Te Tāhū Hauora
Health Quality & Safety Commission

Briefing to the Incoming Minister

February 2025

Foreword

Tēnā koe.

Congratulations on your appointment as Minister of Health.

Established by Hon Tony Ryall in 2010, Te Tāhū Hauora Health Quality & Safety Commission is the only dedicated national health quality and safety agency. We work with clinicians, the wider health workforce, and consumers and whānau to improve health services, within our $16.6 million Crown funding. We have a long track record of measurable success in reducing harm, saving lives, and delivering financial savings that can be reinvested in health care for all New Zealanders.

Independent from commissioning and accountability roles, we have a clear and unique role in identifying, and helping the health system to address, the quality issues that threaten productivity and access. We draw on robust data and analysis alongside insights from our extensive networks, including government agencies, the workforce, consumers and whānau, Māori partners, and groups experiencing inequity.

Many emerging and complex quality and safety issues cannot be solved by a single health agency alone. Our distinctive role, and regular data and insight reports to the Government and health systems, addresses the increased need for oversight of the health system's quality and safety, leveraging the strengths of all agencies with health quality functions to resolve issues quickly and effectively.

The current challenges faced by the health sector are not new, or unique to Aotearoa New Zealand. Our data insights highlight that these issues are a combination of longer-term issues, residual impacts from the COVID-19 pandemic and the impact of the health system reform. Increased pressure on the health system from an ageing population, increasing chronic disease prevalence and resulting increases in acute demand for treatment, compounded by workforce shortages have limited the system's ability to provide timely treatment. Further, the growing complexity of illnesses within populations has created greater barriers to access for some, with health impacts unevenly distributed across groups and regions.

In 2023/24, we restructured to better address these challenges by sharpening our focus on our core legislative role, improving operational efficiency, and delivering greater value for money. Guided by fiscal responsibility and a commitment to quality, this change has enhanced our ability to collaborate and partner with other agencies and providers, ensuring we effectively support the Government's priorities for providing timely access to quality health care.

In 2024/25, we are supporting this by:

- improving data quality and its accessibility including our support and review of Te Whatu Ora | Health New Zealand's initial plan for progressing health targets and their performance measures
- enhancing and expanding mechanisms for gathering and responding to patient experiences
- empowering consumers and whānau to engage with health system and service design

- facilitating clinical governance and effective partnerships across health organisations
- development of a Window on Quality report focused on people with disabilities
- developing a system safety strategy with a focus on continuous improvement as part of a learning health system
- reviewing mortality, identifying and recommending actions to prevent avoidable deaths and illness.

We are available to meet at your earliest opportunity to discuss how we can assist you as Minister of Health. We look forward to working with you to improve quality, safety and access in the health system.

Ngā mihi nui

Rae Lamb
Chair

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Introduction

As well as the harm suffered by individuals, poor quality health care directly harms the productivity of the health system and access to care.

Harm consumes health system resources on longer hospital stays, additional drugs and consumables used, returns to the operating theatre and additional scans and tests and above all additional staff time. Each of these increases cost per case, oftentimes reduces benefit to the patient and reduces the capacity for access to elective (planned) care.

Our approach, which has combined rigorous monitoring of different aspects of quality, and collaborating with the health system on targeted quality improvement interventions has worked; improving outcomes, saving lives, saving money and adding value.

Conservatively, we can point to 1700 avoided serious harms over the last ten years, with these better outcomes accelerating as more improvement schemes are delivered. These improvements are robust and resilient and have continued even under recent system pressures.

These avoided harms are serious, such as major life-threatening infections, falls leading to broken hips inside hospitals, and cardiac arrests in hospital. Each harm has a direct cost in the tens of thousands of dollars and typically costs something in the region of six months to two years of healthy life (reduced life expectancy combined with reduced quality of life). Using the Accident Compensation Corporation's (ACC) approach to valuing this, each year of healthy life is worth around $230,000.

Based on very conservative estimates, our harm avoidance programmes alone have provided over $450 million in direct savings and healthier lives since 2015.

However, our work extends beyond avoiding harm to also increasing quality. For example, our long-standing patient experience survey allows us to identify how patient experience has changed over time. In this we see sustained and continuing improvements in several important areas including patients feeling appropriately involved in their care. The proportion of inpatients who feel they were as involved in decisions about their care as they want to be, has grown by 15 percent over the last ten years (currently standing at over 80 percent). Given over 700,000 publicly funded inpatient discharges (excluding day cases) a year,[1] this represents an extra 100,000 inpatients each year feeling as involved as they wanted to be.

