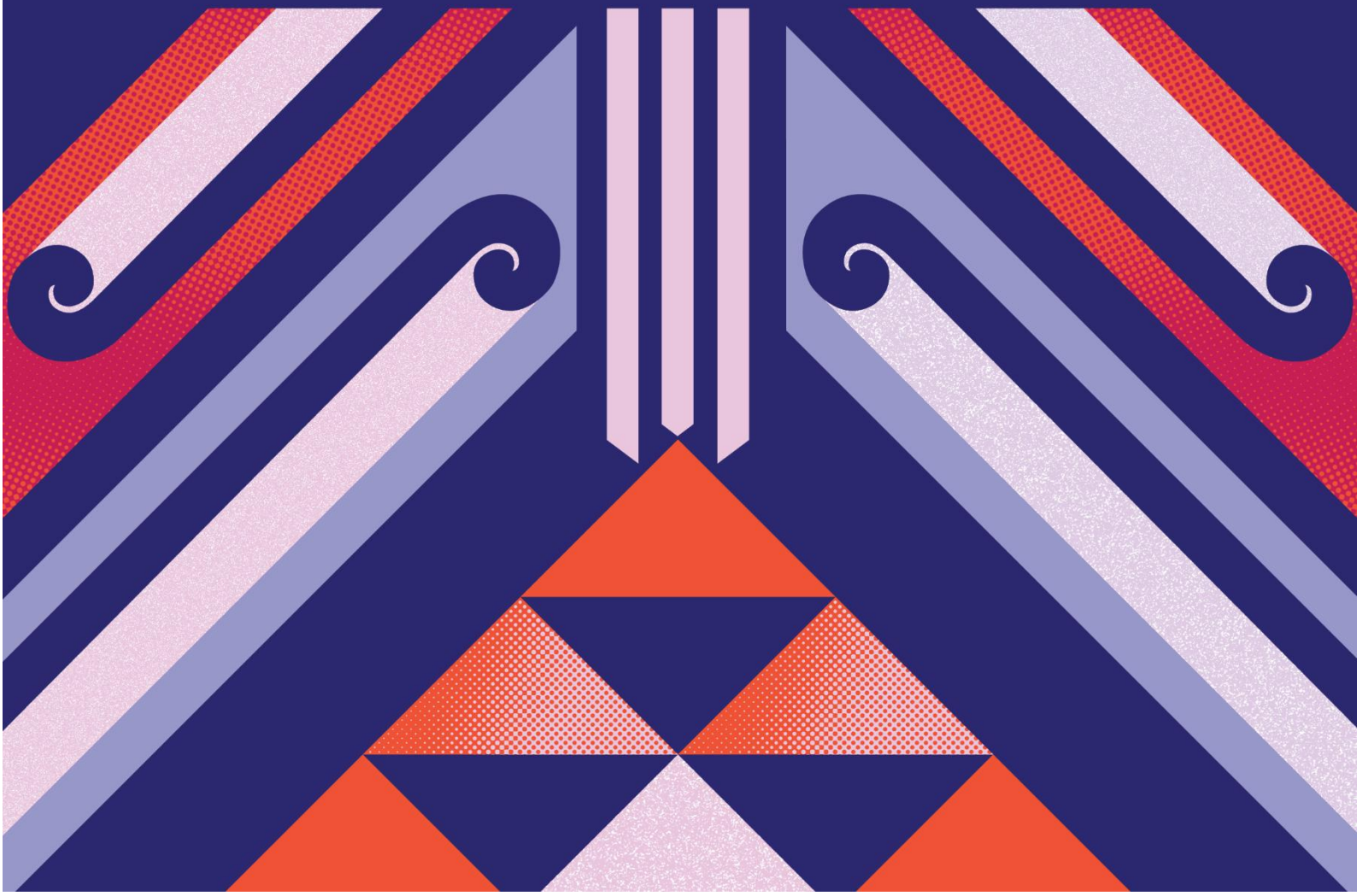
Te Tāhū Hauora
Health Quality & Safety Commission

System Quality and Safety Insights Report Four

September 2025



Contents

Introduction

The *Quality and Safety Insights Reports* are a series produced by the Health Quality & Safety Commission Te Tāhū Hauora (the Commission) on a quarterly basis. They provide information to the Minister of Health on the quality and safety of the health system and insights to the wider sector to support system change.

Each report is a compilation of data collated by the Commission and intelligence from interviews with the health workforce and consumers. This information is considered by an expert advisory group to provide an assessment of the current status of factors contained in the *Quality Assessment Framework (the Framework).*

Each quarter *the Framework* and associated quality alert heat map are presented alongside interview data. On a periodic basis, these will be supplemented with a special topic focus. The special topic for this report is an analysis of integrated pathways for acute care, included as a supplementary paper.

In Report Four we also describe initiatives that are being put in place by the Commission and our health sector partners to address these issues. These initiatives have been developed to support system change.

The methods used across the series of reports are included in Appendix 1.

Insights summary

Report Four describes the current status of quality and safety in the health system. This marks one year since these reports were first commissioned.

The report describes emerging and longstanding issues.

Emerging issues include:

a) Lack of capacity for quality improvement initiatives *(Framework, factors 4 and 6).*
b) Lack of senior leadership support for quality improvement *(Framework, factor 7).*
c) Increased disconnect between central leadership and local service provision.
d) Lack of analytic capability and support to access data that may support safe, high quality health care *(Framework, factor 2).*
e) Lack of functionality of systems for reporting and responding to safety concerns *(Framework, factor 5).*

Long-standing issues include:

a) Funding models for service delivery, although we note the proposed recalculation of the capitation system to be considered in 2026.
b) Adequately resourcing rural and low socioeconomic communities *(Framework, factor 10).*
c) Difficulties retaining international medical graduates to support building the necessary clinical workforce *(Framework, factor 3).*
d) Inconsistent access to care pathways across communities *(Framework, factor 10).*
e) Increased cost of treatment injuries *(Framework, factor 14).*

Some of these issues are being addressed by adaptation within the sector and we discuss both the positive and negative aspects of this in our report.

Workforce

In Report One, we described a reduction in discretionary effort evidenced through reluctance to take on additional roles and cutting corners to finish on time. This evidence continues to build, with some members of the workforce reporting they no longer have the capacity to undertake quality improvement initiatives *(Framework, factor 4).*

Where discretionary effort is still willing and able to be applied, staff from across the sector are doing so because they feel it is necessary to provide safe, high-quality care amidst chronic staff shortages *(Framework, factor 3).* However, the ability to expend this effort is waning.

Those who work most closely with patients require the support of their administrative and back-office colleagues. Quality improvement systems are dependent on having access to both data and people with the capability to interpret it. Where this is no longer available, systems are beginning to fail.

Despite these challenges, consumers we interviewed continued to tell us that the health system has high quality, committed staff.

Infrastructure

General practitioners told us that the capitation system is impacting their ability to provide effective care, particularly in communities where there is a high proportion of people who have chronic or complex health concerns *(Framework, factor 8).* The capitation model is also impacting on the sustainability of the primary care system and there is concern that the current model can drive inappropriate general practitioner to patient ratios.

Over the 12 months of monitoring, we have evidence of increased demand and barriers to care. Some of the long-term trends in accessing services are worsening. For example, difficulties in accessing primary care can drive patient deterioration. Our data shows this is associated with a higher number of urgent emergency department attendances, which can increase the likelihood of subsequent hospital admission.

Because urgent admissions are increasingly displacing elective admissions, non-urgent patients are being managed in the community. As the condition of non-urgent patients also deteriorate, management of their condition in the community by general practitioners takes additional primary care time and resources, further driving pressure on primary care services.

Legacy information technology systems, data and analytics continue to be of concern as enabling services are reliant on data and analytics to measure and monitor what is going on in the system and to support clinical governance decisions. These issues are also affecting our ability to monitor the system.

Whilst the development of regional clinical governance structures is positive, it will take some time for relationships to be re-established. The interface between primary and secondary care, which was disrupted during the health system restructure, has not yet been re-established nationwide.

Emerging issues

Through our workforce surveys, we have noted both positive and negative adaptations in the health system and a reduction in resource availability.

For those positive adaptations, we highlight the importance of evaluating their impact and ensuring effective clinical governance structures are in place to support new models of care.

The supplementary paper provides more detail on the limited integration of care pathways and the impact this is having on flow through the system. The paper shows that the system is not currently functioning optimally to enable seamless care, with increased acute patients, especially older frail patients admitted to hospital, and a lack of community care options impacting discharge plans.

This will impact emergency department processes and capacity and have flow on effects throughout the whole system. The supplementary paper's findings are linked to both emerging and longstanding issues discussed in our Insights Reports.

Signs of improvement

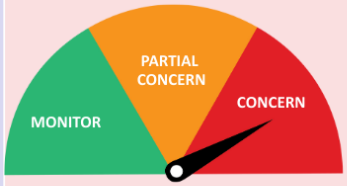
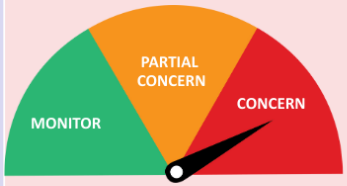
We describe initiatives that are being put in place by the Commission and our health sector partners to address issues described in *the Framework*. These have been developed to support system change and adaptation.

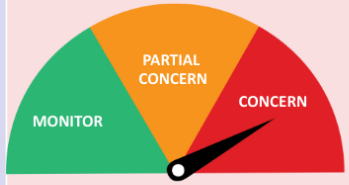
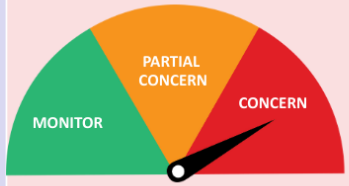
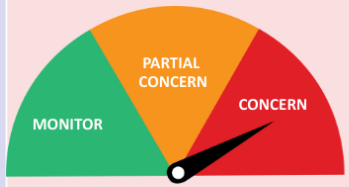
Health Quality & Safety Commission
Te Tāhū Hauora

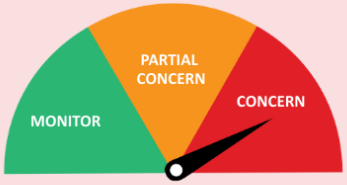
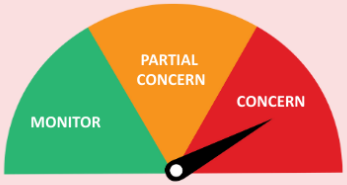
Quality Assessment Framework - September 2025

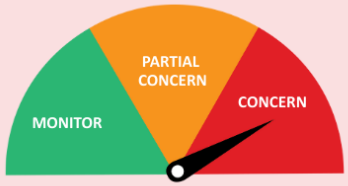
Data from quarter two quality alerts, intelligence from clinician and consumer interviews, and more detailed analysis of the patient experience surveys.

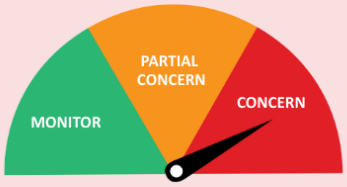
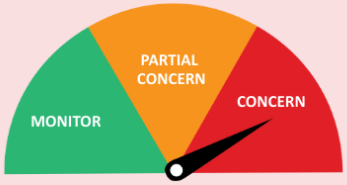
This table should be read alongside the quality alert heat-map on the final page.
The 'status' of each factor is a considered judgement, determined in collaboration with the Expert Advisory Group
*System actions listed are those that have been nominated by Health New Zealand. These will be up-dated as further information is provided by partner agencies

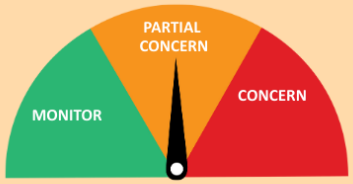
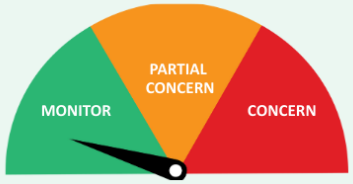
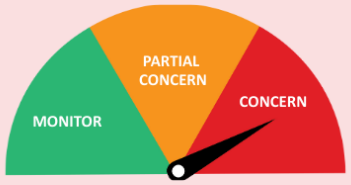
Quality and safety factors	Status	Evidence	System actions to address issues*
1. Structures to maintain quality care are in place, such as clinical governance groups and clinical risk reporting pathways.		It is positive that regional and national clinical governance leadership structures are being or have been developed. HDC has raised concerns about the need for clear, permanent clinical governance structures. "In some cases, we have continued to observe a level of disconnect between districts and the national office… there are opportunities to strengthen the links between regional and national processes and decision-making" (HDC, August 2025) "We have a network of primary care clinical leaders get together on a monthly basis – clinical leaders of PHOs, clinical advisors and health pathways clinical editors. We have attempted to communicate with regional Te Whatu Ora structures, but there is no clinical governance structure to contribute into." (PHO Clinical Lead, June 2025)	Regional clinical governance groups up and running. National Risk Manager appointed July 2025 National clinical governance framework approved by Health New Zealand ELT (July 2025), implemented by end of 2025, with a review of the effectiveness by the end of June 2026. Self-assessment tool for clinical governance being developed. Risk framework being implemented. Extreme and high risks to be transferred to new framework by end of 2025. Escalation process being trialed in Northland.
2. Are we actively monitoring the management and consistent use of services to ensure safety?		Waikato, Wairarapa and Southern all missing large quantities of reporting data in the last quarter. This raises concerns about overall quality and effectiveness of available data. Some of HDC recommendations for local digital improvements are unable to be implemented due to digital workstreams being controlled at the national level. "The biggest challenge is the key enabling services that we are dependent upon, ie data and analytics, audits at the district level, project expertise and resource." (Regional quality and risk manager, May 2025)	Quality and safety dashboard being developed at a national level. HDC open recommendations being provided to Health New Zealand. Working through these for further discussions between Health New Zealand and HDC by the end of 2025.

