Identifying system-level opportunities to reduce harm 2021/22 | Te tautohu mahi hei whakaiti tūkino 2021/22

Introduction | He kupu whakataki

The purpose of this report is to inform providers, consumers and whānau how Te Tāhū Hauora has supported the identification of system-level opportunities to reduce harm in 2021/22. It includes:

- the role of Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora)
- a summary of the adverse events reported in 2021/22
- how we have supported providers to share lessons learnt, develop a health system safety strategy and implement the Healing, learning and improving from harm: National adverse events policy 2023 | Te whakaora, te ako me te whakapai ake i te kino: Te kaupapa here ā-motu mō ngā mahi tūkino 2023 (the 2023 policy)
- how we are further expanding our future focus on healing, learning and improving following harm.

Our role | Ko tā mātou mahi

Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora) has an active role in identifying system-level opportunities to reduce harm and supporting learning in the pursuit of high-quality health care. Our work in 2021/22 has focused on understanding the way the system shapes the experiences of consumers whānau and health care workers.

He toki ngao matariki Aotearoa (the practice of resilient health care) incorporates the weaving of mātauranga Māori and principles of safety science. It acknowledges that high-quality care in complex adaptive systems such as health care is founded on the ability to recognise changing conditions, respond flexibly to these changes and share what we learn.

The aim of this report is to inform providers, consumers and whānau about how we are actively identifying system-level opportunities to reduce harm.

Reporting harm 2021/22 | Te tuku 2021/22

While the move to quarterly public reporting has enabled more timely access to adverse event data, this annual report is focused on identifying overarching system improvement opportunities.

The reporting for 2021/22 is informed by analysis of the adverse event data, combined with soft intelligence from our workforce, partners and networks, to help build our understanding and effective response to complex challenges.

Te Tāhū Hauora received 1,137 adverse event reports between 1 July 2021 and 30 June 2022 (the 2021/22 financial year) compared with 1,027 in 2020/21. Events were reported from across the health and disability sector, and most of the reporting came from the then-district health boards, ambulance services and private medical/surgical hospitals.

It is important to note that this data is based on a snapshot of adverse events in time; once adverse event reviews are completed by organisations, the Severity Assessment Code (SAC) rating may change, or the events may be withdrawn, which affects the adverse event numbers.

Adverse events were categorised according to the codes within the World Health Organization (WHO) Conceptual Framework for the International Classification for Patient Safety (WHO 2009). Events under the WHO codes that include clinical process and procedure, clinical administration and resourcing are then given a more specific clinical management sub-category.

These events then underwent further analysis using control charts to understand if there were significant changes in various categories.

Following the release of specific SAC examples for the maternity sector in 2019 (www.hqsc.govt.nz/resources/resource-library/severity-assessment-code-sac-examples/), reported maternity adverse events increased. While this may have been an expected response, the rate of adverse event reporting alone cannot give a full picture of the quality and safety of the health system. To better understand what is driving this increase in reporting and to inform the revised maternity SAC guide and toolkit, Te Tāhū Hauora will conduct a thematic analysis of maternity events.

Reporting for pressure injury-related harm significantly increased during 2021/22. We are now examining other data sets to understand the problem and inform the scope for future-focused quality improvement efforts.

Māori and Pacific peoples remain over-represented in the sub-categories of delayed diagnosis or treatment adverse events, as previously reported in 2020/21. Additionally, this year, they are also over-represented in the category of pressure injuries.

We conducted a thematic analysis in 2020/21 and identified that further changes to our adverse event reporting data collection were required, alongside a stronger focus on equity and system-focused recommendations. The revised 2023 policy has added this focus, and we are currently revising our data collection methods as recommended by the thematic analysis of Māori and Pacific data.

We are continuing to work on how best to capture harm experienced by disabled people within our reporting processes.

Sharing lessons learnt | Te ako tahi

As part of the implementation of the 2023 policy we have met with stakeholder groups from across the health and disability sector who have been supportive of more formal mechanisms for sharing lessons learnt nationally. While many organisations have internal pathways for sharing, the issue of how relevant information is shared across clinical teams, organisations and networks needs to be further considered to support system improvement. Existing clinical networks and professional bodies play an important part in embedding lessons learnt from adverse event reviews, relevant to their clinical environments.

Health system safety strategy | He rautaki haumaru pūnaha hauora

Te Tāhū Hauora is coordinating a collaborative rōpū focused on developing an Aotearoa New Zealand health system safety strategy (the strategy) using a co-design approach. The strategy will be developed in collaboration with all key stakeholders. This includes consumers and the wider health workforce, as well as health care organisations including Te Aka Whai Ora, Te Whatu Ora, Manatū Hauora, the Health and Disability Commissioner, Accident Compensation Corporation and WorkSafe.

The strategy will form an overarching approach to bring together all elements of the health system to support safe care, for health care workers and people receiving care. It will incorporate the 2023 policy and reinforce processes for national sharing of learnings.

The Ngā paerewa health and disability standard (released in February 2022) now has a criterion (2.2.5) obliging service providers to 'follow the national adverse event reporting policy for internal and external reporting (where required) to reduce preventable harm by supporting systems learning'.

Updated policy 2023 He kaupapa here hou 2023

The updated policy builds on the growing recognition internationally that reporting and learning from adverse events is not resulting in significant reductions in the frequency or severity of harm (Leggat et al 2021). Additionally, a critical analysis of Te Tiriti o Waitangi preceded this to ensure our commitment to Te Tiriti was captured and mātauranga Māori included.

The policy was developed during 2022 and involved a co-design process between Te Tāhū Hauora and a co-chaired national working rōpū that included health and disability sector representatives from across the country. Te Tāhū Hauora released the 2023 policy (effective as of 1 July 2023) alongside a toolkit of resources to help providers with implementation.

Future focus | He aro whakamua

The new policy also has an emphasis on meeting the needs of all people (consumers, whānau and health care workers) affected by harm (Moore and Mello 2017) and engaging in system learning. This approach seeks to make visible the issues across different layers of the system, so that solutions can be designed to minimise the risk of harm and create safer care.

High-quality health care requires strong partnerships of trust, open communication and a willingness to share and learn at all levels. These are particularly important as the sector

adjusts to the health reforms and the new health agencies embrace their roles within it. Te Tāhū Hauora is partnering with Manatū Hauora, Te Aka Whai Ora and Te Whatu Ora to identify ways to collaborate to improve consumers' experience and the quality and safety of health and disability services.

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