DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Proactive Release

The following documents have been proactively released by the Department of the Prime Minister and Cabinet (DPMC), on behalf of Hon Andrew Little, Minister of Health:

Health and Disability System Reform Briefings February – June 2022

The following documents have been included in this release:

Title of paper: Policy Decisions for Pae Ora Bill Departmental Report: Talking Points

Title of paper: Health Reforms: Quality Functions in the Future System

Title of paper: Progress on Health System Functions Transfer

Title of paper: Health Reforms: Policy Critical Path to Day 1

Title of paper: Health Reforms: Key Policy Decisions and Delegation

Title of paper: Implementing the Intervention Framework for the Reformed Health System

Title of paper: Health Research in the Future System

Title of paper: Progress Update on Public Health Transformation Programme

Title of paper: Pae Ora Legislation Committee Report

Title of paper: Supplementary Order Paper for Pae Ora (Healthy Futures) Bill

Title of paper: Update on the Transfer of Functions from Ministry of Health to New Entities

Title of paper: Appendices to the Interim Government Policy Statement

Title of paper: Health Reforms: Role of Localities in the Reformed System

Some parts of this information release would not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act). Where this is the case, the relevant section of the Act that would apply has been identified. Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

Key to redaction codes:

- Section 9(2)(a), to protect the privacy of individuals;
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- Section 9(2)(g)(i), to maintain the effective conduct of public affairs through the free and frank expression of opinion; and
- Section 9(2)(h), to maintain legal professional privilege.

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Briefing

HEALTH REFORMS: QUALITY FUNCTIONS IN THE FUTURE SYSTEM

To Hon Andrew Little, Minister of Health			
Date	18/02/2022	**Priority**	Routine
Deadline	3/03/2022	**Briefing Number**	DPMC-2021/22-1390

Purpose

This paper provides you with advice on how our future health system should best ensure continual quality improvement across services and localities, including advice on the relative roles of the Health Quality and Safety Commission, Ministry of Health, Māori Health Authority and Health NZ.

Recommendations

a. **Note** that we expect the reforms announced to date, and the decisions made on various aspects of the future health system, to have significant, positive impacts on the quality of care in our future health system.

b. **Note** the way we give effect to quality in our future system will be different as a result of applying an interwoven quality framework which links Tiriti o Waitangi principles with the quadruple aim, ensuring we give effect to te Tiriti across all levels of the quality system.

c. **Agree** the roles and responsibilities of future agencies in relation to quality:

i.	Health NZ and the Māori Health Authority will have primary responsibility for front-line quality assurance and improvement on a day-to-day basis;	**YES / NO**
ii.	The Health Quality and Safety Commission will monitor and support quality improvement across the system;	**YES / NO**
iii.	As system steward, the Ministry of Health will have responsibility for assuring that all parts of the overarching quality response system are in place, fit for purpose and working well.	**YES / NO**

d. **Agree** that officials should communicate the expectations in this advice to the boards of the interim agencies, to support and inform their development work in advance of 1 July 2022. **YES / NO**

e. **Agree** that the core elements of the direction for the quality framework should be reflected in the Government Policy Statement to set requirements for health entities to put in place the approach. **YES / NO**

f. **Agree** that Health NZ, the Māori Health Authority, the Health Quality and Safety Commission and the Ministry of Health should report back to you by the end of 2022 with a detailed operating model for the future quality system, setting out how they will collaborate to deliver on the system envisioned by this paper. **YES / NO**

g. **Note** that given the planned approach to Budget 22, we expect agencies will be able to adequately resource the quality system articulated in this paper through to FY2023/24 within baselines, noting that for the quality system to lift its performance long-term additional resourcing may be required.

h. **Note** that we do not recommend making changes to the Health Quality and Safety Commission's legal form at this time, and recommend further consideration over the next two years as the system embeds.

pp. Stephen McKernan Director **Health Transition Unit**	Hon Andrew Little **Minister of Health**
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Contact for telephone discussion if required:

Name	Position	Telephone	1st contact
Stephen McKernan	Director, Transition Unit	s9(2)(a)	
Simon Medcalf	Health Team Lead	s9(2)(a)	✓

HEALTH REFORMS: QUALITY FUNCTIONS IN THE FUTURE SYSTEM

Context

1. The health reforms set out to ensure all New Zealanders receive consistent, high quality care when accessing the health system (CAB-21-MIN-0092 refers). You have previously received advice and made a series of decisions in relation to various aspects of the future health system which will assure quality, including overall future system structures, roles and responsibilities (CAB-21-MIN-0092; DPMC-2020/21-1128 refers); the accountability framework and monitoring arrangements for the new system (DPMC-2021/22-996 refers); and developing a national consumer voice framework to ensure that diverse consumer voices are promoted and embedded across our future health system (DPMC-2021/22-296 refers).

2. All these decisions will bring us some way towards ensuring that all New Zealanders receive high quality care in our future health system. In particular, the aspects of the system model which you have agreed which will have the greatest impact on quality of care include:

    a. a learning approach that is informed by robust benchmarking, shared oversight and challenge, networking and support – all in the context of a single system without the current structural boundaries;

    b. a digital shift that will provide services closer to home, with stronger digital infrastructure across services, more robust data sets, and greater use of predictive tools and artificial intelligence – all of which create the opportunity to improve quality and safety; and

    c. accountability and monitoring systems that will give Ministers good information about how the system is performing in aggregate across a range of measures, and help identify risks and opportunities.

3. To deliver on the opportunity of reform, we need to harness these elements and today's best practice to create a strong, continuously learning, quality and safety[1] system that is focused on service performance and improvement to drive better patient outcomes. This will require the mechanisms, practices and structures to understand how services are performing, with effective levers to embed improvement and address problems. This paper describes how this approach may be developed and what is needed now and in the future.

The challenge

4. As we have signalled in previous advice, our health system performs well in a range of measures of care quality at the aggregate level. There been good improvement in some areas in recent years as a result of coordinated national focus, for instance in

[1] Quality and safety are intrinsically linked, with safety being a constituent part of quality. Wherever quality is mentioned throughout this paper, we are also referring to safety.

reductions in hospital falls leading to a fractured hip (a key cause of disability and premature mortality in older people).

5. However, there is widespread variation in care quality, and aggregate figures can mask pockets of sub-optimal or poor-quality care – including for Māori, Pacific people, and other underserved populations. While most DHBs have well-developed quality and clinical governance systems in place, the health system as a whole struggles to translate these into consistent, systemic practice.

6. The Juran Trilogy is a well-established way of thinking about quality, and its underlying concept is that a strong quality system needs to have three types of approaches present, aligned and integrated:

    a. quality planning (e.g. service design, sufficient capacity, sustainable funding, contracting/commissioning, consumer/whānau engagement and co-design);

    b. quality control (e.g. accountability mechanisms, professional and service regulation); and

    c. quality improvement (e.g. quality improvement science).

7. Our current quality system has tended to prioritise quality control over quality planning and improvement. This has resulted in a system which is fragmented with some essential parts missing, which does not have the right functions in the right places, and which lacks clarity in how it relates to the rest of the system. At the system's worst, these three essential approaches, which should be complementary, perform in opposition to each other.[2]

8. As a result:

    a. Problems identified in one area of the health system are not consistently sought out and addressed elsewhere at the same time. This means that we often solve the same problem many different ways in different places, with differing levels of success.

    b. Inconsistent access to local and national expertise makes it challenging to apply best practice everywhere – particularly at the local level.

    c. Problems can slip through the cracks, particularly those that look small locally but taken collectively are part of a bigger trend, and are not responded to at the right level, at the right time.

    d. Uncoordinated interventions of different types can work against each other, which not only misses the opportunity for improvement and wastes resources, but also reduces trust within the system doing long-term damage to quality of care.

    e. Engagement and co-design with consumers and whānau are patchy and their potential as improvers of the system is largely untapped.