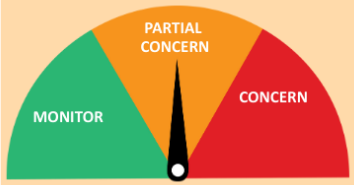
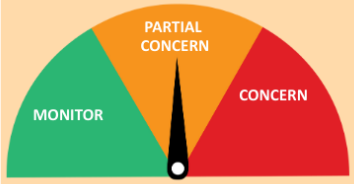
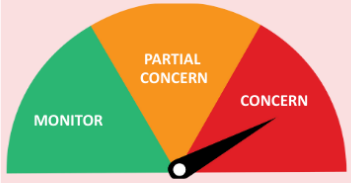
Quality and safety factors	Status	Evidence	System actions to address issues*
3. The necessary clinical workforce is in place and engaged.		**Not fully in place in either primary or secondary care.** "There are two main issues with multidisciplinary teams: finding the [human] resource (clinical pharmacist, nurse practitioners, extended care paramedics…), and providing supervision. (General practitioner, July 2025)." Substantial differences exist in annualised sick leave hours per full-time equivalent by District. May be a reflection of ongoing instability (threat rigidity response). HDC evidence of capacity restraints creating clinical risk. Limited clarity from Health New Zealand concerning medium to long-term planning for service sustainability.	Workforce plan has been developed
4. There are no gaps in the health safety infrastructure.		**Staff have limited capacity for quality improvements** Lack of time is the most commonly reported impediment for engaging with quality improvement initiatives. Quality improvement roles within Health New Zealand not being replaced.	Proposal for developing plan for Quality Patient and Safety functions, including quality improvement resource, going to Health New Zealand ELT 23 September. Ongoing quality improvement training available for frontline staff, including e-learning and 6- and 12-month programmes
5. There is confidence and consistency in the process of reporting safety concerns, and well defined approval and accountability pathways for acting in response to safety concerns.		**Insufficient capacity for reporting and monitoring** HQSC working alongside Health New Zealand to develop a localised approach to perioperative mortality review. However, Health New Zealand's infrastructure is overloaded and senior staff are stretched, making it challenging for them to attend and engage in national quality discussions. Regional quality and patient safety lead keen to work on issues but limited capacity has delayed their ability to respond.	Regional Quality and Patient Safety leads in place, regional reporting being developed. Rapid escalation process in place. Plan for peri-operative mortality review being developed in collaboration with HQSC. Terms of Reference approved, planning to be operational by the end of 2025.

Quality and safety factors	Status	Evidence	System actions to address issues*
6. Staff have the capacity to participate in quality improvement activities. They have the capacity and willingness to report adverse events, near misses and support responses where concerns have been raised.		**Staff reporting, but do have the capacity to participate in quality improvement activities.** Consistent failure to report quality safety marker data due to lack of capacity at Taranaki, Southern and West Coast, Waikato Sustained reduction in hand hygiene compliance observed at Northland, Southern and West Coast. There has been a significant reduction or consistently low levels of pressure injury risk assessment and/or care planning in Counties Manukau, Bay of Plenty, Tairawhiti, Waikato, Wairarapa, South Canterbury. Failure to consistently follow correct approaches to identify and manage deteriorating patients in Waikato (and unable to report in June quarter) and to a lesser extent Mid Central, Taranaki consistently unable to report. HDC reporting reduced ability to respond to safety concerns.	Proposal for quality boards on wards approved by Health New Zealand CEO. Will encourage ownership of quality and safety data and implementation of improvement initiatives. Work to develop the process and template are underway. Plan to roll-out to districts by November and encourage implementation prior to the end of 2025.
7. Senior leaders support and actively promote quality improvement activities.		**Insufficient and inequitable distribution of quality improvement infrastructure in regions and districts.** Insufficient infrastructure being exacerbated by Planning, Funding and Outcome restructure at Health New Zealand, including marked reductions in consumer experience and quality improvement staff, reflected in delays in responding to alerts and less likelihood of taking up (or being offered) quality improvement opportunities in secondary care.	Proposal for plan to develop Quality and Patient Safety functions going to Health New Zealand ELT. Quality system team established in Planning, Funding and Outcomes team, supporting project implementation. Will also support projects from Clinical Governance sub-committees.

Quality and safety factors	Status	Evidence	System actions to address issues*
8. Health service delivery is even and equitable. People are able to access health services when they need. **9. We understand changes in the health needs of the population of New Zealand and the impact of this on services.**		**Evidence of issues for both acute and elective care pathways.** **Acute pathways** Access to primary care remains pressured with more survey respondents reporting delays accessing care. ED attendances have increased but these are in the higher urgency categories – lower urgency presentations have reduced. Acute admissions to hospital are increasing absolutely, as a proportion of all admissions and particularly in occupancy of hospital beds. This particularly reflects the effect of older, frail patients. We estimate that occupancy by this cohort has doubled since 2018, an increase of around 100,000 bed days. Reduced integration of the care pathway is recognised by HDC who believe it reflects capacity constraints in disability and aged care– they have received reports of older people and disabled people being unable to be discharged from hospital due to lack of community and residential supports (including psychogeriatic). **Elective pathway** Preliminary analysis suggests there are hidden waits between first specialist appointment and being placed on the waiting list for treatment and these are growing. HDC report high levels of complaints concerning access to radiology services (an enabler of quality, timely treatment – delayed access to which will add to "hidden waits"). Access to advanced imaging services (e.g. MRI) is particularly constrained in some areas of the country A changing shape of distribution of wait times points to less active management of admissions against wait times. Median CPAC (priority) scores have increased for some procedures. This may indicate worsening of conditions while waiting longer, or it may reflect increased rationing of care.	Ongoing work to look at reducing wait times for diagnostics.

Quality and safety factors	Status	Evidence	System actions to address issues*
10. Pathways for the management of health needs are consistently available and able to be activated.		**Service reductions and differing access threshold across the country result in geographic inequities in access to care** The variations between different parts of the country identified in acute and elective pathway analyses suggest that appropriate pathways for management of disease are not consistently available. The most commonly raised concern at the recent National Quality Forum was a breakdown in system integration.	Initiatives yet to be identified
11. Referrals through the health system can be enacted. There are no pinch-points that increase patient safety risks.		**Lack of community supports for older and frail populations resulting in longer stays in secondary care** The increase in the frailty cohort and the apparent issues around access to step down care (including care at home) creates a larger cohort more at risk of falls and pressure injuries which creates escalating pressures as well as increased harm (and cost – per ACC).	Initiatives yet to be identified

Quality and safety factors	Status	Evidence	System actions to address issues*
12. There is no unwarranted variation in medication prescribing and dispensing within hospitals or the community that could increase patient safety risks.		**More data needed** We will update information on this measure when the Atlas of Healthcare Variation is updated.	National Medicines Committee established. Planning to develop dashboard for medication safety.
13. There are no rapid changes in patient experience of care at the local level.		Responses to the Adult Primary Care Patient Experience Survey reveal that access to primary care has become more difficult. Responses to other questions are generally unchanged or improved since 2020. Most aspects of care in GP surgeries have more positive responses (except cultural and spiritual needs met). This improvement started to occur from mid 2023. Most responses to the Hospital Inpatient Survey questions have improved or stayed the same since 2020. Responses to five questions have worsened: A lower proportion of people report that their cultural and spiritual needs are being met and nurses listen to views and concerns. A lower proportion of patients report discussing their needs on discharge which triangulates with other evidence around disintegration of care pathways (although responses to other discharge questions have remained consistent). A lower proportion of patients report trust and confidence since 2020.	Initiatives yet to be identified
14. ACC treatment injury and claims data do not reveal patterns suggestive of changes in patient safety.		**Need ACC support for data & interpretation** Overall increase in claims volume and value most notably in pressure injury (where increased claims broadly follow what HQSC reports in quality alerts), and infections.	Health New Zealand exploring treatment injury data with ACC to identify opportunities to decease costs.

Quality and safety factors	Status	Evidence	System actions to address issues*
15. Trends in complications and harms resulting from health service delivery do not point to increased risks for patients.		**Pressure injuries remain common** Pressure injuries remains elevated across districts. Most other complications (infections, falls, etc) remain approximately equal to pre-COVID levels. System pressures have not yet led to increase complication rates in the country as a whole but there remain some areas with multiple issues, notably Taranaki and Waikato. We have revised the DVT/PE risk adjustment model to take account of COVID as itself a risk factor for DVT/PE. Application of this model shows that elevated rates were attributable to increased COVID infection.	Discussions have begun within Health New Zealand on work that can be done to address hospital acquired pressure injuries.
16. Mortality rates are consistent throughout the country and between districts.		**Potential variability in intensive care mortality rates** Overall perioperative mortality has reduced over the last ten years, and inequities decreased post 2022. Data from the Australasian Intensive Care Registry indicates that mortality rates may be higher for some districts within New Zealand.	Initiatives yet to be identified
17. Information provided by the Health and Disability Commission or adverse event reporting does not provide evidence of safety risks in the health system.		**Evidence of overall strain in the system** This is the first report in which we have been able to access HDC data. HDC analysis of complaints supports patterns of concern noted in measures 1, 6, 8/9, 10	Initiatives yet to be identified

Quality alert heat map

		Issue 1	**Issue 2**	**Issue 3**	**Issue 4**	**Issue 5**	**Issue 6**	**Issue 8 NEW**	**Issue 9 NEW**	**Isolated issues**							
		Access to primary care	Post op DVT/PE*	Pressure Injury	Missing reporting	Equity**	Hand hygiene	Older people repeat bed occupancy	Child Imms	Patient deterioration	ICU Mortality NEW	*SAB*	*SSI Ortho*	*SSI Cardiac*	Hospital experience	*Pneumonia SMR*	Total issues applying
New Zealand		☑		☑		☑									☑		4
Northern	Auckland	☑		☑		☑		☑							☑		5
	Counties Manukau	☑		( )		☑		☑							☑		4
	Northland	( )		☑		☑	☑		☑			☑			☑		6
	Waitemata	☑	☑	☑		☑		☑							☑		6
Midland	Bay of Plenty	☑		☑	☑	☑	☑										5
	Lakes					☑			☑								2
	Tairawhiti			☑		☑		☑							☑		4
	Taranaki	☑		☑	☑	☑		☑	☑						☑		7
	Waikato	☑		☑		☑				☑			☑		☑	☑	7
Central	Capital Coast/ Hutt Valley	☑	☑	☑		☑									☑		5
	Hawkes Bay	( )		☑	☑	☑	☑	☑	☑						☑		7
	Midcentral			☑		☑		☑	☑			☑			☑		6
	Wairarapa			☑	☑	☑			☑						( )		4
	Whanganui	( )		☑		☑			☑	☑							4
Southern	Canterbury	☑	☑	☑		☑											4
	Nelson Marlborough	☑		☑		☑	☑		☑								5
	South Canterbury	( )		☑											☑		2
	Southern	( )		☑	☑	☑	☑						☑	☑			6
	West Coast				☑		☑		☑								3
Districts alerting		9 (14)	3(2)	16(15)	6(8)	17(12)	6 (4)	6	8	2(1)		*2(1**)*	*2 (1)*	*2 (1)*	12 (9)	*1(1**)*	

Quality alert heat map data for March – Jun 2025 quarter unless stated (italics indicates March 2025).

Vertical yellow lines highlight those issues for which there were alerts for the majority of districts across New Zealand in this quarter.

Horizontal yellow lines highlight those districts that have a high number of alerts for this quarter.

A tick indicates at least one alert inside the issue. ( ) indicates alert turned off

The final row contains the total number of alerts for each issue, with the previous quarter counts in parenthesis. New Zealand total (first row) excluded from the total count of districts alerting. Issue 1 is counted as one alert if either *access to primary care* or *child ambulatory sensitive hospitalisations,* or both alert.

* Post-op DVT/PE uses a revised risk model which accounts for COVID

** Additional equity measures are included in this update which accounts for the additional alerts this quarter

System Quality and Safety Insights: Report Four

People

Exceptional health services are reliant on the discretionary effort and engagement of frontline staff.[1] This goes beyond putting in additional hours and extends to actively engaging with the work, owning problems that appear and working to resolve them.[2]

In Report One we described a reduction in discretionary effort as evidenced through reluctance to take on additional roles and cutting corners to finish on time.[3] This evidence continues to build, with some members of the workforce reporting that they no longer have the capacity to undertake quality improvement initiatives *(Framework, factor 4)*

> "We actually do have something called a quality improvement project where… you could sign up to a quality improvement project for three months where you will do you will still do your regular job, but you'd get one day off a week to work on a quality improvement project and find something in the hospital that you think could be improved…But yeah, no one at the moment is doing them… you have to go to the IMO unit and apply… I just don't think anyone's had it approved."
>
> (Junior doctor, August 2025)

Where discretionary effort is still being applied, staff are doing so because they feel it is necessary to provide safe, high-quality care amidst chronic staff shortages *(Framework, factor 3).* However, the ability to expend this effort is waning.

Our findings correspond with those from the Health and Disability Commissioner (HDC) who reports that compliance with their recommendations have declined from around 96-98 percent in previous years to 91 percent in 2024/25. Reasons for failure to comply include providers leaving the workforce and resource constraints impacting on capacity to undertake quality improvement work.

