

# Briefing report

# Ministerial briefing report

### Briefing report number: HQSC MIN 2024-005

То	Hon Dr Shane Reti, Minister of Health		
Title	Measuring system safety and quality – a proposed approach		
From	Dr Peter Jansen, Chief Executive		
cc	Fepulea'i Margie Apa, Chief Executive, Health New Zealand Dr Diana Sarfati, Director-General, Manatū Hauora Stephanie Buick, Acting Principal Advisor, Manatū Hauora		
Consulted		□ Te Whatu Ora Health New Zealand	
Date	12 August 2024		

# **Purpose**

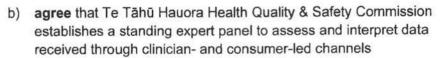
 You have requested a briefing on our view of safety in the system and how you can be informed on a regular basis about how safe the system is, with a particular focus on what intelligence can be gathered from consumers and staff about safety.

# **Executive summary**

- This paper discusses the intelligence currently available to us, our proposal for how we can curate this into a regular overview of the system and how this forms part of a comprehensive view of quality. For the proposed approach to be successful a variety of data will need to be made available by stakeholders.
- The proposed approach involves Te Whatu Ora Health New Zealand (Health NZ) and others. We have shared and advocated for this approach with Health NZ who is in agreement with our proposed approach.

#### Recommendations

- 4. It is recommended that you:
  - agree to the proposed approach by Te Tāhū Hauora Health Quality
     & Safety Commission for providing you with a regular update on system safety and areas of risk



 note that the necessary data collections are held by a variety of providers and that it will take some weeks to gain access to all required data sources





#### Te Tāhū Hauora Health Quality & Safety Commission contacts

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#### Discussion

#### Available Intelligence

- 5. Te Tāhū Hauora Health Quality & Safety Commission holds and develops numerous measures on health service process and outcomes. This includes, through the patient experience survey programme, systemised estimates of patient experience (relevant available measures are set out in Table 1). These are rigorous, and consistent and allow time series analysis. However, they have limitations, all of which are connected with timeliness in different ways:
  - These measures are lag not lead, they report what has <u>occurred</u> not what risks are <u>occurring</u> or are potentially emergent. If not supplemented by leading indicators these risks become nothing more than restatements of known problems.
  - As the majority of measures depend upon coding of events this creates delays of a minimum of six weeks before they can be assessed. This does not invalidate them as methods of identifying systemic problems, but they cannot give an early warning.
  - Different tempo of reporting monthly/quarterly (as per Table 1 below) and how these can be aligned.

#### Table 1: Te Tāhū Hauora currently held measures relevant to safety

Type of data	Reporting tempo	Update schedule
Patient experience surveys cover: access, humanity of care, communication and hand-offs (discharge etc) – could identify a set of 5-10 key	Quarterly	August, November, February, May

questions that pertain (and which are highly predictive of the general pattern)		
Specific harms associated with the Quality and Safety Marker (QSM) and other programmes cover: in hospital falls, post operative DVT/PE, SSIs, in hospital SABs, in and out of hospital pressure injury, in hospital cardiac arrests	Quarterly	September, December, March, June
Perioperative mortality – available from September	Quarterly	October, January, April, July
Other mortality and complications (stroke, heart failure, #NOF, CHD, pneumonia, DVT/PE, falls, SAB) <sup>1</sup>	Quarterly	September, December, March, June
Adverse events – review of reporting and investigation behaviours to highlight failing safety culture is a possibility but this is an 'evidence for expert judgment approach' rather than a 'monitor figures' approach.	Bi-annually at best as measuring safety culture	