Greater patient involvement in care improves health outcomes and reduces costs.[2, 3]

We have led efforts to embed patient and whānau voices into the health system over the past decade. Through consumer co-design, support for local forums, and promoting patient-centred care, we have helped make services more responsive and effective. Our role as the lead agency

[1] Te Whatu Ora Health New Zealand. Hospital events web tool.
URL: https://tewhatuora.shinyapps.io/hospitals-web-tool/
[2] Hibbard, J. H., Stockard, J., Mahoney, E. R., & Tusler, M. 2004. Development of the Patient Activation Measure (PAM): Conceptualizing and measuring activation in patients and consumers. *Health Services Research, 39*(4p1), 1005-1026.
[3] Greene, J., & Hibbard, J. H. 2012. Why does patient activation matter? An examination of the relationships between patient activation and health-related outcomes. *Journal of General Internal Medicine, 27*(5), 520-526.

for the code of expectations for health entities' engagement with consumers and whānau reflects our commitment to ensuring the health system consistently prioritises patient engagement.

Over the last four years, particularly since the restructuring of the health sector, our work has increasingly concentrated on identifying safety risks and informing the sector, including Te Whatu Ora | Health New Zealand (Health New Zealand), about critical issues that need to be addressed. This draws on our roles as a quality and safety monitor, influencer and convener. Examples of this include the Quality Alert that is provided across Health New Zealand at local and national level every quarter, with growing local uptake. In collaboration with Manatū Hauora | Ministry of Health (Ministry of Health) we convene the National Quality Forum which is a meeting that brings together senior leaders from the central health agencies to discuss quality and safety within the system. This has helped advance initiatives such as reducing harm from the use of anticoagulants, strengthening national medication safety governance, and a programme to improve maternity care.

Most recently both Health New Zealand and your predecessor as Minister of Health have asked us to develop ways of monitoring for risk to safety quality at a time of system instability. We have developed a comprehensive method for doing this that includes both prospective weaknesses which may make harms more likely as well as looking back at poor outcomes and experiences. This framework is shared routinely with Health New Zealand and forms the basis of a regular insight reporting to you, as Minister of Health.

Our legislative role

In summary, our legislative organisational objectives and functions under the Pae Ora (Healthy Futures) Act 2022[4] are to:

- provide advice to government on quality and safety in the health system
- monitor and publicly report on quality of care in the health system
- promote and support better quality and safety in services
- support the health sector to engage with consumers and whānau to ensure their perspectives are reflected in the design, delivery and evaluation of services
- make recommendations related to health quality. [5]

In performing our functions, Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora) must, to the extent we see as appropriate, work collaboratively with a wide range of stakeholders: Ministry of Health; Health New Zealand; the Health and Disability Commissioner; providers, professional bodies; consumer groups and any other organisations, groups or individuals with an interest in our work.[6]

Mortality review committees

Te Tāhū Hauora holds legislative responsibility for the national mortality review function under Section 82 of the Pae Ora Act, appointing mortality review committees and directing their functions, supporting their administration, legal framework, work programme and reporting on their progress.[7] This function aims to influence system change to reduce mortality, identifying and recommending actions to prevent avoidable deaths and illness.

Consumer and whānau engagement

Te Tāhū Hauora is also charged with the development of a code of expectations for consumer and whānau engagement in the health sector.[8] Legislation states the expectations of the code are for the purpose of supporting consumer and whānau engagement in the health sector and for enabling consumer and whānau voices to be heard. The code is secondary legislation for the purposes of the Legislation Act 2019.[9]

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[4] Section 79, Pae Ora (Healthy Futures) Act 2022. URL: www.legislation.govt.nz/act/public/2022/0030/latest/versions.aspx
[5] Section 80 (1), Pae Ora (Healthy Futures) Act 2022. URL: www.legislation.govt.nz/act/public/2022/0030/latest/versions.aspx
[6] Section 80 (2), Pae Ora (Healthy Futures) Act 2022. URL: www.legislation.govt.nz/act/public/2022/0030/latest/versions.aspx
[7] Section 82, Pae Ora (Healthy Futures) Act 2022. URL: www.legislation.govt.nz/act/public/2022/0030/latest/versions.aspx
[8] Section 59, Pae Ora (Healthy Futures) Act 2022. URL: www.legislation.govt.nz/act/public/2022/0030/latest/versions.aspx
[9] Legislation Act 2019. URL: www.legislation.govt.nz/act/public/2019/0058/latest/DLM7298125.html

Our strategic direction

Our strategic direction summarises how we work towards our vision of 'Quality health for all' (Figure 1). We have strong partnerships and actively collaborate with other agencies and key stakeholders (involve) to measure, analyse, share and advise (inform); to influence thinking and action (influence); and to coordinate, support and facilitate measurable improvement (improve). This is our mission and defines the way we work.

Our strategic priorities and work programme are structured to fulfil our legislative objectives and functions while aligning with Government priorities. Embedding and enacting Te Tiriti o Waitangi, along with pursuing health equity, underpins our work as enduring priorities, supporting improved health quality for Māori and other groups with the greatest health needs.