Further, the HDC have received some complaints where a lack of capacity to undertake quality improvement work (such as updating guidelines) in secondary services has contributed to adverse events.

Quality improvement systems and structures are more stable within primary health organisations (PHOs) and aged residential care than they are within secondary services. However, there is still a need for more effective mechanisms to raise systemic issues rather than individual service providers creating their own response.

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[1] Berry, L.L. and Awdish, R.L.A., 2021. Health care organizations should be as generous as their workers. *Annals of internal medicine*, *174*(1), pp.103-104.
[2] McPherson M. Work-life balance, employee engagement and discretionary effort: a review of the evidence. Equal Employment Opportunities Trust. URL: https://ndhadeliver.natlib.govt.nz/delivery/DeliveryManagerServlet?dps_pid=IE760557 (accessed 4 September 2025)
[3] Health Quality & Safety Commission Te Tāhū Hauora. 2024. Assessing system quality and safety: insights report. September. URL: https://www.hqsc.govt.nz/assets/Core-pages/About-us/Insights-reports/Te-Tahu-Hauora-Assessing-system-quality-and-safety-insights-report-September-2024.pdf (accessed 5 September 2025)

> "System issues not being addressed…[We] have PHOs and escalation pathways, but these don't deal with systems level issues like GP/nurse to patient ratios are blowing out and that isn't safe, can't replace GPs. Who is looking at the system safety issues?"
>
> (General practitioner, May 2025)

In 2024, the Royal College of General Practitioners asked registered members to complete a diary of the hours they worked over seven consecutive days in the summer and winter. The study was undertaken to estimate 'what a fair and reasonable 40-hour week looks like', where 40-hours was considered the equivalent to a full-time role.[4]

Results showed that general practitioners who are employed in a 0.7 full-time equivalent role (being paid for 28 hours per week) were working an average of 40 hours per week in summer and 45 hours per week in winter. Those in a full-time role (paid for 40 hours per week) were averaging 50 hours per week in summer and 56 hours in winter.[5]

Similarly, pressures continue to exist for staff in aged-residential care and secondary services:

> "Have had to get used to relying on dedicated staff going over and above to provide safe care – missing meal breaks, doing extra hours, extra days… Have started getting used to prioritising the care we can give rather than providing the care that women need and are entitled to."
>
> (Senior doctor, May 2025)

Despite these challenges, consumers we interviewed continued to tell us that the health system has high quality, committed staff.

> "Frontline staff – they care passionately for their patients, and they absolutely work their butts off."
>
> (Consumer, August 2025)

> "Frontline staff working face to face with patients…they're tremendous. You know, I can't say enough to praise them…you were going in for a major surgery and you're in theatre, the people that are working with you are fantastic. They are skilled, they're dedicated, they work incredibly hard, and their care is second to none. It's world class."
>
> (Consumer, August 2025)

> "Real believer in frontline staff, from GP to specialist – have kept me alive more than once and have huge gratitude as well as recognising their skill and dedication. But the structures around them are where the weaknesses are."
>
> (Consumer, August 2025)

While these consumer interviews discuss the value of 'frontline' staff, those who work most closely with patients require the support of their administrative and back-office colleagues. Quality improvement systems are dependent on having access to data and people who can

[4] Royal College of General Practitioners. 2024. Your Work Counts. From: https://www.rnzcgp.org.nz/resources/advocacy/your-work-counts/ (accessed 13 August 2025).
[5] Royal College of General Practitioners. 2024.

interpret it. Where these are no longer available, systems are beginning to fail (see *Information technology, data and analytics* section below).

The infrastructure

Health infrastructure includes facilities such as hospitals, equipment and operational theatres, and soft infrastructure, which includes the skilled workforce, research and regulation, training and educational resources and data connectivity.[6]

Funding as a driver of soft infrastructure[7] *(Framework, factor 8)*

General practitioners told us that the capitation system is impacting on their ability to provide effective care, particularly in communities where there is a high proportion of people who have chronic or complex health concerns *(Framework, factor 8).* They also told us that the capitation model is impacting the sustainability of the primary care system.

Inadequate funding is reducing the financial viability of some practices. The capitation model is viewed as a barrier for providing comprehensive care for those with the most complex health needs, can drive inappropriate general practitioner to patient ratios, and is a source of stress.

This is not a new issue for general practice. While there is work planned for reweighting the capitation system,[8] Box 1 provides an overview of the themes we have heard through our interviews with general practitioners over the past 12-months.

Box 1: General practitioner views on the capitation funding model from interviews between August 2024 and September 2025

Basic assumptions of the model

"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 GP who has signed up to look after them ends up holding the risk for the failing public secondary / tertiary health system."

Delay in review of formula

"Funding formula needs to be changed – Moodie stated it in 2015,[9] Sapere[10] stated it in 2022. High needs patients need the best possible care, and the funding formula perversely incentivises the opposite of that."

[6] New Zealand Infrastructure Commission (2021) From https://tewaihanga.govt.nz/our-work/research-insights/sector-state-of-play-health.
[7] Kavanagh, S.A., Hawe, P., Shiell, A. et al. Soft infrastructure: the critical community-level resources reportedly needed for program success. BMC Public Health 22, 420 (2022). https://doi.org/10.1186/s12889-022-12788-8
[8] Ministry of Health Manatū Hauora. 2025. Capitation Reweighting. URL: https://www.health.govt.nz/strategies-initiatives/programmes-and-initiatives/primary-and-community-health-care/capitation-reweighting (accessed 25 August 2025).
[9] Primary Care Working Group on General Practice Sustainability. Report to the Minister of Health November 2015. URL: https://genpro.org.nz/assets/Uploads/Document-Links/PCWG-on-GP-Sustainability.pdf (accessed 5 September 2025)
[10] Love, T. Peck, C. Watt, D. 2022. A Future Capitation Funding Approach. Addressing health need and sustainability in general practice funding. Published by Sapere. URL: https://srgexpert.com/wp-

"Successive governments' refusal to change the funding formula is destroying rural and provincial practice."

Sustainability of very low-cost access (VLCA) practices

"VLCA model is past it's use-by date – but never made sense as a practice with 50% funding VLCA got the same funding as a 90% VLCA practice. => funding doesn't match needs."

"Relooking at opening hours – cost of running after hours (longer days and weekends) – can no longer continue to sustain that cost. Reducing after hours and weekends, will have significant impact on access and Middlemore ED…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. Current model of funding has to change. No longer sustainable."

"Significantly in debt ($100,000s in the red) – carrying the biggest debt we ever have…Big corporate GPs pay $30 more an hour. Can't compete. GPs that are staying are there for aroha and the kaupapa…VLCA, so cannot put fees up to compensate, 4% increase in capitation doesn't work."

Cost of providing care to chronically unwell

"… chronic schizophrenic patients are being managed in general practice. Previously getting 30-45 min appt with psychiatrist every month. Now getting 15-mins every so often to talk about mental and physical health conditions. No extra funding came with this. Need additional training and time. Taking this on in addition to general practice. Happy to look after them but need the model needed shifting."

Concerns about gaming the system

"Corporate models, they are looking for excess capitation against an ability to service the population. It is in their model. Books still open despite having no doctors or prescribing clinicians. We need robust quality indicators for primary care, e.g. late presentations, unnecessary hospitalisations, ASH rates – could be a reflection of acute access. Telehealth has a place, but not as a replacement for general practice…important adjunct."

Systems and structures: threat rigidity and system functioning *(Framework, factors 5, 7 and 17)*

In our September 2024 report we described risks to health quality and safety, including a lack of clinical governance systems and structures, challenges raising clinical concerns, delays in access to care and the eroding of a safety culture.[11] The interviews undertaken highlighted how the restructure of the health system occurred at a time when the system was dealing with the impact of the COVID pandemic, which had compounded a long-term increase in demand for services and barriers to accessing those services.

> "New Zealand has increasing pressure on the health system from an ageing population, increasing chronic disease prevalence and resulting increases in acute demand for treatment. New Zealand continues to experience difficulties in securing sufficient clinical workforce. These pressures have been compounded by delays in care due to the COVID pandemic.

content/uploads/2023/07/A-Future-Capitation-Funding-Approach-July-2022.pdf (accessed 5 September 2025)

[11] Te Tāhū Hauora Health Quality and Safety Commission. 2024. Assessing system quality and safety: insights report. September. Published by Te Tāhū Hauora. (page 4)

> In this context the reform of the New Zealand health system reduces the system's ability to respond to these longstanding issues."
>
> (September 2024 Insights Report)[12]

Within this context, the behaviours we have been reporting over the past 12-months can be explained by a threat rigidity response (Box 2). Threat rigidity describes how the effects of responding to threat manifest at the individual and group level.

Examples of threat-rigidity occur across the health system. However, it appears particularly focused at senior leadership level (both nationally and regionally). Whilst the process of devolved decision-making to the regions is occurring, this response is contributing to limited clarity in decision-making authority when responding to quality and safety alerts *(Framework, factor 7)*, reduced proactive planning and reduced staff engagement in quality improvement initiatives *(Framework, factor 17).*

Health New Zealand's quality improvement infrastructure appears to be overloaded, manifested as limited capacity to attend cross-agency meetings *(Framework, factor 5)* and a reduced ability to respond to concerns and implement changes.

There is an overlap between threat rigidity, short-staffing and increased staff absenteeism.[13] Reduced availability of staff in some positions features alongside an increased expectation for discretionary effort from senior management, with reduced capacity to spend such effort by staff who are increasingly burned out.

Threat rigidity may also be driving the lack of coordination between primary and secondary care. This manifests as reduced information flow, impacting on possible responses to the current pressures on care provision.

[12] Ibid (page 3)

[13] There is substantial variation in annualized sick leave hours per full-time equivalent contracted employee within Health New Zealand Te Whatu Ora. The median ranges from 40 hours in Lakes to 71 hours in Midcentral. Health New Zealand Employed Workforce Quarterly Report: 1 October to 31 December 2024. URL: https://www.tewhatuora.govt.nz/publications/health-new-zealand-employed-workforce-quarterly-report-2024-25-quarter-two (accessed 8 September 2025)

Box 2: Threat rigidity as a response to structural reform

Imposed reforms create threats to organisational performance and culture.[14,15,16,17,18]. Frequent repeated change allows neither employees nor managers to recuperate.[19]

The need for managers to find psychological coping methods in the face of these external threats is the subject of threat rigidity theory.[20,21] Threat rigidity describes how the effects of responding to threat manifest at the individual and group level. The individual level effects reflect a combination of psychological stress and anxiety. This decreases sensitivity to peripheral information, reduces flexibility and induces well-learned responses.[22]

Group level effects are increased group cohesiveness and a tendency to increase uniformity,[23] with the attendant risks of exclusion of "deviant" thinkers[24] and groupthink.[25] Faced with threats over which they perceive they have little control,[26] executives respond by seeking to assert control through two responses: constricting decision-making authority to a tight circle around the executive and limiting the flow of alternative sources of information.[27,28]

[14] Chapple, S. 2019. From Mandarin to Valet Public Service? State sector reform and problems of managerialism in the New Zealand public service. Policy Quarterly, 15(4): 49-56. https://doi.org/10.26686/pq.v15i4.5924
[15] De Vries, M. S. 2013. Reform fatigue: The effects of reorganizations on public sector employees. Studies on administrative reform: building service-oriented government and performance evaluation systems: 71-86.
[16] Grunberg, L, Moore, S. Greenberg, E. S. Sikora, P. 2008. The changing workplace and its effects: A longitudinal examination of employee responses at a large company. The Journal of Applied Behavioral Science, 44(2): 215-236, https://10.1177/0021886307312771
[17] McMurray, R. 2010. Our reforms, our partnerships, same problems: the chronic case of the English NHS. Public Money & Management, 27(1): 77-82, https://10.1111/j.1467-9302.2007.00558.x
[18] Pollitt, C. 2007. New Labour's re-disorganization. Public Management Review, 9(4): 529-543, https://doi.org/10.1080/14719030701726663
[19] Wynen, J, Verhoest, K. Kleizen, B. 2017. More reforms, less innovation? The impact of structural reform histories on innovation-oriented cultures in public organizations. Public Management Review, 19(8): 1142-1164. https://doi.org/14719037.2016.1266021
[20] Muurlink, O. Wilkinson, A. Peetz, D. Townsend, K. 2012. Managerial autism: Threat–rigidity and rigidity's threat. British Journal of Management, 23, S74-S87.
[21] Staw, B. M., Sandelands, L. E. Dutton, J. E. 1981. Threat Rigidity Effects in Organizational Behavior: A multilevel analysis, Administrative Science Quarterly, 26(4): 501-524, https://doi.org/10.2307/2392337
[22] Staw et al. 1981
[23] Staw et al. 1981
[24] Schachter, S. 1951. Deviation, rejection, and communication. The Journal of Abnormal and Social Psychology, 46(2), 190.
[25] Irving, J. L. 1972. Victims of groupthink: A psychological study of foreign-policy decisions and fiascoes, Houghton Mifflin, Boston
[26] Muurlink et al. 2012
[27] Chattopadhyay, P. Glick, W. H. Huber, G. P. 2001. Organizational actions in response to threats and opportunities. Academy of Management Journal, 44 (5): 937-955. https://www.jstor.org/stable/3069439
[28] Staw et al. 1981

As a result, executives enact more directive leadership,[29] reduced participation of lower levels of management in issue resolution[30] and demand for greater employee conformity.[31] Restricting flows of information limits the range of information that executives access and act upon, and restricts the frames through which they assess it to those which already exist, encouraging entrenched behaviour and delivering solutions that may be irrelevant to a changed situation.[32]

Identified negative effects linked to threat rigidity include reduced innovation,[33] reduced managerial support for innovation,[34] "defensive silence" among employees (i.e. a refusal to speak up and provide valuable feedback and insight),[35] absenteeism,[36] reduced strategic autonomy for senior managers,[37] and reduced proactivity among employees.[38]

Increased demand and barriers to care

Over the past 12-months, we have not seen a shift in the negative long-term trend of increased demand and barriers to access care. For example, in general practice:

- In 2024 we reported that 40 percent of general practices nationally had open books. This has changed little. In the January to March 2025 quarter, Health New Zealand data report that 30 percent of practices have open books, with a further 15 percent open to restricted enrolments.
- Regional variation continues to exist. Almost 52 percent of practices in the Central region have closed books, compared with almost 20 percent of practices in the Northern region.