[2] Tenbensel, T., Silwal, P. and Walton, L. (2021), "Overwriting New Public Management with New Public Governance in New Zealand's approach to health system improvement", Journal of Health Organization and Management, Vol. 35 No. 8, pp. 1046-1061. https://doi.org/10.1108/JHOM-10-2020-0417

f. Quality is often seen as just preventing things from going wrong, rather than understanding why things go right and encouraging services to continuously get better. This particularly inhibits us from lifting service performance for Māori, Pacific peoples, disabled people and other underserved communities where services may be considered to be doing 'well enough' when they perform for only some communities, typically Pākehā and those with high socio-economic status.

9. Through the reforms we have an opportunity to strengthen our quality system in all areas, building on the best of what happens today, so that challenges can be addressed effectively now and into the future. This paper sets out how we propose that future agencies discover, diagnose, and resolve issues in order to enhance quality. We consider that these features will contribute to a future quality system which will:

   a. have clear expectations of different health agencies including how they work together to continuously improve quality and respond to quality problems;

   b. have the right mix of skills, knowledge and access to expertise at every level of the system to continuously improve quality both of local services and overarching system functioning and respond to the types of quality problems they are likely to face at their level;

   c. have a consistent quality infrastructure within Health NZ which allows oversight of quality deficits at national, regional and local levels NZ, and processes in place for when escalation is required;

   d. include consumers and their whānau as partners in improving and assuring quality;

   e. engages all health workers in quality through a culture that supports quality issues to be raised by individuals without fear of repercussion;

   f. lift overall performance and consistently determine the causes of poor quality, with coherent responses following; and

   g. have safety as a fundamental component – one where consumer and whānau voices are at the centre, and desired reduction in adverse events, healthcare harm, and subsequent costs are routinely monitored and evaluated.

10. This paper also explores what is required to deliver on this system, including how the roles of the agencies at the core of the quality system – the Health Quality and Safety Commission (HQSC), the Ministry of Health (the Ministry), Health NZ and the Māori Health Authority intersect in delivering quality improvement. This advice links closely to advice on outcomes frameworks and accountabilities, as quality improvement in services will be a key domain for system improvement over time, and an area where Ministerial expectations will be high.

11. There are other agencies who have an important role in the quality system, such as responsible authorities, professional bodies and the Health and Disability Commissioner (HDC). This paper does not seek to provide advice on their roles in the future system – noting that you have already received related advice on some of their functions and potential reforms relating to them through advice on the consumer voice and health workforce settings.

Embedding te Tiriti in our quality system

12. As with the overall health system, a high performing quality health system in Aotearoa must give effect to te Tiriti o Waitangi across all levels of the system.

13. Traditionally, the goals of quality improvement in health were framed by the 'triple aim' – individual experience and outcomes, population health and equity, and system value for money and sustainability – and more recently the 'quadruple aim', which adds a focus on workforce sustainability. These frameworks do a good job of painting the system-level outcomes we want to achieve through a quality system, but do a relatively poor job at capturing indigenous conceptions of quality or reflecting the status of te Tiriti o Waitangi, including the implications for how we consider and act on quality for Māori.

14. To that end, we have developed an interwoven framework which links the quadruple aim to the WAI2575 Hauora principles and the articulation of the articles of te Tiriti o Waitangi, as a reflection of the aspirations of our health system in giving effect to te Tiriti. We have tested and received widespread support for this framework from the Transition Unit's Hauora Māori team, the Māori Provider Expert Reference Group and HQSC's Māori team. We set out this framework in full at Annex A.

15. This is the framework by which all the following advice has been tested. While the relationship with Māori is of foremost importance, this framework also forms a basis for describing high quality care for all groups of people. This framework inherently changes how we conceive of the quality system – enhancing the quadruple aim by considering what quality means in the context of our obligations under te Tiriti o Waitangi. This recognises that quality means different things to different groups of people, and creates a system that delivers quality care to Māori and all New Zealanders.