Figure 1: The strategic direction of Te Tāhū Hauora

More information on our strategic direction and work programmes can be found in our Statement of Intent 2023–27 (see URL: www.hqsc.govt.nz/statement-of-intent-202327) and Statement of Performance Expectations 2024/25 (see URL: www.hqsc.govt.nz/statement-of-performance-expectations-202425).

Information on our Board and Chief Executive is provided in Appendix 1.

Our work and how we support you

Monitoring health quality and safety

We enable the system to rapidly respond to emerging quality risk areas by providing health quality insights into health system delivery.

Te Tāhū Hauora provides a central point for measuring, analysing and reporting on health data to deliver system-wide insights for data-informed quality improvement.

We provide numerous interactive analytic and reporting tools, including quality alerts, for sector and public use spanning 300 measures of health care quality and ongoing intelligence received from consumers and whānau, the health workforce and other stakeholders. This health data information is well used across the system.

Through our monitoring of the quality and safety challenges shown in our data and communicated to us, we provide oversight and bring important issues to the attention of the Minister of Health and our sector colleagues.

We identify current and emerging health care quality and safety changes, challenges and gaps, which can then contribute to evidence-informed quality improvement initiatives. Providing transparent and accessible health quality and safety analysis is crucial to ensure that the health care system is accountable and responsive to the needs of patients and the public.

We work with the relevant agencies and others to address these challenges and to influence interventions such as within our role convening the National Quality Forum, which facilitates collaborative quality governance at a national level (more information can be found on page 13). We also work directly with agencies to partner with them and to influence improvement that is needed.[10]

Our analysis draws on our quality indicators, including quality alerts, and ongoing intelligence received from consumers and whānau, the health workforce and other stakeholders.

Quality and safety insights reporting

One of our core functions is to give you, the Minister of Health, an independent, credible assessment of the quality and safety of health services to support your leadership of the health system.

Your predecessor commissioned quarterly reporting on system safety and areas of risk. These reports highlight complex issues which require further analysis and collaboration with our partner agencies to progress.

The reports are developed through the collation of datasets that we hold, additional data from Health New Zealand and interviews with clinicians, other health workers and consumers. Input

[10] Additional examples of areas that we have worked on recently include fetal anticonvulsive syndrome, the use of anticoagulants, test result follow-up, informed consent and encouraging faster action to prevent harm to patients from surgical mesh.

from interviews is anonymised to ensure that feedback can be provided in a free and frank manner.

To date, we have delivered two Insights Reports.

- Assessing System Quality and Safety – September 2024 (HQSC MIN 2024 006 refers) outlined our view of quality and safety in the health system using the data we regularly collect and insights from the health workforce and consumers.
- Assessing System Quality and Safety – November 2024 (HQSC MIN 2024 007 refers) focuses on general practice.

The reports outline issues that are currently being faced by the health sector. These include a combination of longer-term issues, the impact of the COVID-19 pandemic and the impact of the health system reforms.[11] There are long-term, amenable inequities in health status, health care quality and outcomes experienced by Māori, Pacific peoples and disabled people. These are worsened by the inability of the health system to meet demand, at all levels of the system.

In combination, the reports' findings point towards essential quality and safety structures either not being in place or not functioning optimally. These represent deficiencies in safety defences for the health system.

❖ A summary of these reports is available for your consideration when convenient.

Monitoring and reporting tools

We analyse risk of harm through:

- quality alerts, which bring together widespread sources of data on key measures of risk at the local level
- quality and safety markers, which are a more comprehensive form of targets from the early 2010s, which linked process targets to expected safety outcomes[12]
- mortality surveillance systems to support improvements to our national mortality review function
- health quality and safety 'measures library', a centralised reference library that publishes a range of quality-focused measures and resources to create a common understanding of health system and service quality and safety measurement.

[11] Health Quality & Safety Commission. 2022. *A window on quality 2022: COVID-19 and impacts on our broader health system (Part 2) | He tirohanga kounga 2022: Me ngā panga ki te pūnaha hauora whānui (Wāhanga 2)*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/a-window-on-quality-2022-part-2-whakarapopototanga-matua-he-tirohanga-kounga-2021-wahanga-2

[12] Te Tāhū Hauora. (nd). Quality & Safety Markers. Wellington: Te Tāhū Hauora. URL: www.hqsc.govt.nz/our-data/quality-and-safety-markers.

Equity and variation are a particular focus of:

- the Atlas of Healthcare Variation, a multi-indicator, online-only approach to presenting data that continues to be highly used by the system[13]
- other bespoke reporting tools covering specific issues commissioned by third parties.

