



9 October 2024



Tēnā koe

RE: Accident Compensation Corporation surgical mesh adverse event and risk of harm reporting to Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora)

Thank you for your email which we received on 17 September 2024 under the Official Information Act 1982 (OIA) regarding the Accident Compensation Corporation (ACC) surgical mesh adverse event and risk of harm (ROH) reporting to Te Tāhū Hauora.

You requested the following information.

- 1. The total number of surgical mesh RoH notifications sent to you by ACC in the last 5 years.
- 2. Can this information be broken down to clarify the type of procedure that these notifications relate to, SUI/POP hernia and rectopexy (rectal/bowel) surgical mesh procedures.

As advised in our email to you on 27 September 2024, we have transferred questions 1 and 2 of your request to ACC for their response, in accordance with Section 14 of the OIA. You will hear from ACC regarding these questions.

The two remaining questions are addressed below.

ACC cover specialists assess the ROH after the claim is decided, this analysis includes both Potential consequence and Potential likelihood criteria relating to an assessment of future risk to the public.

3. Taking into consideration both the Potential consequence criteria and the Potential likelihood criteria, has HQSC seen any improvements regarding the format for ROH notifications made by ACC to the HQSC, or overall improvement in the number and type of claims reported.

Te Tāhū Hauora has not seen any improvements regarding the format for ROH notifications made by ACC to Te Tāhū Hauora. Regarding overall improvement in the number and type of claims reported we have historically provided advice on how to strengthen the thematic ROH

provider reporting using the World Health Organisation clinical management classification codes.

4. Has HQSC requested that ACC make changes to the ROH reporting process, if so, can you please provide detail on what was requested and if these improvements have been made.

Te Tāhū Hauora and ACC have collaborated to improve the ROH reporting process. In 2020, we worked together to reduce double up of reporting by the hospital sector at that time and to standardise risk of harm language, particularly in areas where focused quality improvement and sector guidance was in place, such as pressure injuries. ACC replicated our severity assessment classification (SAC1) guidance in their treatment policy, and since then have provided monthly reports of the risk of harm data that meets our SAC1 criteria.

The two organisations meet to discuss this data and manually compare against our database to determine which events have also been reported to us as SAC1. However, as we do not receive patient identifiers, this process is not an exact science. In the 2022/23 year, we received 113 risk of harm events from ACC. Of these, 34 events (30 percent) were reported to both organisations (ROH ACC, adverse event SAC1 Te Tāhū Hauora), an increase from 11 percent two years ago. This provides insight into potential under-reporting of harm and where we can focus our provider support to improve the quality and safety of the health system at all levels.

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Nāku noa, nā

Dr Peter Jansen Chief Executive Officer Te Tāhū Hauora Health Quality & Safety Commission