[29] Garretsen, H. Stoker, J. I. Soudis, D. Wendt, H. 2022. The pandemic that shocked managers across the world: The impact of the COVID-19 crisis on leadership behavior. The Leadership Quarterly, 35(5) 101630.
[30] Dutton, J. E., Jackson, S. E. 1987. Categorizing strategic issues: Links to organizational action. Academy of management review 12 (1): 76-90. https://doi:10.2307/257995
[31] Olsen, B. Sexton, D. 2009. Threat rigidity, school reform, and how teachers view their work inside current education policy contexts. American Educational Research Journal, 46(1): 9-44.
[32] Staw et al. 1981
[33] Wynen et al. 2017.
[34] Wynen, J. Boon, J. Kleizen, B. Verhoest, K. 2020. How multiple organizational changes shape managerial support for Innovative Work Behavior: evidence from the Australian Public Service. Review of Public Personnel Administration, 40(3): 491-515, https://doi.org/10.1177/0734371X18824388
[35] Wynen, J. Kleizen, B. Verhoest, K. Lægreid, P. Rolland, V. 2020. Just keep silent… Defensive silence as a reaction to successive structural reforms. Public Management Review, 22(4): 498-526
[36] Wynen, J. Verhoest, K. Kleizen, B. 2019. Are public organizations suffering from repetitive change injury? A panel study of the damaging effect of intense reform sequences. Governance, 32(4): 695-713.
[37] Kleizen, B. Verhoest, K. Wynen, J. 2018. Structural reform histories and perceptions of organizational autonomy: Do senior managers perceive less strategic policy autonomy when faced with frequent and intense restructuring? Public Administration, 96(2): 349-367. https://doi.org/10.1111/padm.12399
[38] Verlinden, S. Bach, T. Wynen, J. Kleizen, B. Verhoest, K. 2023. Does organizational change trigger civil servant proactivity? The impact of past changes experienced. Public Management Review: 1-20. https://doi.org/10.1080/14719037.2023.2284225

- Variations within regions also exist. In the Northern region, around 10 percent of practices in Waitematā have closed books compared with 48 percent in Northland.[39]

Clinicians told us that closing books is a safety mechanism to maintain the wellbeing of service providers, manage patient demand and ensure enrolled patients can access services.

> "I've shut my books because people can't get in to see us and my staff are breaking."
>
> (General practitioner, August 2025)

Where practices have a high caseload of patients with chronic or complex health needs who need to be seen more frequently, the need to manage patient demand may result in a reduced patient to general practitioner ratio than in other areas.

In further evidence of increased demand, we have found that:

- Demand is outstripping capacity for some secondary services. As a result, the Health and Disability Commissioner (HDC) has raised concerns with Health New Zealand about national oversight of ongoing capacity constraints which are leading to clinical risk and adverse clinical outcomes.[40]
- There are ongoing challenges in retaining international medical graduates. The retention rate for overseas qualified professionals two years after New Zealand registration is 40 percent, compared with 94 percent for New Zealand trained professionals.[41]
- The impact of retention challenges is larger in provincial areas which have the highest percent of international medical graduates. For example, Whanganui, South Canterbury and the West Coast have over 60 percent of medical professionals who are overseas trained, compared with 36 percent in Auckland and Canterbury.[42]
- 28 percent of international medical graduates registered to be a general practitioner or other doctor in primary care.[43]

Evidence of the impact of barriers to accessing services in a timely manner remains in our current monitoring:

- Over the last three years there has been a 21 percent increase in more urgent emergency department presentations (triage 1-3, Figure 1) and a 10 percent fall in less urgent (triage 4-5, Figure 2) patients.

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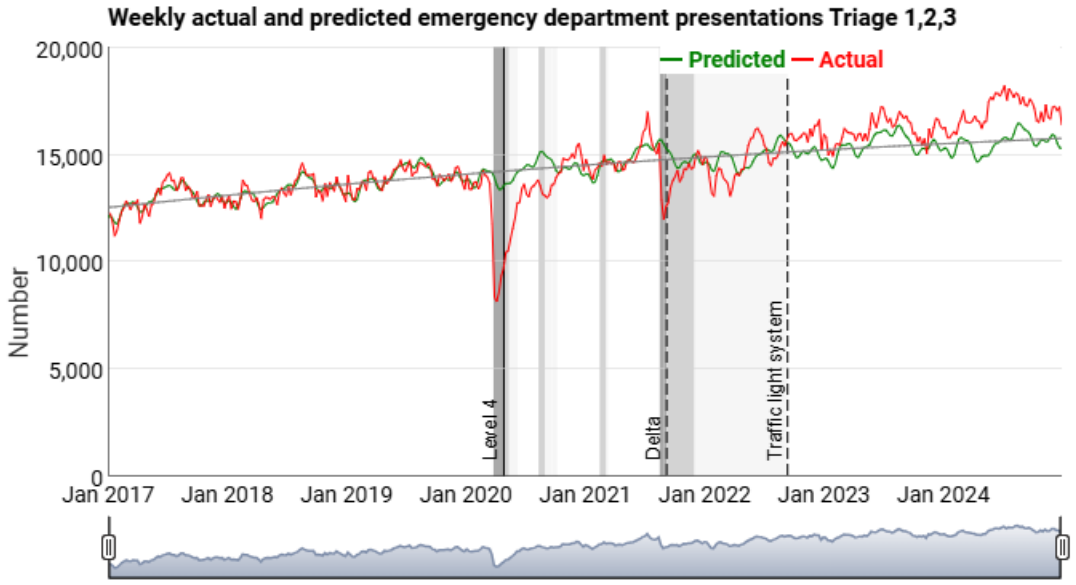
[39] Health New Zealand. 2025 General practice enrolling status 2024/25 Q3 (Jan to Mar 2025). URL: https://www.tewhatuora.govt.nz/assets/For-health-professionals/Data-and-statistics/Primary-care/2025Q3_PHO_Enrolling_Status.xlsx (accessed 5 August 2025)
[40] See, for example Health and Disability Commissioner complaint reference 23HDC02667 (decision released 27 August 2025).
[41] Te Kaunihera Rata o Aotearoa Medical Council of New Zealand. Our data: Retention. URL: https://www.mcnz.org.nz/about-us/our-data/retention/ (accessed 5 August 2025)
[42] Te Kaunihera Rata o Aotearoa Medical Council of New Zealand. Our data: Registered doctors by region. URL: https://www.mcnz.org.nz/about-us/our-data/registered-doctors-by-region/ (accessed 5 September 2025).
[43] Te Kaunihera Rata o Aotearoa Medical Council of New Zealand. Our data: International Medical Graduates. URL: https://www.mcnz.org.nz/about-us/our-data/international-medical-graduates/ (accessed 5 August 2025).

Figure 1: Emergency department presentations over time (triage 1-3)



In our November 2024 report we noted the risk of increased urgent presentations in emergency departments:

> "Primary care access seems [to be in] a 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)."
>
> (November 2024 Insights Report, Appendix 2)

The excess number of triage 1-3 emergency department patients has extended beyond what was presented in previous reports (21 percent compared with 12 percent previously)[44] and is particularly concentrated at triage 2 level, as described below:

> "The people we are seeing come into our hospital are significantly more unwell because they have not been able to access their basic primary care doctors in time. Will be a combination of access and money... At clinic this week, almost everyone said "I have tried, I can't get an appointment with my GP". Urgent appointments being cancelled because GPs are unwell... Come to clinic and are admitted to hospital – needed a lot more than they would have if they had been seen a month earlier...Number of people turning up to ED who are subsequently admitted – the percentages are going up. Coming later and sicker and admission is inevitable... Set into a cycle that is hard to break."
>
> (Senior doctor, July 2025)

Difficulties in accessing care in primary and secondary care interact so that pressure increases in tandem rather than one substituting for the other. Delayed access to primary care increases the likelihood of acute admission later; increased acute admissions reduce

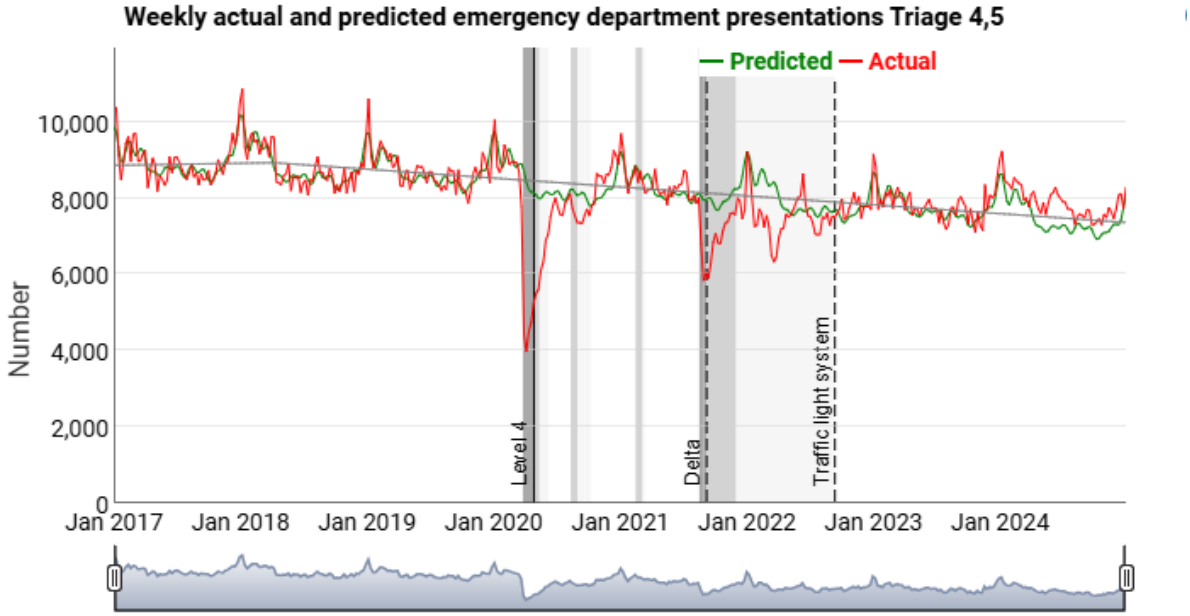
[44] Health Quality and Safety Commission Te Tāhū Hauora. 2024. Assessing system quality and safety: insights report. November. Published by Te Tāhū Hauora. (Appendix 2)

hospital capacity for elective patients, leaving elective patients waiting longer and requiring more primary care intervention in the meantime. Results from our most recent Adult Primary Care Patient Experience Survey show that the percentage of people who are waiting over a week for an appointment with their general practitioner or nurse has increased from 11 percent in August 2020 to 28 percent in May 2024 and 34 percent in May 2025. Of those who had to wait in August 2020, 4.1 percent reported that they had to wait too long. This increased to 9.3 percent in May 2025.[45]

In our previous reporting, excess urgent patients were counterbalanced by a lower number of less urgent patients. The reduction in less urgent numbers has now reversed and is higher than what would be predicted by the long-term trend (Figure 2).

This reversal reflects the long-term, worsening, difficulties of accessing primary care, as highlighted above.

Figure 2: Emergency department presentations over time (triage 4-5)



The HDC is also noting increased complaints that relate to accessing services. The percentage of complaints that relate to access to primary care have increased from 4 percent of all complaints in 2021/22 to 10 percent of complaints in 2024/25.

As an extension of the increased urgency in emergency department patients, in September 2024, we also highlighted the increase in acute admissions as a percentage of all admissions.

> "Acute admissions as a percentage of all admissions have increased slightly since before COVID-19, while waiting list admissions are slightly lower. Local

[45] Health Quality and Safety Commission Te Tāhū Hauora. 2025. Adult primary care patient experience survey. URL: https://reports.hqsc.govt.nz/APC-explorer/_w_55852ae9/?_gl=1*biije6*_ga*MTQwMDk4NzYyMi4xNzM4MDMyMTg1*_ga_TG4RCRSBWS*czE3NTcwMTU0NDkkbzEwOSRnMSR0MTc1NzAxNTUzNSRqNTYkbDAkaDA.#!/ (accessed 5 September 2025)

> pressure points exist with shifts of 5-10% from elective to acute admissions in Canterbury, Nelson Marlborough, Counties Manukau and Auckland districts."
>
> (September 2024 Insights Report)

As shown in Table 1, this continues and most of the hotspots we highlighted previously (Canterbury, Nelson Marlborough, Counties Manukau) continue to be hotspots. They are joined by Taranaki and Whanganui.