Overall system performance is covered by:

- the dashboard of health system quality,[14] which brings together aspects of safety, effectiveness, patient experience and equity, showing patterns of results for related measures, changes over time and variation between different parts of the country
- a detailed series of narrative reports (including our 'window on quality' series – more information can be found on page 12), which cover different aspects of health service quality.

Further, we have contributed significant expertise in the design and implementation of health targets and wider system quality and safety performance and the development of iwi-Māori partnership board indicators. More detail is provided below on some of our key work programmes.

Patient experience surveys

A vital tool in identifying quality and safety issues in the system and in supporting improvement, the patient experience survey programme[15] is a core component of our organisational work programme, which we continue to develop with sector stakeholders and expand.

The national surveys fill an important accountability and monitoring function for Te Tāhū Hauora, Ministry of Health and Health New Zealand. Survey data is also being used by some iwi-Māori partnership boards. The *Government Policy Statement (GPS) on Health 2024 – 2027* requires Health New Zealand to measure patient involvement in decisions about their care and treatment, as reported in both our hospital and primary care patient experience surveys. The primary care patient experience survey supports the Minister's focus on primary and community care, and priority of improved access to quality care.

Surveys are one of the most effective ways of understanding the experience of a large population such as people receiving health care. Evidence shows that regularly undertaking, and then sharing and publishing the results of surveys is a way of highlighting then improving performance, both directly and indirectly.[16]

We collect patient-reported measures through validated and standardised quarterly surveys, which enable systematic collection, analysis, and reporting.

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[13] Te Tāhū Hauora. (nd). Atlas of Healthcare Variation. Wellington: Te Tāhū Hauora. URL: www.hqsc.govt.nz/our-data/atlas-of-healthcare-variation.

[14] Te Tāhū Hauora. (nd). Dashboard of health system quality. Wellington: Te Tāhū Hauora. URL: www.hqsc.govt.nz/our-data/quality-dashboards/dashboard-of-health-system-quality.

[15] Te Tāhū Hauora Health Quality & Safety Commission patient experience surveys. URL: www.hqsc.govt.nz/our-data/patient-reported-measures/patient-experience/

[16] Fung C, Lim Y, Mattke S, et al. 2008. Systematic review: the evidence that publishing patient care performance data improves quality of care. *Annals of Internal Medicine* 148: 111–23. DOI: 10.7326/0003-4819-148-2-200801150-00006.

- The adult hospital **inpatient** experience survey has been running since 2014; it invites around 50,000 patients per year and receives feedback from around 12,000.
- The adult **primary care** patient experience survey has been running since 2016; it invites nearly 1 million patients per year and receives around 140,000 responses.
- The adult hospital **outpatient** experience survey began in June 2023.
- The **home and community support services** experience survey began in July 2024.

In 2024/25 and 2025/26, the programme will focus on implementing two new surveys and improving reporting of existing surveys. The new survey for 2024/25 looks at the experience of those receiving **maternity inpatient** services, and for 2025/26 will look at the experience of **mental health service** users. As with other surveys, these will be developed in collaboration with key sector stakeholders to ensure the surveys provide data that can be used and are sustainable.

❖ We can provide you with a briefing providing more detail about our current surveys, improvements and their findings, and will update you on the new surveys being released.

'Window on quality' series

Each year we publish on the quality of Aotearoa New Zealand's health care[17] providing insights into the key issues affecting the quality and safety of the healthcare system using validated indicators and other evidence in national data sets and making recommendations for change.

In June 2024, we released our eighth report in the series, *A window on quality 2024: Turbulence, quality and the future | He tirohanga kounga 2024: He hūkeri, he kounga ki anamata hoki.*[18] The report gave detailed evidence and data of what has happened in the most recent period since the COVID-19 pandemic to access to healthcare and its quality and safety. It includes deep dives into workforce and the use of telehealth.

The focus of this year's report is on health services for disabled people.

❖ We will brief you in advance of the release of the Window 2025 report and the key findings.

Our leadership and collaboration

We inform and influence the health quality and safety agenda, serving as a catalyst for improvement.

We have well established networks and partnerships nationally and internationally.

[17] Health Quality & Safety Commission. 2021. *Window on the quality of health care | Te kounga o te tauwhiro hauora.* URL: www.hqsc.govt.nz/our-data/window-on-the-quality-of-health-care
[18] Te Tāhū Hauora Health Quality & Safety Commission. 2024. *A window on quality 2024: Turbulence, quality and the future | He tirohanga kounga 2024: He hūkeri, he kounga ki anamata hoki.* Wellington: Te Tāhū Hauora Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/a-window-on-quality-2024-turbulence-quality-and-the-future-he-tirohanga-kounga-2024-he-hukeri-he-kounga-ki-anamata-hoki/

Nationally, we collaborate across government, the health sector and with consumers and whānau to lead improvements to the quality and safety of the health system and its services. These relationships are essential to our work. This includes working with our partner agencies like the Ministry of Health, Health New Zealand, ACC, Whaikaha – Ministry of Disabled People, health providers, iwi-Māori partnership boards and professional bodies.

