Te Whatu Ora
Health New Zealand

03 October 2023

s 9(2)(a) [redacted]

Your request for official information, reference: HNZ00028294

Thank you for your email on 16 August 2023, asking for the following which has been considered under the Official Information Act 1982 (the Act):

> *Sorry quick clarification required- the response mentions- Of the 18 recommendations five have been implemented/completed, 11 are in progress and two have been accepted in principle but our response is yet to begin.*
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> *What are the five recommendations which have been completed?*
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> *What 11 are in progress?*
>
> *And why are two only accepted in principle?*

Due to the time that has passed, one further recommendation has been completed and one of the two that were accepted in principle is now in progress. So instead of five, there are now six completed and 11 still in progress. The recommendations that have been completed are:

- Recommendation 1 - the establishment of a Te Whatu Ora Report implementation oversight group is meeting to progress the remaining recommendations.
- Recommendation 3 – a regional clinical governance board is in place with an established risk register. Terms of reference have been agreed and a digital clinical subgroup is being set up which will focus on the central region. This will include adopting lessons identified and learned from other parts of the motu.
- Recommendation 11 – there is now the ability for the radiologist to note “no report needed” with a single click and or a similar response is automated, which saves the clinician time.
- Recommendation 12 – the regional radiology information management system has been upgraded and considered stable enough to onboard Hutt Valley and Wairarapa. Monitoring of the system will continue to ensure any necessary upgrades are completed and issues dealt with quickly.
- Recommendation 14 – The support process has been developed to encompass the region and has strong governance with the digital enablement teams. There is still ongoing refinement as the organisation transitions to a new Te Whatu Ora Data and Digital operating model over the next few months.
- Recommendation 17 – Safety1st is the risk reporting tool in use in the region, a full review of the system, process and training has occurred with refresher courses ongoing. High trust relationships with the patient safety and quality teams have been developed and there is an ongoing engagement and training curriculum to ensure current staff are upskilled and new staff are inducted appropriately.

The 11 that are in progress (please note one recommendation that was accepted in principle is now in progress) are:

- Recommendation 2
    a. On the issue of reducing the risk of patient harm the regional radiology information system (RRIS) was upgraded.
    b. Tighter operating procedures have been implemented to ensure images were separated when they needed to be, or indicated as not when it made clinical sense.
    c. The improvement in recommendation 2 sign off processes are still being progressed due to the size of the task which will need alignment across the region and include support processes.
    d. While there is little evidence to support claims of extensive significant patient harm, a review of the Safety 1st and other regional risk reporting tools are underway. This is being done to ensure that all reported incidences are captured.
    e. A targeted review is underway to collaborate the findings in the review of the risk reporting tool. The target of the review will be in cases where the pattern of the ordering and sign off would indicate a high risk of the report not being sighted by the referring clinician.
- Recommendation 4
    a. A review of the organisation's cultural safety and education has shown a good consumer engagement lead and cultural Pou which are now contributing to the mahi of the steering group.
    b. A review of quality improvement reports has shown good reporting that can highlight any variation in service access and outcomes by ethnicity.
    c. Having the person's ethnicity visible to the reporting radiologist will require a change to the RRIS and as this is a large regional system, the change has been prioritised in the system change list and is awaiting deployment soon.
- Recommendation 5
    a. A full independent assessment and internal review has looked into the conflict of interest with the Te Manawa Taki upgrade to the RIS and has been supplied to the office of the auditor general. The review's findings are due and we look forward to the independent assessment on this recommendation
- Recommendation 6
    a. A large amount of this work has been ongoing with the upgrades. A final review after the onboarding of Hutt Valley and Wairarapa is imminent.
- Recommendation 7
    a. This recommendation aligns with recommendation 2 around audit and the two sign-off processes. It is part of the audit of work to determine how to stabilise the system and then review the different sign off processes within the region and to determine the best way to optimise this.
- Recommendation 8
    a. This overlaps with linked/split images within recommendation 2. While the standard operating procedure and modality naming is in place, a formal review after the Hutt Valley and Wairarapa went live is required to ensure the workload has been accommodated and the operating procedure is well embedded.
- Recommendation 9
    a. Some issues have been resolved. The issue of linked/split images requires changes to the information technology which have been agreed to by all parties. The provider is working on the changes and once deployed and tested, a patch release will be planned.

- Recommendation 10
    a. This overlaps with the items in recommendation 2 and 7 – and is part of a review of the product, the order form and the options within the region to duplicate.
- Recommendation 13 - was the item accepted in principle.
    a. After further investigation it was determined a large portion of the work to link the PACS archives was already in place, and so this recommendation has been accepted as part of the work along with the changes needed for the external radiology providers.
- Recommendation 16
    a. This recommendation is currently on hold while the current department vacancies are being recruited to.
- Recommendation 18
    a. The recommendation is currently pending the hospital and specialist services tranche 2 clinical networks establishment. Currently there is a national radiology advisory group providing input to the review.

The final recommendation that has been accepted in principle is recommendation 15. This is a whole of Te Whatu Ora review that is needed, and the review and remediation is the focus of the digital shift within Pae Ora and forms part of the roadmap over the next three years. This is being worked on under that remit.

How to get in touch

If you have any questions, you can contact us at hnzOIA@health.govt.nz.

If you are not happy with this response, you have the right to make a complaint to the Ombudsman. Information about how to do this is available at www.ombudsman.parliament.nz or by phoning 0800 802 602.

As this information may be of interest to other members of the public, Te Whatu Ora may proactively release a copy of this response on our website. All requester data, including your name and contact details, will be removed prior to release.

Nāku iti noa, nā

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