Last year, a workforce interview participant from one of these hotspots described how increase in acute admissions compounded the impact of staffing issues, and reduced their ability to provide a service for those on the elective list:

> "Lost a list last week because there was no staff. We have a regular loss of surgical lists. We are not able to do what we are contracted to do because of staffing issues and the acuity of those who need a response."
>
> (Senior doctor, August 2024)

More recent interviews from staff in the same location show that there hasn't been any improvement. Limited ward beds have flow-on effects to emergency department capacity, which reduces capacity to provide care for those waiting:

> "We have a lack of bed capacity, both in the wards and the emergency department… last night my partner was on-call and they had someone collapse with an asthma attack in the wait-room. They were having to run infusions in the wait-room. This is a daily if not weekly occurrence…It is a waste of doctor resources as [the limited bed capacity means that] we can't see anyone new."
>
> (Junior doctor, August 2025).

This is a potentially serious safety issue as the situation above describes an inadequate monitoring environment and a lack of access to suitable equipment to provide an effective response.

These interviews demonstrate a supply and demand mismatch. The precise impacts of the mismatch are presented in greater detail in Appendix 2.

Table 1: Acute versus elective admissions per week, pre (2015-19) and post (2023 onwards) COVID, Medical and Surgical specialities only [source: REACH[46] analysis of NMDS]

	Acute			Elective			
	Pre	**Post**	**Change**	**Pre**	**Post**	**Change**	**"Butlerian Swing"[47] to acute**
Auckland	1,087	1,116	3%	1,107	1,000	-10%	6%
Bay of Plenty	457	503	10%	445	439	-1%	6%
Canterbury	995	1099	11%	856	791	-8%	9%
Capital and Coast	504	493	-2%	411	428	4%	-3%
Counties Manukau	947	991	5%	426	343	-20%	12%
Hawke's Bay	334	320	-4%	240	292	22%	-13%
Hutt Valley	253	250	-1%	277	289	4%	-3%
Lakes	207	207	0%	173	192	11%	-6%
Midcentral	253	277	10%	209	199	-5%	7%
Nelson Marlborough	204	223	9%	209	185	-12%	10%
Northland	351	409	17%	311	383	23%	-3%
South Canterbury	95	92	-3%	101	106	5%	-4%
Southern	562	524	-7%	413	375	-9%	1%
Tairāwhiti	99	94	-5%	72	71	-1%	-2%
Taranaki	219	248	13%	215	225	5%	4%
Waikato	816	795	-3%	856	876	2%	-2%
Wairarapa	74	70	-5%	67	80	19%	-12%
Waitematā	979	978	0%	629	737	17%	-9%
West Coast	63	58	-8%	43	46	7%	-7%
Whanganui	125	135	8%	91	87	-4%	6%
Total	**8626**	**8881**	**3%**	**7150**	**7144**	**0%**	**2%**

[46] REACH is an HQSC approach for public hospital system analysis, originally designed to determine the impact of COVID. (The Rapid Effects Assessment of COVID-19 on healthcare, REACH)
[47] Butlerian swing is a measure of change in proportion of two mutually exclusive variables calculated by summing the absolute change of each variable and dividing by two.

Clinical governance: the interface between primary and secondary care *(Framework, Factors 1, 10 and 11)*

A recurring issue throughout our reports is the breakdown in the interface between primary, secondary and community care.[48] This is not a long-term issue and has been created as a result of the health system restructure:

> "We used to have a team of five GP liaisons…"
>
> "We've lost the relationship that we had…We don't have our joint clinical council meeting anymore."
>
> (Primary and secondary care clinicians, August 2024).

While the removal of governance structures has impacted on the mechanisms available to address concerns shared between primary and secondary care, of equal importance is the dissolution of the relationships that previously existed. This presents a roadblock to coordinated development of services:

> "We have a network of primary care clinical leaders get together on a monthly basis – clinical leaders of PHOs, clinical advisors and health pathways clinical editors. We have attempted to communicate with regional Te Whatu Ora structures, but there is no clinical governance structure to contribute into. To date have also not been able to get senior regional leaders to attend."
>
> (General practitioner, June 2025)

In addition, the lack of coordination prevents a joint approach to address quality and safety issues that may exist during patient transitions between primary and secondary care:

> "Would be good to be more integrated with the hospital to allow review from both sides – would be good to share information to support this process."
>
> (General practitioner, August 2025)

Service integration was discussed at a recent National Quality Forum meeting (August 2025). Agency participants noted that the breakdown in service integration has been compounded by limited clinical governance structures *(Framework, factor 1).* Improvements in clinical governance structures would better support service integration. The HDC have also highlighted their concerns about the lack of permanent, stable clinical governance structures:

> HDC has been raising concerns over the past few years about the need for clear, permanent clinical governance structures. It is positive that permanent regional and national leadership structures are being or have been developed.

[48] Our November 2024 report highlighted the difficulties that community pharmacists face communicating with both primary and secondary care. They noted concerns about errors in prescriptions, ascribed to increased pressure and lack of time with doctors. (see page 7, https://www.hqsc.govt.nz/assets/Core-pages/About-us/Insights-reports/Te-Tahu-Hauora-Assessing-system-quality-and-safety-insights-report-November-2024.pdf, accessed 19 August 2025).

> Anecdotally, we have noticed an increasing number of providers making complaints directly to HDC due to difficulties escalating their concerns at a national level.[49]

The New Zealand Health Strategy[50] and *Collaborating for Quality*,[51] the Commission's framework for clinical governance, outline the importance of engaging with communities, consumers and whānau to give them greater control over the design of health services.

However, alongside the breakdown in the relationship between primary and secondary care (an impact of the loss of District Health Boards and local clinical governance structures), there has been the disestablishment of consumer councils at the district level. This is reducing consumer participation in the design health system - a requirement of the *Code of Expectations for Health Entities' Engagement with Consumers and Whānau*.[52]

Trust in the health sector as an institution amongst consumers is reducing.[53] While consumers that we speak to continue to hold respect and admiration for those who deliver care, there are frustrations about their ability to access services and a perception that consumers need to self-advocate. This is reinforced by an analysis of HDC complaints, which highlight difficulties accessing radiology services, delays in obtaining medical reviews in emergency departments and service reductions or differing thresholds for services across the country *(Framework, factors 10 and 11)*.[54]

Reduced levels of trust can reduce engagement with preventative and health promotive initiatives. Robust mechanisms are required for ensuring effective consumer input into the design, delivery and evaluation of the health system.

> "There is a view, a view not held by everyone but by some people: why is there a need for both district and regional consumer councils? And the perspective that I've always taken is that is where the rubber hits the road at the district level. So, my view of the whole thing is that nationally we're governed, regionally we're managed, and the action happens in districts and that doesn't seem to be happening… But they don't realise it's just not about responding to people complaining about food or waking up in the night. It's much broader and bigger than that."
>
> (Consumer, August 2025)

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[49] Health and Disability Commissioner. 2025. Insights from HDC complaints. Personal Communication, 28 August.
[50] Minister of Health. 2023. New Zealand Health Strategy. Wellington: Ministry of Health. URL: www.health.govt.nz/system/files/2023-07/new-zealand-health-strategy-oct23.pdf (accessed 25 August 2025)
[51] Te Tāhū Hauora Health Quality & Safety Commission. 2024. Collaborating for quality: A framework for clinical governance. URL: https://www.hqsc.govt.nz/resources/resource-library/collaborating-for-quality-a-framework-for-clinical-governance/ (accessed 12 September 2025)
[52] URL: https://www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/code-of-expectations-for-health-entities-engagement-with-consumers-and-whanau/ (accessed 8 August 2025)
[53] Public Health Advisory Committee. 2025. Determining Our Future: Social, Cultural, Economic and Commercial Determinants of Wellbeing in Aotearoa New Zealand: Actions to improve our health and wellbeing. Wellington: Ministry of Health. URL: https://www.health.govt.nz/publications/determining-our-future (accessed 29 August 2025)
[54] Health and Disability Commissioner. 2025. Insights from HDC complaints. Personal Communication, 28 August

Information technology, data and analytics *(Framework, Factor 2)*

> "The biggest challenge is the key enabling services that we are dependent upon, i.e. data and analytics, audits at the district level, project expertise and resource."
>
> (Senior doctor, May 2025)

In September 2024, health staff told us they were concerned about information technology projects being put on hold and the challenges recruiting to non-clinical roles. There was concern that those making decisions about staffing resource were unaware of the importance of non-clinical roles which were necessary for clinical services planning and measuring and monitoring system functioning.

Since that time, access to data and information continues to be a challenge for those in secondary services in particular.

> "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 the Ministry of Health wasn't transferred when the reporting functions were. Quality and safety aspects have been neglected."
>
> (Allied health professional, May 2025)

> "Incident systems, where you put information in about safety concerns, not sure if they keep patients safe… often don't hear the outcomes when you put an incident report in."
>
> (Senior doctor, May 2025)

> "Have lost key positions to support clinical governance work – i.e. head of consumer engagement was disestablished, risk manager and coordinators taken into regional space and disestablished…a lot of the things that have happened over the last 12 months have just by their nature and purpose of what they do, while not having much direct contact with patients, have a major impact on our monitoring and reporting functions."
>
> (Senior doctor, August 2025)

While individual PHOs are setting up their own data collection and reporting systems, there is concern that there is a lack of a national view of general practice.[55] There is a post-code lottery for access to digital systems.

In addition, the inoperability of patient administration systems employed by PHOs is described as creating a significant patient safety risk as information is not transferred between general practitioners appropriately.[56]

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[55] Of note, the Commission is currently working with General Practice New Zealand on a dashboard which may provide a unified view of PHO data.

[56] https://www.hinz.org.nz/news/700240/GP2GP-being-stabilised-then-replaced.htm (accessed 5 September 2025)

The HDC have reported difficulties discerning what quality improvement work is occurring at regional vs national level, with specific reference to digital improvements. HDC recommendations have not been able to be implemented due to the nationalisation of digital workstreams and resource constraints impacting on capacity to undertake quality improvement work *(Framework, factor 2)*.[57]

The experience of secondary services is in contrast with that in aged-residential care. Larger aged-residential care providers report having robust clinical quality dashboards and internal auditing programmes that help to focus on standards such as Ngā Paerewa. Quality indicators are also reported to the board and clinical governance sub-committees. However, such approaches are not universal – smaller and medium-sized providers may struggle to do similar activities.

Emerging issues

In September 2024, we described the potential for both positive and negative adaptations to evolve as a result of the changes being implemented:

> "Amalberti has observed that systems continuously adapting to new social and technical demands may approach the boundaries of safe operation and later move into unsafe practice. When such practices become ingrained due to the need to do more with less, patient harm, negligence, or reckless conduct may emerge.
>
> "Violations… are a complex multifaceted phenomenon. They occur frequently and may save time and bring benefits to both individuals and systems. They may be tolerated by the wider clinical team and even actively encouraged if there is pressure to increase workload and throughput of patients. However, extreme violations may put both people and systems at risk."" (pg. 67)[58]
>
> (September 2024 Insights Report, page 13)

Positive adaptations

Adaptations, which are considered positive by the workforce and consumers, have become apparent through our interviews. However, there is little evaluation to determine if these adaptations are associated with better health outcomes and safer care for patients.

Preliminary evidence from General Practice New Zealand provides evidence of some positive impacts, including:

> "…faster access for musculoskeletal problems where a physiotherapist is available and better medication compliance where there is a pharmacist, but also to improved engagement in overall health care, increased health literacy,

[57] Personal communication, Health and Disability Commission. 28 August 2025.
[58] Amalberti R, Vincent C, Auroy Y, de Saint Maurice G. Violations and migrations in health care: a framework for understanding and management. Qual Saf Health Care. 2006 Dec;15 Suppl 1(Suppl 1):i66-71. doi: 10.1136/qshc.2005.015982. PMID: 17142612; PMCID: PMC2464877

and early evidence of reduced emergency department presentations and hospital admissions."[59]

In our interviews, workforce participants and consumers described:

- Increased adoption of new models of care, interdisciplinary practice and use of allied health professionals.
- Acceptance of telehealth by consumers (as reported by some consumers in rural communities).
- Enrolment support services increasingly available in some communities.
- Increased use of triage systems for acutely unwell to be reviewed by general practitioners.

For example:

> "[I] can use telehealth. Unless I need to be seen physically, I am happy to be using telehealth. I live semi-rurally and it saves a trip into town. Better than face-to-face unless they have to see you or do some tests…Hospitals in the home would take it a step further. It saves hospital beds and people are happy not to have to go into hospital."
>
> (Consumer, August 2025)

> "Feel like primary care is good at keeping people well in the community and have adapted well to telehealth and the use of AI. Also, good adaptation to the rapid expansion in the range of the multidisciplinary team."
>
> (General Practitioner, August 2025)

> "If anyone turns up to ED who is not enrolled at a GP, we get them enrolled. Twenty percent turning up weren't enrolled. We have established a pathway to get them enrolled. Has improved and has been a real focus."
>
> (General Practitioner, August 2025)

> "Combined with immunisation coordinator – urgency to get young babies enrolled to facilitate immunisations. [We] facilitate the process for families and whānau with young babies. Otherwise it was left to the family to navigate the enrollment process. Would like to see this replicated in other districts."
>
> (Hauora Māori, August 2025)

Box 3 highlights the potential of adaptations to address some of the emerging systems gaps, particularly addressing the breakdown in clinical governance structures between primary and secondary care.

[59] General Practice New Zealand. 2025. Extended primary care teams: Current state, future opportunities. Auckland, New Zealand. URL: https://gpnz.org.nz/wp-content/uploads/250401-GPNZ-workforce-current-state-future-opportunities_FINAL.pdf (accessed 19 August 2025, page 10)

Box 3: Creative service provision and re-establishing a primary-secondary care interface in Tai Rāwhiti

Pinnacle Midlands Health Network in Tai Rāwhiti have been collaborating with iwi, Māori health providers, NGOs, churches, social services, hospital specialists and aged residential care to ensure comprehensive service provision for consumers in the region.