We have a strong working relationship with the Health and Disability Commissioner through regular updates and the sharing of insights from the Commissioner help to highlight issues of national significance.

Our Chief Executive participates in the Health Leadership Forum alongside the chief executives of the other key national agencies. Chaired by the Director-General of Health, this forum fosters cross agency engagement and provides a platform for whole-system leadership and oversight at the chief executive level. This ensures visibility and input into the delivery of actions by health sector entities.

We also maintain strong relationships with international health quality and safety counterparts and agencies.[19] These partnerships enable knowledge exchange, enhance our understanding of international best practices, and support the alignment of our efforts with global health, policy, and research initiatives.

Convening the National Quality Forum

We convene and co-chair with consumers[20] the National Quality Forum. The forum is a collaboration of health agencies and stakeholder representatives[21] in which complex quality and safety issues are raised or escalated and multiagency interventions are planned with clear responsibilities, outcomes and actions.

Meeting quarterly, the forum acts as an escalation point for quality concerns that cannot be managed within districts or regions, or that require cross-health sector or cross-government attention and intervention. Such topics include the additional challenges of fiscal restraint and growing demand for health care services.

We have supported the forum by highlighting emerging issues, providing up-to-date data analysis, and helping establish better collaboration across agencies. The forum is continuing to evolve and aims to establish better ways to collaborate across agencies for quality.

At the recent meeting held in Wellington on 20 November 2024 the forum's three main areas of focus were discussed with your predecessor in attendance. These were improving the quality of maternity services for all consumers, improving outcomes through optimal use of medicines,

[19] We work with the Australian Commission on Safety and Quality in Health Care and the Health Services Safety Investigations Body (England).
[20] Since 2022/23, a consumer representative has co-chaired the forum, alongside our Chief Executive, to strengthen the consumer voice.
[21] Members of the National Quality Forum currently include: consumer representation; Te Tāhū Hauora executive team members; Manatū Hauora | Ministry of Health – Office of the Chief Clinical Officers, and senior leaders; Office of the Health and Disability Commissioner; Whaikaha – Ministry of Disabled People; Accident Compensation Corporation; Pharmac Te Pātaka Whaioranga, primary care representation; Te Whatu Ora | Health New Zealand; and Te Whatu Ora | Health New Zealand district professional groups.

and coordinating system safety reporting. Other potential areas for quality improvement include supporting workforce growth and development and advancing digital health.

We, alongside the Ministry of Health and Health New Zealand, provided an overview of our respective reports on the quality and safety of the health system, including opportunities for better information sharing.

- ❖ We can provide you with a briefing providing more detail about the National Quality Forum areas of focus and actions including an agenda for the next meeting being held in Wellington on 25 February 2025.

Working with iwi–Māori partnership boards

We are working with three iwi-Māori partnership boards to develop ways of providing meaningful data and intelligence about their regions. This work supports each board's analysis of issues and trends, which it then uses to improve services to best meet the needs of its populations.

With Ātiawa Toa Hauora (Greater Wellington/Hutt) and Te Karu o te Ika Poari Hauora (Wairarapa), we have developed an advanced prototype of a mapping tool that brings together data on demographic, socioeconomic and commercial determinants of health.

With Te Tauraki – Ngāi Tahu, we are convening a collaboration with All of New Zealand, Acute Coronary Syndrome – Quality Improvement (ANZACS-QI) (the interventional cardiology national improvement collaborative) to undertake a similar pathway analysis for its populations.

In parallel with this work, we have engaged in discussions with Health New Zealand Hauora Māori Services to explore opportunities for scaling and aligning this approach across the country. The intent is to ensure that the mapping tool and its associated platform are accessible to all iwi-Māori partnership boards. This aligns with the commitment to equity and supports their ability to independently analyse data, identify trends, and advocate for services tailored to the needs of their respective populations.

Reducing harm

Te Tāhū Hauora maintains an active role in identifying opportunities to reduce harm by working alongside our partners.

We are working with the Ministry of Health and Health New Zealand to rethink and restructure the cross-system approaches to governance for the use of medication and infection prevention and control. Both issues were initially raised at the National Quality Forum.

Our work on national quality improvement initiatives, such as the paediatric early warning system and the deterioration early warning system in aged residential care, is ongoing. We will continue to support efforts to reduce healthcare-associated infections and have initiated a cross-sector initiative to reduce harm from sepsis.

We continue to work with ACC through our Trauma Quality Improvement Programme to improve care for those patients and whānau who have suffered trauma.

