Thank you very much for that very kind introduction.

Ko Carl Horsley tōku ingoa.

It's lovely to be here today and to share a bit about the work we've been doing at the Commission. I'm just going to share. Here we go.

So, today we're going to be talking a bit about the background of He Toki Ngao Matariki Aotearoa. And this is the programme that we have been working on for a while now, which is really about what does resilient health care – what does resilience engineering, these new ways and think about safety, look like for Aotearoa?

So, I'm going to give you a bit of background about how we got to this place. And some of you have seen my talks before, and hopefully there's a bit of nuance that you can understand about how we get to where we are now.

So, currently, a lot of our approach in our health care system are really based around the ideas of the 1990s around health productivity and production. And so very much we see a big focus that has been put through about efficiency and effectiveness and really about how do we push more people through a straining system.

And so when we have this kind of approach, this almost industrial approach, since the mid-90s is we kind of have this idea about how health care happens, which is that people turn up, they go through the system, they get treated, and off they go again.

And when you think about health care as an industrial activity, essentially about doing more for more people faster and, you know, quicker, we become very focused on certain things. We get focused on outputs. How many cases do we see? What's going on? We think in industrial ways in terms of that safety becomes in about reliability. How do we make sure that everyone gets exactly the same thing every time?

Our focus becomes on bureaucratic constraint, about how do we make sure people are doing the right thing? How do we check on them? How do we have control systems to make sure that that's happening? People within the system unfortunately are therefore seen as really components or products. Staff are components within the system: we need to make sure they're well trained to do all these things, but they're sort of – we upgrade the components by doing those things.

And often, patients are the product of the system. They kind of – they're the widget that moves through this industrial process. And it also has implications for communication in terms of we just need to make sure that people are doing the right thing. We're sent orders from the Ministry or from the Commission or whoever it might be, and basically it's a transmissive model of communication: Here's what we need you to do.

And in this model, very much safety is then seen as something where, you know, the normal functioning of the system is that it's safe and that really the only problems that we have are really when there are unacceptable outcomes, failures, malfunctioning, people don't do what they're meant to do. And that's where we've put all our attention on for safety.

And we see that really with many aspects of adverse event learning and also with HDC and other things that are going on in the system. And the aim the safety in an industrial approach is really that as few things as possible go wrong; that we minimise things going wrong.

There's some really interesting and curious kind of side effects of this approach, which really come back down to this idea that, well, if there's no harm, there's no problem. So we pay attention to these harm events, but we're not really interested in about how risk is changing, what's going on. As long as the numbers look OK, then we're sort of blind to that kind of – what work is being done to keep the system going, the work that people are doing.

It means that because we focus on safety as being the same as reliability, we're very focused on constraining the performance of systems so we add in more and more checklist audits, whatever they might be, but ways of constraining the system. And that's palpable on the workforce – for the workforce.

And this leads, unfortunately, to quite bureaucratic approaches to safety often, where we have proceduralised approaches. And this drives the [INAUDIBLE] phenomenon which is really that we kind of focus on bureaucratic closure sometimes. Have we done the report? Have we sent the Part B? And have we done all these things? Rather than what have we learned and what have we changed? And as part of this, we also see that there's a big emphasis on rituals of verification. Audits. Can we fix the problem?

And the trouble with this is that really we then end up with this – when we're looking at events from this model is that we also have a problem where we have an illusion of learning, where when we think about what's going on for this person here – a clinician who's navigating a system of making decisions – when they make the decision, their aim is to get the patient through the system to achieve the goals, keep them safe, and they make the best decisions that they think they can at the time.

But in hindsight, what we see is the choices people make and how that led to an outcome, and we are blinded somewhat by hindsight bias, this understanding of looking back and telling a story that leads to an outcome and also the judgement that comes from knowing the outcome – the poor outcome – of how we judge people's actions in the moment. So, we're subject to outcome and hindsight bias.

And so the problem here is really one of simplification after an incident, which doesn't reflect the complexity and the realities of people who are doing the work. But because we have this approach when we've written a report and we find something, we have this illusion that we have learnt something, that we have fixed something.

And very often this means we end up discussing what didn't happen, what the staff should, would or could have done rather than trying to explain what they did, trying to explain what actually did happen.

And the other thing we see is that often there's some faulty assumptions built into this. If you have a perfect system that's working really well, then you assume the system will function into the future if we just keep doing the same thing, that the past is the same as the future.

It also implies that sometimes that we can do pilot and scale. We can do one thing one place and we can just roll it out and it'll be the same place everywhere else; that everywhere is the same; that context doesn't quite matter. It's just the industrial process will flick it through. And that the people within the system, the patients, have the same needs.

And one of the things we've really seen is that this approach also makes them brittle.