The collaborative approach has been supported by the long-term development of the workforce and a recent injection of comprehensive primary and community team funding. As described by the district manager:

> "my team for an example, is quite interdisciplinary. So we, you know, we're getting groups of newly diagnosed diabetes as an example, and doing a lot more in the education space and lifestyle management. So it's around giving them the skills to be able to self manage rather than using clinicians one-on-one. So we're doing a lot of bringing them into a group facilitated with non clinical teams and then just bringing the clinicians in to deliver the specialist education components ...the comprehensive teams that we set up with our iwi partners, like the way of working that we've developed from that has been a really big win too for all of our community, but also for the clinicians and how we work ... an example is dieticians. We have them sitting in our space, so why wouldn't we share them with our partners? For the support of the community..."

Tai Rāwhiti have also retained the services of a GP liaison that sits on the clinical governance structures of the secondary services in the area and is able to present a general practice view.

> "[We meet regularly and] she will feedback to me if she has any concerns... So there are really good pathways to escalate."

Pinnacle also have shared clinical governance structures with iwi, which builds on the relationships that exist and have provided learnings for all.

Those we spoke to in general practice generally view the extended care teams and comprehensive primary and community practice teams in a positive light, but have concerns that the clinical governance structures for some components of the new models of care have not yet been established, as described:

> "[What is working well in the health system?]: New models of care are being developed...Comprehensive primary care teams – bringing paramedics and pharmacists into practices."
>
> (General practitioner, May 2025)

> "There are two main issues with multidisciplinary teams: finding the resource (clinical pharmacist, nurse practitioners, extended care paramedics…), and providing supervision. [We] need to acknowledge that it is going to take time to train and supervise – ideally supervising under a medical supervision model. [We] also need to train the GPs to take a more consultive approach rather than nose down...[We] need to understand the legal responsibilities – currently being looked at by the [Medical Protection Socety]...Currently people holding vicarious liability."
>
> (General practitioner, July 2025).

While being encouraged to adapt to support new models of care, general practitioners continue to feel trapped by the funding model that currently exists:

> "...team based care is the way to go. And there's a lot that we can delegate and not have to do as a GPs ourselves. And we should be focusing more on the complex sort of care where our skills are best focus...[but] we are stuck in that model at the moment where we're betwixt and between yes, we recognise we can use nurses and allied health people to do a lot, more health coaches etcetera, psychologists. But we can't quite change the model of care because the funding doesn't quite represent, ... and we don't incentivise or fund adequately the complex care that occurs."
>
> (General practitioner August 2025)

Negative adaptations

Some adaptations have the potential to negatively impact on health service provision:

- Reluctance by general practitioners to refer for specialist treatment due to automatic declines of routine referrals with only urgent or semi-urgent accepted.
- Increased use of locums.
- Consumers feeling that they have to self-advocate to receive the care they need.
- Some general practitioners moving to only working in telehealth rather than supporting face-to-face services.
- Secondary services less likely to be involved in quality improvement activities.

For example:

> "Increased use of locums is reducing continuity of care and physical access as some only work telehealth rather than agreeing to do face-to-face sessions. More difficult for PHOs to apply clinical governance to a transient workforce. It creates risks."
>
> (General practitioner, June 2025)

> "[I] decline all routine priority referrals as I don't have the capacity. Semi-urgent patients expected to be seen within 56 days (although changed recently to 90 days), waiting 8-9 months."
>
> (Senior doctor, June 2025)

> "Difficulty getting proper diagnosis and care even when people are strong advocates. 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."
>
> (Consumer, June 2025)

> "So many of my friends are leaving general practise, doing telehealth now. It pays more."
>
> (General practitioner, September 2025)

This is also reflected in complaints to the HDC, who report that access to radiology services is one of their key areas of focus noting that it is an enabler of quality, timely treatment.[60] Service reductions, differing access thresholds across the country and the resulting geographical inequities in access to care are a common issue in complaints to the HDC *(Framework, factor 8).*

There are risks in the move from public specialist appointments to private providers.[61] As well as the potential to increase costs and reduce efficiencies, Mathias notes that there can be a reduction in the ability to train medical professionals due to limited access to patients with complex health needs and multiple comorbidites, as described below:

> "...evidence suggests the best way to find doctors who want to work in rural or low-income communities is to ensure they can train in these settings.
>
> Private health care diverts cases from low-income and rural communities and limits the volumes of procedures done in public hospitals. When operations are done in private care, this further reduces learning opportunities because the cases most suited to trainees (low complexity and without multiple health problems) are moved to private care."[62]

Increased reliance on private healthcare may also further exacerbate access problems. Where there is a lack of clinical governance support of private health care, there is no reason to question the value or need for diagnostic tests.[63] Referral for unnecessary tests drives up utilisation of a hard to access resource (for example, radiology services). As a result, there is increased costs for tests, but a lower proportion of positive tests.

The negative effect of the adaptations listed above impact on the accessibility of specialist services, reduced sustainability of the workforce and a reduced ability to track quality and safety indicators. In our interviews with community pharmacists in November 2024, we found that increased locum use also increases the risks of "things falling through the cracks" as a result of poor record keeping, in particular in regard to prescribing (see page 9).[64]

Data received from Health New Zealand (Figure 3) provide an illustration of reduced staff capacity on reporting systems. In Figure 3 there has been a reduction in the monthly number of unique events recorded in the National Minimum Data Set for Waikato and Wairarapa districts (see bottom lefthand corner, *Framework, factor 6*).

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[60] Health and Disability Commissioner. 2025. Insights from HDC complaints. Personal Communication, 28 August

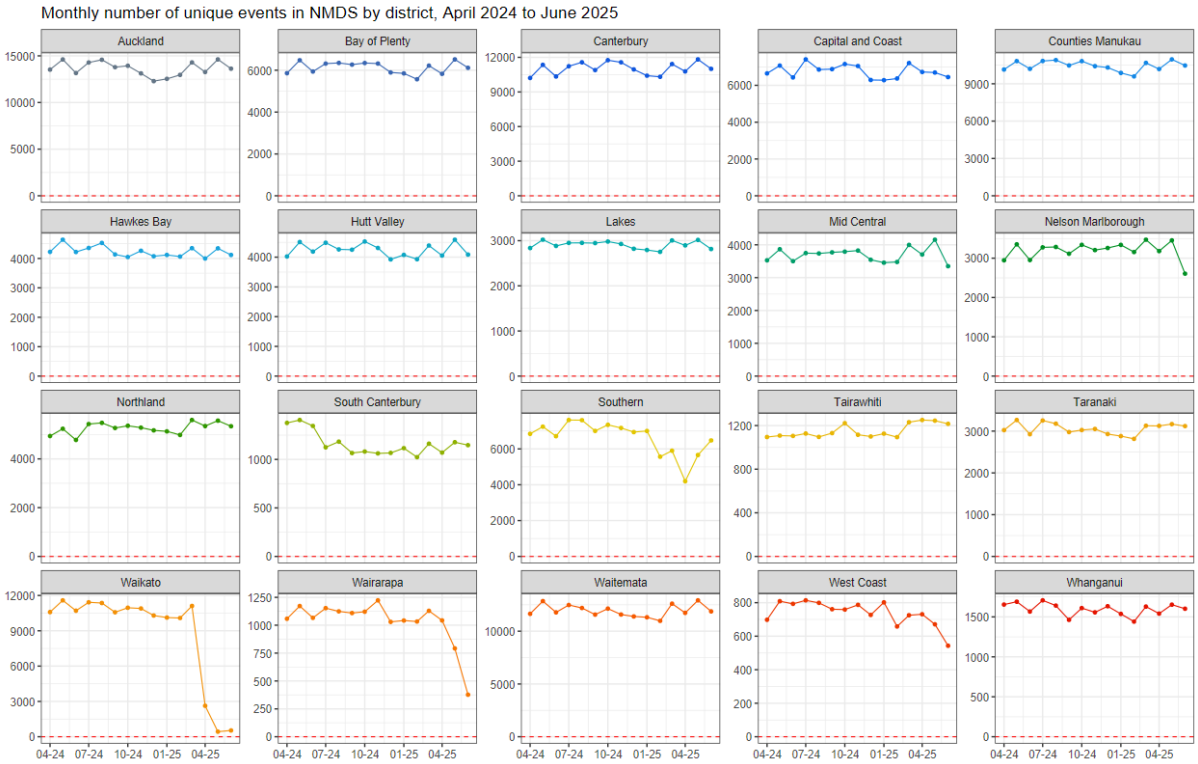
[61] Mathias, K. 2025. NZ's shift to more private health care will likely raise costs and reduce quality: what the evidence tells us. The Conversation. DoI: https://doi.org/10.64628/AA.fgr57n6qy (accessed 5 September 2025)

[62] Mathias, K. 2025.

[63] Kaabi SAL, Varughese B, Singh R.(2022).Public and Private Healthcare System in Terms of both Quality and Cost: A Review,J Clin of Diagn Res. 16(8), IR01-IR08. https://www.doi.org/10.7860/JCDR/2022/55387/16742

[64] Te Tāhū Hauora Health Quality & Safety Commission. 2024. Assessing system quality and safety: Insights report. November. URL: https://www.hqsc.govt.nz/assets/Core-pages/About-us/Insights-reports/Te-Tahu-Hauora-Assessing-system-quality-and-safety-insights-report-November-2024.pdf (accessed 19 August 2025).

Figure 3: Hospital discharges (unique events) reported to the National Minimum Data Set of Hospital Discharges, April 2024 to June 2025.



Special topic: Care pathways

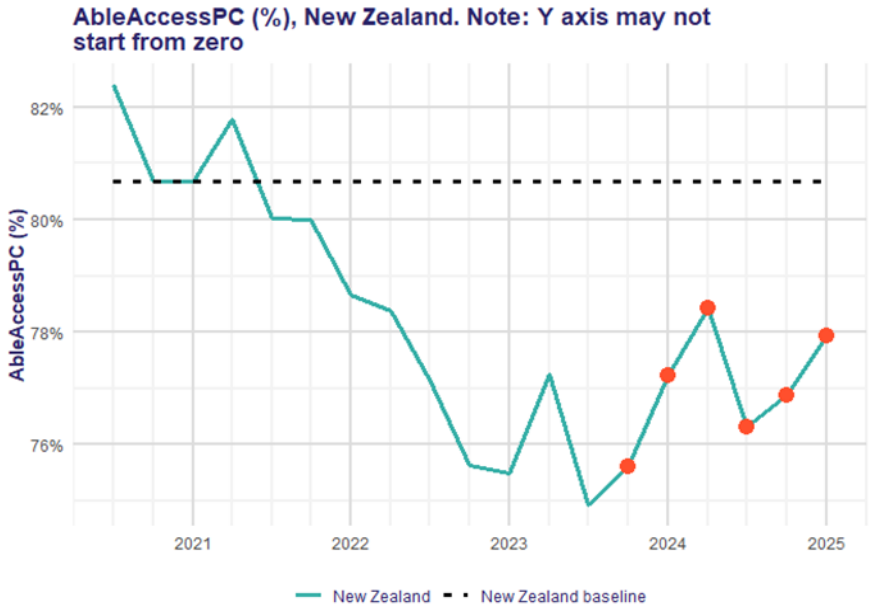
Throughout our reporting, we have found a lack of integration between primary and secondary care. Some of the the relationships that previously existed have been disestablished, as described in the *Clinical Governance* section above. This will adversely impact on pathways for care.

In this special topic section, we provide an overview of the data available to understand the impact on both acute and elective care. A detailed description of our work on acute care is presented in the Supplementary Paper. Our work on elective care is continuing and we expect it to be presented as a special topic in the December quarterly report.

Acute care

As shown in Figure 4, access to primary care remains difficult, with the proportion of those who had **no difficulties** accessing primary care reducing from around 83 percent in 2021 to 78 percent in 2025. The two main reasons reported for experiencing access difficulties were wait times and lack of access to the preferred general practitioner or nurse. This finding highlights the importance of continuity of care for the patient population and reflects the increased use of locums or other models of care.

Figure 4: Percent of primary care patient experience survey respondents who indicated that they did not experience problems accessing care



As noted in Figures 1 and 2, the number of ED attendances have increased, particularly since 2024 and for higher urgency patients (triage 1-3, Figure 1). Because there is not a substantial increase in the number of lower urgency patients in ED (Figure 2), our data indicates that patients are **not** attending ED because they cannot access primary care.