Our work through our Mental Health and Addictions quality improvement programme has seen a consistent fall in seclusion rates for mental health patients. Through the use of a cultural kete of interventions we have demonstrated a reduction in seclusion as well as a reduction in the equity gap for seclusion which remain a significant harm event for consumers.

Improving experience for consumers and whānau

We support and increase consumer and whānau voice being sought as a matter of course in all aspects of system design.

The Pae Ora Act formalised our role in consumer engagement, directing us to support the health sector to actively engage with consumers and whānau so their perspectives can be incorporated into the design, delivery and assessment of services.

Implementation of the code of expectations

Directed by Section 59 of the Pae Ora Act, we developed and launched the code of expectations[22] in August 2022. We lead and support the implementation of the code, in partnership with the Ministry of Health. Under the Pae Ora Act, named health entities, including Te Tāhū Hauora[23] are required to implement the code which is secondary legislation under the Legislation Act 2019.

We support the health entities and the broader health sector to actively collaborate with consumers, whānau and communities by producing implementation guidance and other resources. Health entities report to us through the consumer and whānau engagement quality and safety marker,[24] providing examples of progress in involving consumers, whānau and communities in designing, delivering and evaluating the Aotearoa New Zealand health system. All submissions and progress ratings are publicly available.[25]

This year, we are undertaking a review of the code, and updating, if necessary, to ensure it remains fit for purpose. You will be provided with findings from the Code review to consider.

- ❖ We will provide you with the findings from the review of the code of expectations for you to consider.

[22] Health Quality & Safety Commission. 2022. Code of expectations for health entities' engagement with consumers and whānau. Wellington: Te Tāhū Hauora. URL: www.hqsc.govt.nz/resources/resource-library/code-of-expectations-for-health-entities-engagement-with-consumers-and-whanau.

[23] Under the Pae Ora Act, the health entities that must give effect to the code of expectations are Te Whatu Ora | Health New Zealand, Pharmac Te Pātaka Whaioranga, the NZ Blood and Organ Service and Te Tāhū Hauora.

[24] Te Tāhū Hauora Health Quality & Safety Commission. 2024. Consumer and whānau engagement quality and safety marker.
URL: www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/consumer-engagement-quality-and-safety-marker/

[25] Te Tāhū Hauora Health Quality & Safety Commission. (nd). Consumer and whānau engagement quality and safety marker self-assessment summary. URL: https://reports.hqsc.govt.nz/content/ce4ea63e-68e6-4ac1-93ae-32ace685bdc6/#!/supporting-self-assessment

Reporting on our efforts

Along with championing consumer and whānau engagement within the health sector, we also reflect on our own practices and efforts to enhance consumer and whānau engagement through the consumer quality and safety marker.

We support consumer and whānau engagement at all levels of the organisation. Our reporting demonstrates our ongoing support for consumer representation on advisory groups and forums, with careful consideration given to methods of engagement, meeting set-up and mode of delivery. We prioritise gathering of consumer experiences and developing consumer resources.

Consumer health forum Aotearoa

Established in 2022, alongside the launch of the code, we convene the consumer health forum Aotearoa, which now comprises over 1,000 members. The forum helps consumers and whānau build knowledge and engage more effectively with the health system. It focuses on increasing the diversity of consumer and whānau voices within the health sector and fostering active partnerships between communities and the sector.

Strengthening systems for quality services

We support and enhance system safety through continuous learning and improvement approaches.

Over the last 10 years we have supported improvements to our health system that have provided an additional 1,672 years of healthy life to New Zealanders. This is demonstrated by our key quality improvement initiatives, which have provided an estimated value of $454 million[26] for the health system, resulting in a minimum return on investment of 2 to 1.[27]

This return increases over time as improvements are sustained. These improvements are a result of a reduced number of disability-adjusted life years (DALYs) lost due to complications and poor outcomes in areas such as in-hospital fractured neck of femur, infections following heart, hip and knee surgery and in-hospital cardiac arrests.

We have supported and facilitated programmes aimed at directly addressing specific quality and safety challenges. Examples of improvements resulting from these programmes are shown in the table below, and more information is in our Annual Report 2023/24.[28]

Improving the quality and safety of health services and systems can lead to significant savings, which can be reinvested into other areas of the health system, further boosting its effectiveness and efficiency. We know and can measure the positive impact of our efforts on system-level

[26] $454 million is made up of $44 million avoided costs of harm, $410 million value of avoided disability-adjusted life years (DALYs), further explained in: https://silo.tips/download/new-zealand-estimates-of-the-total-social-and-economic-cost-of-injuries-for-all.
[27] This is based on return of key quality improvement programmes against our total funding of approximately $200 million since 2011.
[28] Te Tāhū Hauora. 2024. *Annual Report 2023/24 | Pūrongo ā-tau 2023/24*. Wellington: Te Tāhū Hauora. URL: www.hqsc.govt.nz/annual-report-202324

improvements which are preventing harm, reducing hospital stays, lowering morbidity and mortality rates and adding healthy years to the lives of New Zealanders.