 When we don't understand the adaptability, and we suppress innovation through, you know, this focus on constraint is that when things change, when conditions change, then suddenly we've got a system that's really set up to not deal with that adaptability and innovation. And we've seen this with COVID whereby what was required was this massive reconfiguring of the system, and actually, that was something that was not how the system was set up before that

The other bit that we have in this approach is really that we don't meet the needs of those harmed. And reports from the ACC on adverse events, when you talk to families, that often their needs aren't being met by our current approaches when we just go back and say, what did people do wrong? Here's what they did wrong. Write a letter. You know, write a new policy. We're not really meeting their needs; we're not hearing what the harm was.

So, it's not really that surprising that we have problems with staff burnout and patient disengagement. We have systems designed around churning more and more people through in our system. We're blind to the risk that's happening. And we're not really understanding the needs of the people within the system.

And when we think about this, then we start to see that issues such as safety and equity and productivity and quality improvement, you know, the limitations that we have with trying to effect real change, the burnout issues we face, the staff engagement problems we face, and patient experience, we kind of face with all these problems all at once.

And these are creating a lot of stress in the system at the moment. And I guess what I want to talk about today is really about why is that? What is the thing that links these problems together? And this comes from Brené Brown. ‘When we fix the wrong thing for the wrong reasons, the problems continue to happen.’ And I guess that's one of the things – let's think about with some of the problems we're really struggling with, what is it that holds them in that way? What is it that keeps making it so?

So, let's just take a step back. When we think about simple systems, even complicated systems, they're decomposable. A car is complicated. We can take it to pieces. We can fix the broken component. We can put it back in, and that's fine. That's a complicated system. You can fix just the component or one little piece of it, and it has no impact on the rest of the system.

But health care is not complicated. It is complex. And it really depends on where we look at it. And I understand there are some parts that are less complex, but all parts of the system at times will go through change and dynamic shifts of risk and interactions.

And so at all stages and all parts, health care is at times complex because it's massive, big heaving system. And when we think about complexity, what we focus on here is not about just the components but about the interactions between those components. We don't focus on just the person, we think about how is the person informed by their context, their environment, the task, the tools they get to use, the organisational culture.

And when we do that, we have to focus then – thinking more away from – moving away from thinking about components of systems. It's much about the relationships of the system between the people who co-create care, between the people and their work systems, about how are people shaped by their environment and thinking also about the relationships between different institutions in different parts of the system.

When we think about complex systems, we have to understand that the whole is other than the parts. It is different to the parts. So, for example, describing all these different parts of the human doesn't explain who I am as a person. They are – there is something other than. And that's the same when we think about systems.

When we take a particular component and we add another component, that doesn't tell us about what is achieved as a whole. So the emergency department is quite different from just putting nurses and doctors and other people in a room. There's something other than.

And so we can't explain things just by looking at components alone. And this really means that when we're thinking about how we want to look at a problem, we need to be thinking about the system as a whole. And we'll talk about system boundaries, but essentially, we need to understand the way these things all come together in relationships because we can't just understand the components in isolation.

And health care is really – and this has been really seen in the last sort of few years. We're operating in this volatile, uncertain, complex and ambiguous world where the problems we faced in the past about health spending and efficiency gains and productivity and stuff really were sideswiped by a massive pandemic that changed so much of the work that we had to do. And the future was certainly not a good – was not represented well by the past at all.

And so, when we see this, we start to see that, actually, in this dynamic and uncertain and complex world that the messiness of everyday work, the work as done by people who are doing the work, is quite different from how we imagine it in the policy procedures guidelines or by people who don't do the work.

And really, when we think about this as the way that people navigate complexity, the way they cope is by making trade-offs; they have to navigate what is the risk that we see here? What is it we're trying to achieve? How do I do that? And they're constantly making efficiency and thoroughness trade-offs to keep the system going to; keep it safe enough.

The other thing with complex systems is that outcomes are not resultant. It's not this leads to this leads to this. It's more – it's not the Swiss cheese of the holes lining up – it's more like the perfect storm of all these conditions coming together and creating an outcome. And this really comes back to the idea that there are emergent behaviours; there are complex behaviours that arise from the interactions within the system that are not predicted by just looking at the relationships that we normally do with the linear things.

And so, we really need to stop thinking about the five whys and really think about the five hows. How did this happen? How did these things come together at this time to lead to this outcome? So, when we move to this model, we start to see that safety is more about the fact that people are constantly creating safety as they navigate complexity: they're making decisions to try and get the best outcomes they can. And that most of the time, that works otherwise we wouldn't do it, but sometimes it doesn't.

So, we need to think then less about how do we restrain people and more about how do we dampen down unwanted source of variability, and how do we enhance the ability for the system to adapt under changing conditions?

So, the new aim of safety is really that as many things as possible go right. How do we create the conditions for good work? So, when you change your perspective, you start to see very different things. And a move to system safety is really this idea that the Commission is now moving to this focus on system safety, and a system is really an interconnected set of elements that is coherently organised to achieve something. So, there must be elements, connections and functional purpose.