- 6. Measures such as those in the above table need to be supplemented by leading indicators (see appendix 1) and so-called 'soft intelligence', i.e. the aggregated, curated and interpreted narratives, observations and opinions of clinicians, consumers and other participants in the health system such as the Health and Disability Commissioner.
- 7. Te Tāhū Hauora has good links to gathering, and experience of curating, this sort of intelligence through:
  - <u>Consumers</u> The Commission holds long established consumer councils and fora.
     These channels can support a pipeline of monthly intelligence and we propose to continue and extend this to share emerging issues with you. Currently this information is provided to our board.
  - Staff We propose to adapt an approach we used to report on emerging issues in different parts of the sector during the Omicron outbreak in early-2022. This built on semi-structured interviews with typically a dozen or so stakeholders each week, thematic analysis of intelligence gathered, and rapid reporting. Our proposal would be for a panel of representative voices from different professions, grades, specialties, sectors and parts of the country approached on a rotating sample basis for short interviews, synthesis and analysis by a clinician-led expert group and a broader sharing of this with you, the Ministry of Health (the Ministry) and Health NZ.

#### Regular reporting - what we can provide and what we know now

8. We can provide you with a monthly memorandum based upon the latest available intelligence which populates the framework set out below. This framework has twelve

<sup>&</sup>lt;sup>1</sup> DVT/PE – deep vein thrombosis/ pulmonary embolism

SSIs - surgical site infections

SABs - staph aureus bacteremia

<sup>#</sup>NOF - fractured neck of femur

CHD - coronary heart disease

- 'leading' (forward-looking) factors and five 'lagging' (events already occurred/occurring) factors. Each factor is framed as a question.
- Appendix 1 shows the factors (questions) and potential sources of intelligence (and what
  the Te Tāhū Hauora can provide) alongside our current safety assessment and status,
  based upon the Te Tāhū Hauora existing data sources.
- 10. From our data, and from interactions with the system, we conclude that of the 'leading' (forward looking) factors:
  - seven give us cause for concern now, in some cases because robust data are not available to us
  - for two of the others our data is not concerning but is very partial, so more complete data is required
  - two potential factors require further development of method to be included on a routine basis
  - d. one (reported patient experience) remains broadly stable.

#### 11. Of five 'lagging' indicators:

- a. two (safety outcomes and mortality) give concerns in some services and geographical locations but are broadly stable at a national level
- b. for three Te Tāhū Hauora does not hold enough data to make a confident judgment, and this needs to be supplemented with data from Health NZ and others.
- 12. While recent data shows positive outcomes are generally being achieved, the leading indicators point to essential quality structures either not in place or not functioning optimally. Noting the increased pressure on the system, the poor performance in lead indicators represent deficiencies in safety defences.
- 13. We cannot populate large parts of the framework with our current intelligence. This is of itself a risk to quality we respect and acknowledge both the expertise, detailed local knowledge and the large range of data held by others. Siloed storage of key data is counter-productive and carries risk. Much of the intelligence needed to populate this framework is held by Health NZ, and they need to be closely involved in this process. Investing in an approach to gathering the most relevant information in a timely manner will be vital.
- 14. A key data source will be the primary care information. General practice, as the gateway to healthcare, can provide a wealth of understanding around both how it is functioning and also as precursor to pressures on hospital-based care. Currently access to general practice data is difficult and requires discussion with relevant organisations.
- 15. As Health NZ moves to a more decentralised regional approach, consideration will need to be given about how the data received is structured and analysed to gain the most benefit from it.
- 16. We have shared Appendix 1 with Health NZ as our suggestion of how they should structure their own understanding of system safety, and with the recommendation that they should share their data sets to enable ongoing analysis.

#### Regular reporting – underpinning principles and way forward

17. The framework in Appendix 1 is based on principles which derive from our analysis of the most recent literature and our experience of seeking to understand system safety.