+	Avoided harms	Avoided direct cost ($ m)	Avoided disability-adjusted life years (DALYs) lost[29]	Value of avoided DALYs loss ($ m)[30]
Avoided in-hospital fractured neck of femurs since 2014	288	$13.52	472	$109
Avoided infections from heart surgery since 2018	226	$9.00	113	$26
Avoided infections from hip and knee surgery since 2016	188	$7.50	94	$22
Avoided postoperative deep-vein thrombosis/pulmonary embolism cases between 2013 and 2020[31]	308	$6.50	185	$43
Improved trauma care reducing DALYs loss[32]			932	$211
Avoided in-hospital cardiac arrests since 2019 through consistent use of early warning scores	662	$7.58	We are currently working to calculate the estimated cost savings and DALY implications of the 20 percent reduction in in-hospital cardiac arrests	

[29] This is a measure of the number of years of healthy life gained as a result of avoiding harm. These are based on estimations of DALY loss associated with a range of complications calculated by:

a) Jha et al. 2013. The global burden of unsafe medical care: analytic modelling of observational studies, *BMJ Qual Saf* 22: 809–15. URL: https://qualitysafety.bmj.com/content/22/10/809

b) Cassani et al. 2016. Burden of six healthcare associated infections on European population health: estimating incidence-based disability adjusted life years through a population prevalence based modelling study. *PLOS Medicine* 13(1): e1002150. URL: https://pubmed.ncbi.nlm.nih.gov/27755545.

[30] Based upon a method for turning Value of a Statistical life into DALYs developed by ACC in O'Dea D and Wren J: New Zealand estimates of the total social and economic cost of 'all injuries' and the six priority areas (see: https://silo.tips/download/new-zealand-estimates-of-the-total-social-and-economic-cost-of-injuries-for-all) respectively, at June 2008 prices.

[31] Since 2021, an effect of COVID-19 has been an increase in the number of postoperative deep-vein thrombosis/pulmonary embolism cases.

[32] Gabbe BJ, Isles S, McBride P, et al. 2022. Disability-Adjusted Life Years and cost of health loss of hospitalised major trauma patients in New Zealand. NZ Med J 135(1563): 62–9.

Framework for clinical governance systems and structures

In November 2024, we released the new clinical governance framework 'Collaborating for quality: a framework for clinical governance'.[33] The new framework was welcomed by your predecessor at the National Quality Forum on 20 November 2024.

Clinical governance is the mechanism by which organisations continuously improve the quality and safety of care for patients and whānau. It encompasses many quality assurance and quality improvement activities and makes explicit the accountabilities for addressing these within organisations and systems.

The new framework replaces the previous one released in 2017 to reflect changes in the health sector, including the Pae Ora (Healthy Futures) Act 2022. It is purposefully broader than the previous framework to provide guidance for organisations outside hospitals where the concept began. The framework describes the importance of clear and consistent escalation pathways locally, regionally and nationally to raise issues related to quality and safety. It provides a starting point for organisations to develop their own context-specific clinical governance models and presents guidance to support best practices and equitable care.

We worked closely with Health New Zealand to ensure their emerging model for regional clinical governance aligned with the clinical governance framework. In addition to working with Health New Zealand, we are planning to engage with other parts of the sector such as primary care, emergency service providers and aged residential care in applying the framework in their unique contexts. These documents will be published as resources and guides for other organisations across the sector in how to apply the framework.

System safety strategy development

We are leading the development of a system safety strategy to build on Aotearoa New Zealand's commitment to minimise harm in health care and improve patient safety, as specified in the *GPS on Health 2024 – 27*.[34]

The strategy will define system safety and set expectations for the health system, using international practice as a reference. We have established a cross-sector group to oversee the development of the strategy and engagement with consumers, the wider health workforce, health agencies, and the primary and community health care sector. An agreed strategy will be completed and provide to you for your approval prior to its release in 2025/26.

- ❖ We can provide you with more detail about the development of the system safety strategy as it progresses.

[33] Te Tāhū Hauora Health Quality & Safety Commission. 2024. *Collaborating for quality: a framework for clinical governance*. Wellington: Te Tāhū Hauora Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/collaborating-for-quality-a-framework-for-clinical-governance/

[34] Minister of Health. 2024. *Government Policy Statement on Health 2024 – 2027*. Wellington: Ministry of Health. URL: www.health.govt.nz/publication/government-policy-statement-health-2024-2027

Oversight of mortality review

Our work guides the improvement of systems and services to prevent and reduce avoidable mortality and morbidity.