And it's not about people or systems, it's about people in systems – so, seeing people within the situated context in which they work. That means we need to be thinking about the work systems that people work in – the technology, organisation, tasks and environments they work with.

But also, we need to start thinking about the social systems in which people work; and not just looking down here at the staff and management but also the way that regulators and funding affects and creates the context for work.

It means we need to be supporting the conditions for success and quality improvement, this is vital. How do we make success more likely? And that means understanding the realities of work and the different contexts. So, what works in a busy, you know, Middlemore ICU is not going to work the same way in a community provider. And so, we need to understand the realities of that work situation.

And this really comes down to the idea about bringing in human factors and ergonomics, about this focus on both human wellbeing and system performance. And we're starting to do this with the Commission now, working with the WorkSafe and the Human Factors Society to bring in human factors training into heath care.

And with WorkSafe, this really is their focus now on better work – how do we design good workplaces? Understanding that really the provider satisfaction, the provider sense of the work they do, is the underpinning of the other three parts of the triple aim. It means we need to be learning different lessons. Rather than sitting back and judging people in retrospect, we need to be understanding how did what people do make sense to them at the time?

And really this is about putting ourselves in a situation that occurs and asking ourselves, why did that make sense? Could someone else in that same situation make that same choice?

And it means that we need to move from just focusing on the incident to much more understanding about the way that is shaped by the context – government regulation, media, all those things. And we need to focus on meeting the needs of those harmed. And that’s something that we're not doing now, but it's the work that's going on with the Diana Unwin Chair, with Jo Wailing and restorative practice. And this work is also ongoing in our Adverse Events Policy Review, and I hope that all of you will have a say on that.

The other bit is about really how do we build resilient systems. This is not about individual resilience: it's more pizza, more yoga. This is about the capacity of our system to adapt to challenges and changes and opportunities at different system levels to maintain high-quality care.

And we saw this particularly in community providers – Māori, Pasifika, particularly where I work – as they responded to really adapting to how they normally work to respond to this unheralded event. And what was prominent in this was that it's all about relationships, learning from each other, seeing value in the different viewpoints, the different ways of seeing and working together on the shared problems, and enhancing the mana of all those involved in those relationships.

For leadership, this means this is a real challenge. We have to move away from market control to really think about what is it we're trying to achieve? How do we create the space for people to contribute to that work? And how do we balance creativity and constraint?

And when we think about data, which is a really big part of the Commission's work, is about what do we measure? And who is it for? Data is for what? And are we using it to build an understanding of our system? And for us in the Commission, we're now starting to work out how do we build these relationships across the sector, so working with ACC, HDC, WorkSafe, all these organisations, to try and put together a more coherent understanding of the work that we all do together.

So He Toki Ngao Matariki Aotearoa is really – He Toki is an adze, a chisel, an adze to cut away, to form, to make. And Ngao Matariki is the finest work, the most important work, and the things that we do. And really this is about the idea that this is an overarching framework when we think about how does complexity change the work that we do in system safety?

And we are the new builders of the waka; and this is a name that was gifted to us by Huataki Whareaitu from Ahuahu Kaunuku within the Commission. And so, when we think about this industrial approach now, we're thinking about this idea that's focused on outcomes, safety as the ability to match conditions, balancing creativity and constraint, the people as the purpose and communication as co construction. It is human-centred; it meets the needs of the people within the system rather than just the needs of the system. It's built on understanding the different contexts and the different solutions.

And it's about the relationships between Māori and the government and the Crown but also across the sector between different parts of the system and bringing together these multiple viewpoints to better understand, to see different things and to answer the question what is this care that we build together?

For quality improvement work and safety work, it's about meeting the conditions, understanding where we can use reliability, about where we need to start thinking quite differently about work and really moving from this loading up the adaptive capacity of the front line to much more thinking about how does the system, as a whole, recognise changing conditions and respond as a whole system?

And I think one of the really big things I want to stress to you guys is that really this focus – that I think that the secret weapon for Aotearoa is really that we live in a Māori world. And Māori have been dealing with issues of navigating complexity and relational ways of working and interconnectedness. That that’s central to mātauranga Māori. And so this is something I think that we have is a real benefit here. And the question is not to say resilient health care is the same as mātauranga Māori. It's to say we have these different kaupapa; how do we bring them together to create something better? How do we lead the way on this? And I really believe that, in New Zealand, we can take some of these modern safety ideas about coping with complexity, and we can see and use mātauranga Māori to really lead the way internationally. This is my hope for a lot of this programme.

Finally, I'd like to say no work ever occurs in isolation. This work has been led by the System Safety team of the Commission, the Ahuahu Kaunuku are partners in that, but also participants of the Resilient Healthcare Aotearoa hui that we held last year and many more across the motu. So, my thanks to all of you.

Thank you very much.