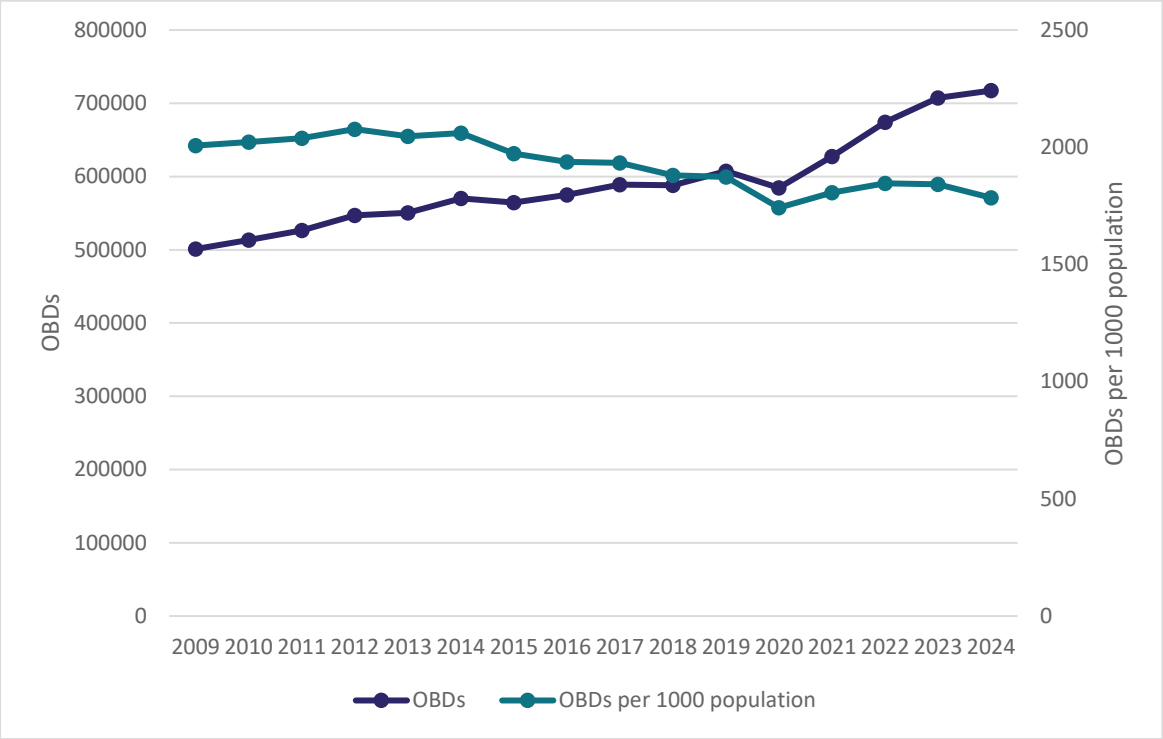
Instead, the data suggests that inaccessible primary care is resulting in patient deterioration, creating more urgent need for care. Data from our primary Care Patient Experience Survey shows that the proportion of people who said they attended ED because it was an emergency has remained consistent at around 75 percent since 2020.[65]

Table 1 also shows that acute admissions to hospital are increasing as a proportion of all admissions and particularly in occupancy of hospital beds. The supplementary paper shows that this particularly reflects the effect of older, frail patients. We estimate that occupancy by this cohort has doubled since 2018, an increase of around 100,000 bed days, as a result of both more admissions and longer length of stay (Supplementary paper, Figures 5-7). The effect of an increased older population by itself are minimal (Supplementary paper, Figure 8).

Further, there is increased length of stay, combined with an increased number of bed days being occupied by older people who are frequently admitted to hospital within a one-year period (a reversal after a decade of reduced occupancy rate by this group, see Figure 7). In addition, there are increased bed days being occupied by very long stay patients.

[65] URL: https://reports.hqsc.govt.nz/APC-explorer/_w_55852ae9/?_gl=1*1gew3ne*_ga*MTQwMDk4NzYyMi4xNzM4MDMyMTg1*_ga_TG4RCRSBWS*czE3NTczODc0OTIkbzExMyRnMSR0MTc1NzM4NzY2MSRqNDUkbDAkaDA.#!/ (accessed 9 September, 2025)

Figure 7: Bed days per 1,000 people aged over 75 years who admit acutely more than once in 12 months (NMDS, Stats NZ)



The lack of integrated care pathways is recognised by the HDC, who have received reports of older people and disabled people being unable to be discharged from hospital due to lack of community and residential supports. They have also received reports of a lack of access to psychogeriatric beds in some areas of the country.[66]

A recent review[67] of aged-care funding and service models support the analysis above and the disintegration of care pathways described by the HDC, finding:

- A potential shortfall of 12,000 aged-residential care bed by 2032.
- Substantial regional variation in the number of aged-residential care beds. For those aged 85 years and over, the number of beds per 1,000 population 85+ ranges from 149 beds in Northland to 272 beds in Canterbury.
- Regional variations for wait times for high priority individuals: from 82 days in Midcentral to 219 days on the West Coast.
- The proportion of older people utilising aged-residential care is declining, but the acuity of those who enter an aged residential care facility is likely increasing.
- New Zealand European individuals who have been assessed as a high priority for moving out of a home environment are twice as likely to be admitted to an aged

[66] Health and Disability Commissioner. 2025. Insights from HDC complaints. Personal Communication, 28 August.
[67] Moore, D. Loan, J. Rohani, M. Trill, R. Manning, N. Yee, D. 2024. A review of aged care funding and service models. A strategic assessment of aged residential care and home and community support services. Published by Sapere. URL: https://www.tewhatuora.govt.nz/assets/For-the-health-sector/Specific-life-stage/Health-of-older-people/FINAL_A-review-of-aged-care-funding-and-service-models_strategic-assessment.pdf (accessed 5 September 2025)

residential care facility within 12 months than Māori individuals with a similar high priority assessment.

- The average wait time for high-needs dementia and psychogeriatric care residents to be admitted to an aged residential care facility after being assessed as high priority for moving out of a home setting is almost six months.

Some aged-residential care providers are reporting increased needs for older people:

> "Not always easy [to provide clinically safe care] – increasingly fragile and complex [aged-residential care] resident population that we are beginning to see...Don't have the same staffing levels as acute care providers...Being able to afford the skill mix and staffing levels – legislating for staffing levels would support the argument of senior nurses within aged-residential care facilities."
>
> (Allied health professional, May 2025)

While the analysis in the Supplementary paper particularly relates to older, frail people, lack of integrated care pathways are also impacting on bed occupancy for other population groups, and will have flow-on effects to elective capacity, workforce discretionary activity and efficient operation of care pathways as described below:

> "Doctors not discharging in a timely fashion – too slow and bed-block. Homelessness in Rotorua and Taupō so patients are not being discharged because of the social issues, high comorbidities that exist. Means that other people aren't able to access health care...Introducing a supportive transfer service (START) – accelerated rehab, supports patients to be discharged earlier than previously. [We are hoping that this will] enhance availability of beds."
>
> (Nurse, May 2025)

> "Access is very difficult at this time – some parts of the community that find it very difficult to access care. When you see them they have huge health needs. Parts of the health system that don't recognise that it is very hard to access stuff. ED has been overflowing with stuff that should have been seen at primary health but they can't get into the GP. Had a child who waited 17 hours in the ED because the beds in the children's ward were blocked with adults. Normalised, swept under the carpet and said to be OK."
>
> (Nurse, May 2025)

> "Hard to manage within infrastructure safely. [We] have done a number of programmes in the community trying to keep people out of hospital and manage acute care. [But] demands increase year on year, acute care outstrips the staff available. [We] need real investment and commitment to planning."
>
> (Senior doctor, August 2025)

Elective care *(Framework, Factors 8, 9 and 11)*

Our emerging work on elective care indicates that there are hidden wait times between first specialist appointments and being placed on the waiting list for treatment. The data suggest

that these hidden wait times are growing, and the experience of wait by patients is not wholly reflected by targets or target performance.[68]

Throughout this series of quarterly reports, consumers and the workforce have reported difficulties accessing community diagnostics, and especially radiology services. This is supported by complaints to the HDC who identify radiology, in particular, as an enabler of quality, timely treatment. Delayed radiology adds to the hidden wait times for people accessing specialist appointments and access to advanced imaging services (e.g. MRI) is particularly constrained in some areas of the country

Median clinical priority assessment criteria (CPAC) scores have increased for some procedures. This may indicate worsening of conditions while patients are waiting longer, or it may reflect increased rationing of care. Our interviews with general practitioners provide evidence of the costs associated with delayed access, although this cost may be carried more by individual general practitioners than the health system:

> "Time pressure of complex patients. Even with 20 mins you are not peeing or not eating – you are run off your feet."
>
> (General Practitioner, July 2025)

> "When we can't access the services that patients need, we are seeing them two, three, four, five times more than we are paid for under the utilisation agreement. So it ends up that their GP who has signed up to look after them ends up holding the risk for the failing public secondary or tertiary health system. We end up personally paying for that. It's not the managers at the DHB, it's not the SMOs at the hospital."
>
> (General Practitioner, August 2024)

The hidden costs associated with treatment delays are also reflected in the burden carried by patients. For example, the HDC report complaints about a lack of communication for expected timeframes for treatment, alternative options and safety netting advice, as well as difficulties getting in contact with specialist services or their primary care clinic.

The dissolution of care pathways for both acute and elective surgery may be long-standing issues, as there have been historical inequities in access to services across regions. However, the restructure has exacerbated a problem that was already growing as a result of a population who were aging and had more complex health conditions (*Framework, factors 8, 9 and 11;* Supplementary paper).

Signs of improvement

In this section we describe signs of improvement and initiatives that have been launched to address some of the issues raised in our reports. The initiatives described in this section are supporting systems change and adaptation.

[68] This is preliminary evidence generated from work that we have commissioned from NZIER. We anticipate being able to provide more detail on this work in our December quarterly report when this work will have been completed.

Staffing *(Framework, Factor 3)*

Some staff are seeing potential for improvement in the future, but this is counterbalanced against the actual gains not yet realised *(Framework, factor 3).*

> "I have hope for the future – improvement over a year ago."
>
> (Senior doctor, August 2025)

> "Last year general practice were in the worst doldrum that I had seen in a 40-year period…Were at the point that principals were earning less than the locums they were employing…Fortunately the minister has responded…[I feel] more hopeful now, although the mood is still a bit depressed – [some] can't see a solution to the demand."
>
> (General practitioner, August 2025)

> "Some improvement – people are more stabilised, but regional nursing leadership remains a problem in particular, as well as general practitioner cover…Rural and remote villages having to consider other types of GP cover, which must be provided under ARC contract…Not just capacity, but capability and competence."
>
> (Allied health professional, May 2025)

This change is particularly noticeable in our interviews with people who work in primary care. Recent changes in funding allocations, while treated with some scepticism, are creating hope for some in the sector, as described above.

Improvements are also evident in our discussions with some secondary care providers:

> "Sense of some stability forming, in the last week our district executive lead has been appointed, the board has been appointed and the chair…But some systems and processes still unclear – for example, what will the regional space look like? A year ago [it] was going to be 4 big regions with a lot of autonomy. [I have a] sense that it is going back to more central and district with regional enabling. [We still have] no details, but at least a sense of progression."
>
> (Senior doctor, August 2025)

> "Staffing has picked up a bit in the last 6 months – increase in midwives. [We are] still under-staffed but have more new graduate midwives. More bodies on the floor but aware that need to provide clinical coaching and support. [It seems that the] pipeline for student midwives has suddenly expanded."
>
> (Senior midwife, secondary care, June 2025)

> "Secondary intake of new grads [nurses]. This hasn't happened before."
>
> (Nurse, May 2025)

> "Registered nurse availability is better than it has been for a long time. Put through more nursing students who have now graduated, hospitals not employing which has helped the aged care sector."

(Allied health professional, May 2025)

Staff we interviewed told us about the importance of a sustainable pipeline for new health professionals. For midwifery care, the establishment of the Maternity Care Assistant roles are an important part of developing functional, safe midwifery graduates. While these roles were initially developed in Auckland during the COVID pandemic to support the workforce, they have subsequently expanded throughout the country. Box 4 provides an overview of the role and the strengths and weaknesses of the current system.

Box 4: Maternity Care Assistants

The role

Maternity Care Assistants (MCA) are described under the MERAS Collective Agreement as

> an employee who works in a supportive role to the midwifery team and is able to perform tasks relating to the care of women/birthing people, new parents, babies and their whānau. They take a housekeeping role to create an environment that is welcoming and supportive of whānau. They work solely under the direction and supervision of a midwife. The employee needs to be enrolled in a New Zealand Bachelor of Midwifery programme.[69]

Strengths

Students perform the MCA role alongside their studies. Those who have been employed in these roles describe the following benefits:[70]

- Relationships – they felt part of a team, making it easier to make the transition as a graduate midwife.
    - Enhanced safety for graduates as more able to ask questions;
    - Enhanced trust between senior midwives and graduates who had come through the MCA roles.
- Understanding of systems – beneficial when graduating to an LMC or core midwife role.
    - More responsive in emergency situations.
    - More familiar with where equipment and supplies are kept.
- Financial support when completing studies
- Cognitive load of being a student removed => enhances training.

Weaknesses

[69] Midwifery Employee Representation & Advisory Services. 2023. Te Whatu Ora – Health Nz and MERAS Midwives Collective Agreement. URL: https://www.tewhatuora.govt.nz/assets/For-health-professionals/Employment-relations/Nursing-and-Midwifery/MERAS-Midwives-Collective-Agreement-2023-2025.pdf (accessed 22 August 2025). Page 7.

[70] Woods, C., Groom K., Cronin R., Jordan V., Wihone D., & Gafa S. (2025). Exploring the Impact of the Maternity Care Assistant (MCA) Role on the Transition from Student to Registered Midwife in Aotearoa. Perinatal Society of Australia and New Zealand Annual Congress, Brisbane, Australia, April 7-10.

- Patient centre care hours that are not counted towards training hours – needs improved integration.
- Positions not available throughout the country.
- While there is a national job description, the operationalisation of the job description can vary across the country.
- Students who have participated note a lack of role clarity, or a frustration with the limits placed on them when employed in the capacity of an MCA, and noted the potential for a credentialed role:

  "It is a bit disconcerting cause you are working one day with them as a fourth-year student, and they'd be catching a baby and popping in IV and suturing and doing full assessments on complex woman and doing it really well. And the next day [employed as an MCA], they'd be stocking shelves and you'd be desperate for someone to give you a hand at a birth. But you knew that they couldn't."
  (Allied health professional, August 2025)

Clinical governance, the interface between primary and secondary care, and quality improvement

The Commission is supporting the re-establishment of relationships between primary and secondary care by working closely with districts to ensure that their clinical governance structures are in line with the recently published clinical governance framework.[71]

Box 5: Supporting the development of clinical governance systems

Clinical governance structures: How we are supporting the system to connect

In 2024, the Commission released *Collaborating for Quality: A Framework for Clinical Governance*.[72] The framework was intentionally aspirational and developed to enable those working across the health sector to develop their own clinical governance systems, appropriately adapted to their context and settings.