Mortality review is a specific quality improvement tool that involves learning from avoidable mortality to improve systems and practice within services and communities in ways that reduce morbidity and mortality.

We have held legislative responsibility for the national mortality review function since our establishment. Until 30 June 2023, we carried out this function through five mortality review committees, which focused on reviewing and reporting on data regarding specific types of premature deaths, with the aim of preventing such deaths in the future.[35]

In 2022/23, we reformed the national mortality review function and established the single National Mortality Review Committee on 1 July 2023. Information on the eight current committee members, appointed by the Board of Te Tāhū Hauora, is on our website.[36]

Section 82 of the Pae Ora Act gives the National Mortality Review Committee powers to acquire and use information and set up the regime that applies to that information and those accessing it. This includes obligations of confidentiality and offence provisions for non-compliance.

The reformed national mortality review function strengthens the core structure of our mortality review process by enabling the committee to address inequitable and preventable mortality that cut across specific populations and causes, and to strengthen the uptake and impact of resulting recommendations. The function is now more consolidated, and we are modernising how data is stored and presented so information on preventable mortality is up-to-date and more accessible.

[35] The previous five mortality review committees were the Child and Youth Mortality Review Committee, Family Violence Death Review Committee, Perinatal and Maternal Mortality Review Committee, Perioperative Mortality Review Committee and Suicide Mortality Review Committee.

[36] See: www.hqsc.govt.nz/our-work/mortality-review-committees/national-mortality-review-committee/meetings-and-members.

Financial information

In 2024/25, Te Tāhū Hauora received Crown funding of $16.6 million. This is a total of around 0.058 percent of Vote: Health.

We are prioritising our work within our funding levels, so we best deliver on our objectives under the Pae Ora Act. In 2023/24, we restructured the organisation to sharpen our focus on our core legislative role, enhance operational efficiency, and deliver greater value for money. We have 80 full-time equivalent (FTE) staff to carry out our functions.

We maintain sound management of public funding by complying with relevant requirements of the Public Service Act 2020, the Public Finance Act 1989 and applicable Crown entity legislation. We continue to be prudent and work within our agreed Crown funding levels set out in our Statement of Performance Expectations 2024/25.

In addition to our core funding, specific improvement programme revenue from ACC, Ministry of Health and Health New Zealand is budgeted at $4.7 million for 2024/25.[37] These will reduce significantly in 2025/26 to less than $1.0 million (along with a reduction in our FTE) as Health New Zealand looks to deliver some of these services themselves.

[37] Third-party funded programmes for the 2024/25 financial year are healthcare-associated infections, major trauma quality improvement programme, mental health and addiction quality improvement programme and patient experience surveys. More information can be found in our Statement of Performance Expectations 2024/25.

Appendix 1: Our governance and executive leadership

Our Board

We are governed by a Board of no fewer than seven members who are appointed by the Minister of Health under section 28 of the Crown Entities Act 2004.

Rae Lamb is the current Board Chair, beginning in the role in June 2023. She was previously Deputy Chair, appointed in October 2019. She has an extensive background in journalism (politics and health), and in national statutory roles having worked as New Zealand's Deputy Health and Disability Commissioner and as Australia's Aged Care Commissioner. She has served on the ACC ethics committee and on an international board for the Cochrane health library. She is the Chief Executive of Te Pou and Blueprint for Learning, a non-governmental organisation focused on developing the mental health and addiction workforce and delivering mental health and addiction workshops to government and non-government organisations and the community.

Recently, the Ministry of Health and Rae Lamb have undertaken due diligence interviews for the previous Minister of Health to fill three vacancies on the Board, following a resignation (Professor Peter Crampton in November 2024) and two board members' terms coming to an end (Dr Jenny Parr and Dr Andrew Connolly).

More information on our Board members is available on our website.[38]

Board of Te Tāhū Hauora as of November 2024. From left: Shenagh Gleisner, Dr Tristram Ingham, Tereki Stewart, Professor Peter Crampton, Rae Lamb (Chair), David Lui, Professor Ron Paterson, Dr Andrew Connolly [seated] (Deputy Chair), Dr Jenny Parr.

[38] See: www.hqsc.govt.nz/about-us/our-people/board-members.

Our Chief Executive

Chief Executive Dr Peter Jansen (Ngāti Hinerangi, Ngāti Raukawa), assumed the role in May 2023.

Dr Jansen is a specialist medical practitioner with extensive experience in health service governance, management, research and service delivery. Prior to his current role Dr Jansen was the medical advisor to the ACC.

Dr Jansen is a distinguished Fellow of the Royal New Zealand College of General Practitioners for his work on cultural competence and health equity for Māori. He was also one of the first Board members when Te Tāhū Hauora was established in late 2010.

As of 10 February 2025, Dr Jansen has taken leave to undergo medical treatment.