- 18. The framework needs to enable judgements based around expert interpretation of a wide range of intelligence. Trying to run or judge such a large and complex system off a handful of 'killer indicators' risks over-concentration on a few topics and missing emergent problems. It is our view that:
  - a. The framework must consider the risks to safety and quality and not just measure past outcomes. This means the use of 'leading' measures concerning the presence and operation of quality structures and behaviours.
  - b. Operationalising any safety framework to improve and address issues requires experts from across agencies and specialties to consider, interrogate, and reach conclusions based on all available intelligence, and identify actions with accountabilities in response. We advocate for a standing system-wide group to undertake this role.
  - c. Healthcare operates in a dynamic environment with issues changing over time; so too should both the framework and the intelligence that populates it.
  - d. A lack of intelligence about an issue will normally of itself be a negative indicator (because our intelligence is deficient which increases risk).
- 19. While many conditions and causes apply nationally, the precise combinations of these operate differently in different places. Safety failures occur locally and affect different groups disparately. Wherever possible all intelligence should be disaggregated to appropriate geographical locations, ethnic, gender and age groups to identify issues and inequities.

#### Developing a system going forward

- 20. The most fundamental limitation of any data-based system of risk management is the lagging nature of most safety indicators. While Te Tāhū Hauora can provide reasonable amounts of data and analysis, this will always have the problem of both delay (as measures have to be derived from clinically coded data) and tempo (sufficient numbers to have statistical power limits practical frequency of update). This is why the framework emphasises leading measures they are essential to identify and address safety risks before these become failures.
- 21. Many leading indicators rely on so-called 'soft intelligence'. While these are important, they only provide a partial picture.
- 22. While there is no unique set of data that the Te Tāhū Hauora holds that can provide you with different intelligence about system risk, our specialisation in quality and safety, consumer engagement and analysis, together with our unique position in the system, means we are best placed to provide you with the following:
  - Convening of the appropriate clinicians, consumers and others from across the broader health system to gather, test and interpret rapidly assembled intelligence about current system risks and safety
  - Creative use of hard data to test and model risks associated with imbalance of demand and supply, changing patterns of patient flow through the system and identify rapidly changing outcomes such as mortality
  - c. Long-established robust and efficient routine reporting of relevant quality and safety data

- d. The relative independence of Te Tāhū Hauora and its high level of trust within the system makes it ideally positioned to convene the required experts to interpret all of the above to give a regularly updated state of play on identified risks to quality together with likely best solution to mitigation and who holds the levers to mitigate.
- 23. Developing a reliable structure to allow collaboration on population and interpretation of the framework between the relevant bodies (Health NZ, the Commission, Accident Compensation Commission, Ministry of Health, Health and Disability Commissioner, the Te Tāhū Hauora Consumer Network and primary care organisations) seems to us the most essential next step to get this to be useful.
- 24. To give effect to the collaborative process outlined in paragraphs 18b and 22, we propose an expert group which has common access to all the required data, and the right links to clinicians and consumers for their insights, to provide the interpretive layer to report to the right level is needed to attach this monitoring framework to intervention and improvement both on the ground and at a strategic policy level. This group needs to be wide enough to have a comprehensive view but tight enough to be effective (i.e. avoid being a talking shop/representative group). We envisage that under this approach data could be updated on a monthly basis (allowing that not all underpinning data updates on this schedule).
- 25. We welcome the opportunity to discuss your views on this approach and any other opportunities for how the Te Tāhū Hauora can best support you.
- 26. We note that establishing the monitoring system proposed above will take some weeks and will depend on data access, availability, and internal resource capacity. Additionally, we can only report on what that data shows while acknowledging any limitations it may have.

#### Consultation

27. Health NZ and the Ministry have been provided previous iterations of this paper and Prof Lester Levy has requested Health NZ provide him with a report on how to monitor system safety, which Te Tāhū Hauora has helped to draft.

# Financial implications

28. At this stage there are no financial implications, however we do note that there will be a degree of resource intensiveness required to collect the appropriate data, analyse it and report back on it that will require a reprioritisation of activities.

# **Next steps**

29. If the approach articulated in the paper is approved, we will move to identify appropriate individuals to form a clinician-led expert group to work alongside consumer and staff networks to synthesise the data and identify areas of interest. This will be reported back to you on a monthly basis.