Since the release of the framework, we have been working alongside our health sector partners to support them to progress clinical governance within their own context.

Our engagement has included:

- National health agencies
- Community service providers;
- Aged-care providers;
- Hauora Māori;
- Ambulance services;

[71] Health Quality & Safety Commission Te Tāhū Hauora. 2024. Collaborating for Quality: A Framework for Clinical Governance. URL: https://www.hqsc.govt.nz/resources/resource-library/collaborating-for-quality-a-framework-for-clinical-governance/ (accessed 12 August 2025).
[72] URL: https://www.hqsc.govt.nz/assets/Our-work/Leadership-and-capability/Building-leadership-and-capability/Publications-resources/Clinical_governance_A3_complete.pdf (accessed 22 August 2025)

- Health New Zealand regions.

Feedback from those who have participated in these workshops are positive, focused on the improvement of relationships with key stakeholders, including consumers and whānau as outlined within the Clinical Governance Framework. Key takeaways as described by Robyn Shearer who was acting Deputy Chief Executive, Central Region at the time of our workshop include:

> "Relationships matter to improve clinical quality, consumers are our important partners to understand what is needed for improvement, be empowered to act on issues quickly."

Participants have also noted how the framework can easily be built into other strategic planning documents and organisational standards:

> "The Framework will enable us to continue our plan of including input into clinical governance from across all areas of the organisation and our current work on our strategic intent and mapping against the Ngā Paerewa Standards."

Clinical governance structures between primary and secondary care are being established in localities where there has been funding to support additional roles. Box 3 (above) illustrates the systems and structures that have been established in Tai Rāwhiti as part of the comprehensive primary care teams. As well as ensuring a relationship between primary and secondary care, there have been wider benefits for the community:

> "Have been some amazing things that have happened in the last year – integration between primary and secondary care has grown a lot and CPCT [comprehensive primary and community teams] has enabled partnership with Iwi.
>
> GP liaison that sits on hospital clinical governance structure – provides the GP voice into this space…Good pathways for communication and escalation…Good relationships to reach in and bridge between primary and secondary care…Benefits of being part of a smaller community."
>
> (General practitioner, August 2025)

Workforce participants have described quality improvement initiatives they have been involved with, although these are occurring sporadically in secondary services. For example:

> "We had an 'All Labour and Birth Outcomes Day', which included secondary and tertiary hospitals, and some of the primary ones, in New Zealand. We met in Palmerston North and [everyone] presented their … birth data and birth outcomes data… Mike Robson, who was one of the early pioneers of looking at birth outcomes, came to New Zealand… and because it was so successful, he's coming back and we're having another day at the end of 2025…it's really good, but it's kind of challenges you to look at your statistics and think about why they are like they are and what you might consider doing to reduce, for example, caesarean sections or address breach birth."
>
> (Allied health professional, June 2025)

As of August 2025, systems issues identified through this series of reports are being presented at the National Quality Forum (see Box 6). This provides an opportunity to identify solutions and for collaboration between agencies.

Box 6: Systems issues raised at the National Quality Forum

Creating a collaborative approach to addressing quality and safety

In August 2025, the Commission led a workshop in which Forum members discussed four key issues that have been evident throughout the insights reporting. These included:

- Ongoing difficulties retaining trained workforce, and upcoming GP retirements, are raising concerns about the sustainability of the workforce.
- Staff shortages and infrastructure limitations are linked to flow challenges between primary and secondary care and access to diagnostics. There is increased pressure to keep chronically unwell patients in the community.
- Primary–secondary interface: Distinct issues in how these sectors connect, particularly in clinical governance processes.
- Structures for clinical reporting being established, but concern about decision-making and feedback loops continues.
- Limited to no capacity to participate in quality improvement work, with activities often increasingly discretionary and deprioritised. Declining participation in quality improvement activities noted, particularly in secondary care. Limited time and opportunity are key constraints; workforce fatigue may be a contributing factor.

As highlighted above, service integration was noted as a major concern at a recent National Quality Forum meeting. Participants believed that strong clinical governance structures would support service integration but are not currently fulfilling that function.

Improving access to data

To address difficulties in accessing data for quality improvement, the Commission has analysed responses from its Adult Inpatient Experience Survey for those who received maternity care and produced a maternity-specific report for each district. A summary of the contents of the reports is captured in Box 7.

The individual reports have been positively received by both individual localities, Colleges and the National Clinical Network, as described:

> “This is fabulous and a great report to celebrate the areas of our care which we have received a positive level of feedback on, and we can create better resources and improve aspects of care were identified too. I will share with the midwifery managers.”
>
> (Allied health professional, September 2025)

> “There is lots of really good information for us to look at, work on, and feed back to staff.”
>
> (Senior doctor, September 2025)

Box 7: Generating locally appropriate data for quality improvement

The goal of the Adult Patient Experience Survey for those receiving inpatient maternity services is to better understand their care experiences; to identify whether some demographic groups have a better or worse experience; to understand areas where services perform well and where there are areas for improvement; and to identify district variation in patient experience.

Results are reported in three themes: communication and involvement, cultural safety, and discharge experiences. We report on these themes because they are core questions, persistently low scoring, show high variation between populations, or are particularly relevant for maternity care. We also included free-text response options to allow survey respondents to explain their answers. Where these are helpful to provide additional context to locality-specific outputs, we have included these in our reports.

Nationally, the highest scoring results were people reporting they were treated with respect and kindness by doctors (94 percent) and other members of the healthcare team (90 percent). 93 percent of those who had an operation or surgery understood what would happen and what to expect. People generally reported both themselves and their family / whānau were involved in decisions about their treatment and care, and that their cultural and spiritual needs were met.

Lower scoring questions related to discharge experience, specifically being informed about what would happen prior to discharge (75 percent reported they were kept informed), whether they had information they needed to manage at home (70 percent discussed the help they would need at home), and being informed on side effects of medication they left hospital with (66 percent were informed). One third of respondents reported receiving conflicting information by doctors or staff involved in their care.

Addressing pressure injuries *(Framework, Factor 14)*

As highlighted through this series of reports, there are widespread quality alerts for pressure injuries.[73] This corresponds with an overall increase in treatment injury claims to ACC, both in terms of quantity and the value of claims *(Framework, factor 14).* Pressure injuries can occur both in hospital and in the community. Community acquired pressure injuries can drive emergency department visits and hospital admissions.

In 2023, analysis of Commission adverse event data for pressure injuries revealed an increase in non-hospital acquired pressure injuries. Non-hospital acquired pressure injuries occur in the community (80 percent) and aged-residential care settings (20 percent).

Analysis showed that the highest incidence of non-hospital acquired pressure injuries occurred in Pacific people, followed by Māori, and especially occurred in those aged 75 years and older. Our data shows an increasing incidence and late detection of pressure injuries within the community among Māori, Pacific, and people with darker skin tones, and older adults supported by whānau. Pressure injuries in the community were found to be increasing at a higher rate than hospital-acquired pressure injuries.

In 2025/26, the Commission is supporting work to improve knowledge and awareness of the prevention and management of pressure injuries in whānau-led care in the Counties Manukau area. This project will have a focus on pressure injury prevention and early

[73] Pressure injuries are damage to the tissue, usually over bony areas of the body because of sustained pressure or friction. They can be prevented through knowledge and appropriate care provision.

detection in those aged over 55 years with darker skin tones. Resources will be co-designed with whānau family and relevant stakeholders.

While the scope of the project is in the South Auckland area, any new resources will be shared with all districts across New Zealand.

Focusing on care pathways

The 13 National Clinical Networks are working to make health services more connected, efficient, and patient-focused. Members of our expert advisory group have provided examples of their work programmes:

- Joining forces on long-term conditions: Several networks have worked together to help produce new Cardiovascular Kidney Metabolic (CKM) guidance. These conditions are the leading cause of delays in planned care, as well as major contributors to illness and early death. The guidance provides clear, practical direction to health providers, helping ensure people receive consistent, evidence-based care wherever they are.
- Freeing up eye care services: The Eye Health Network has developed a new approach where optometrists will take on follow-up checks after cataract surgery. This simple but important change will free up specialist ophthalmology appointments for new patients, meaning more people can be seen sooner.
- Improving flow through radiology: The Radiology Network has identified and prioritised key procedures that will make the most significant difference to patient flow. By focusing resources in this way, radiology services can help more people access timely investigations and treatment.

Together, the Networks are aiming to find practical solutions that span primary and secondary care, reduce bottlenecks, and improve outcomes for patients and whānau.

In our December quarterly insights report, we will provide more detailed information on the operations of the National Clinical Networks and their work programmes.

Appendix 1: Methods

We have used a combination of both quantitative and qualitative data. Quantitative data generally measures past events, while qualitative data offers insights into current conditions, providing additional information about classes two to five of Vincent's model for measuring system safety. Combining these measures allows us to make general statements about issues in need of attention.

Quantitative measures

Patient experience surveys

The *code of expectations for health entities' engagement with consumers and whānau*,[74] required by the Pae Ora (Healthy Futures) Act 2022, underscores the importance of understanding the experience of consumers, whānau and their communities when assessing system quality and safety.

We conduct national patient experience surveys to regularly collect, measure and use patient experience feedback for quality improvement. These surveys are designed to find out what went well and what can be improved about patients' experiences of health care in New Zealand. Every three months, a national selection of adult hospital and primary care patients are invited to participate, while children under 15 years are not surveyed. Participation is voluntary and anonymous.

The patient experience survey programme includes 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 the Commission

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 reductions in harm.[75] Quality measures are dependent on district reporting. There is varying level of engagement with quality alerts across different regions of the country (see *Framework*).

Perioperative mortality data

As part of the National Mortality Review function, the Commission publishes the perioperative mortality explorer.[76] Perioperative mortality refers to deaths that occur during the hospital admission for the index surgery or within 30 days of the surgery. The explorer

[74] Te Tāhū Hauora Health Quality & Safety Commission. 2022. Code of Expectations for health entities' engagement with consumers and whānau. URL: www.hqsc.govt.nz/resources/resource-library/code-of-expectations-for-health-entities-engagement-with-consumers-and-whanau/
[75] See URL: www.hqsc.govt.nz/our-data/quality-and-safety-markers/qsms-january-march-2024/
[76] From https://www.hqsc.govt.nz/our-data/subscribed-apps/perioperative-mortality-explorer/

enables an examination of differences in perioperative mortality by ethnicity, gender, and deprivation level, as well as between surgical specialties and groups of surgical procedures.

Health New Zealand measures

We obtained 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

Rather than having a minimum number to interview at each time point, we sought saturation. This means that we continued the interviews until we began to hear consistent themes being raised by interview participants.

Consumer survey

To supplement the information from patient experience surveys, which assess the quality of care received after services are accessed, an email invitation was sent to the members of the consumer groups the Commission coordinates to participate in a short questionnaire: the Consumer Advisory Group, Consumer Network and Young Voices Group.

Over the reporting period we have had 51 consumers respond to the survey.

In 2025 consumers were invited to take part in an interview instead of the survey. An additional 6 consumers have participated in the interviews.

Health workforce interviews

Over 12 months of collecting information, 124 health managers, clinicians and allied health professionals were invited to take part in an interview about their perceptions of safety in the health system.[77] The members spanned:

a) primary health care
b) secondary health services
c) aged residential care
d) allied health services.

Of those invited, 68 (55 percent of those who were invited) participated in an interview.

Table A2.1 provides an overview of the districts spanned in the health workforce interviews, while Table A2.2 outlines the roles titles. Our November 2024 report focused specifically on

[77] Due to the tight timeframes involved in the production of this report, participants were known contacts of the Commission, or drawn from recommendations to the project team. We spoke to participants from a range of professions, regions and facility size.

the experience of general practice, therefore we have an over-representation of general practitioners and primary health organisation management in the cohort.

Note: we have not provided a description of roles by district to maintain the confidentiality of participants.

Table A2.1: Distribution of workforce respondent districts

District	Number
Auckland	6
Bay of Plenty	8
Canterbury	1
West Coast	1
Capital and Coast	7
Counties Manukau	6
Lakes	4
Mid central	2
National	8
Nelson Marlborough	6
Northland	5
Southern	4
Tairawhiti	1
Taranaki	2
Waikato	3
Wairarapa	3
Waitematā	1

Table A2.2: Distribution of roles represented

Role	Number
Aged residential care	4
Chief medical officer	3
College of GPs	3
Community rheumatologist	2
Extended care paramedic	1
Health NZ	2
HSS Manager	3
Community mental health	2
Midwife	3

Neonatologist	2
Pacific general practice	4
Prevocational training	2
Primary care	3
Quality & risk manager	3
Resident medical officer	1
Rural health specialist	2
Senior medical officer	1
Staff nurse	2
GP	13
Primary care clinical director	2
Practice manager	2
Nurse practitioner	1
PHO CE	1
GP Owners Assn	1
Hauora Māori	5

Pharmacy survey

We also include responses to a survey of community pharmacists in the November 2024 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.

We received 16 responses to the survey. Geographical distribution of the respondents is presented in Table A2.3.

Table A2.3: 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