Ideal future state

16. Our health system is complex, and quality issues can arise at any and all levels of the system, at the same time. As such, quality improvement must take place simultaneously at all levels of the system. This means that the quality system needs to be conceived of as a system with different agencies playing different interconnected roles, with cogent relationships between these agencies being as critical as their individual activities.

17. As noted above, some aspects of our quality system are already high-performing, and it will be important to maintain that performance as the system transitions to a new model. However, to embed a more consistent and effective approach across the whole of New Zealand, a range of systematic changes are required across the board to make a difference, including to metrics, methods and management. In brief:

    a. Metrics are mechanisms that allow accurate knowledge about the quality of the system – ranging from operational intelligence to early warning systems.

    b. Methods are the array of actions that we can take in response to the metrics in order to improve the quality of the system – from building capability and capacity to service redesign and policy change.

c. Management refers to how the methods are operationalised and governed to maximise the chances of their success over time – with an emphasis on collaboration, inclusion and ongoing partnerships over hierarchy and control.

18. These broad aspirations will need to be translated by agencies into practice. If our health quality system is performing well in future, it will display the following major changes from how it operates today:

a. Proactive quality improvement approaches are integrated within the planning and commissioning of health services, meaning we invest to improve rather than rolling over the status quo.

b. The organisational values and culture of our health system will be ones which encourage trust, openness, teamwork and safety to express concerns.

c. Through a more dynamic system of frequent data analysis and reporting, the future system will anticipate and address quality issues before they result in widespread disruption or harm, and when they do emerge, they will be addressed as quickly, as locally and as transparently as possible. This will be achieved through better metrics for quality which are more actively monitored at a local, regional and national level, and with a 'toolkit' of interventions which are used regularly to respond to issues and then ensure learnings and improvements are shared more widely.

d. There will be broad and transparent accountability for quality – evidenced by most enquiries into serious failures of health systems, including the Mid Staffordshire NHS Foundation Trust Enquiry.[3] This has two important implications. First, that there is appropriate informing and escalation of issues within Health NZ and Māori Health Authority to support and provide accountability to resolve them. Second, issues should be addressed through community-inclusive escalation, meaning that there is involvement of consumers, whānau and communities – via the consumer health forum as required – and iwi-Māori partnership boards (IMPBs) as a minimum.[4] Consumers and their whānau will be more consistently seen as partners in helping to improve and assure quality, and their potential for helping to improve the healthcare system will be realised.

e. Agencies will contribute to a holistic quality system with everyone having clear roles and responsibilities. While a measure of overlap is a healthy feature of the system, agencies and service providers at national, regional and local levels will have better tools to collaborate and collectively discharge their functions in a way which improves the performance of the system as a whole.

f. How we conceive of quality will be deliberately inclusive of the lived experiences of Māori, Pacific peoples, disabled people, LGBTQI+ communities, Asian peoples and other historically underserved communities – ensuring that the needs of diverse New Zealanders are seen as an essential element of quality, rather than a focus for targeted services only.

g. Research and innovation will be embedded into day-to-day practice at all levels of the healthcare system. Research and innovation are critical enablers for a

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

[4] https://assets-global.website-files.com/5e332a62c703f653182faf47/5e332a62c703f6f7f92fde06_boyd.pdf

continually evolving, fit-for-purpose, and future-focused healthcare system. In our future health system, data (including qualitative insights such as surveys) and analytics will inform research questions and deliver (in collaboration with the wider sector, including research institutes) rapid evidence synthesis to inform any interventions or changes to current practice. We will provide further advice to you on research functions in our future health system in the coming months.

19. These changes will, in part, be enabled by the structural shifts effected through the system operating model and unpacked for each agency below. But they will also require cultural shifts in how we approach quality, including to a higher trust and more transparent model where opportunities to strengthen service provision are readily identified, shared, and acted on within and across agencies. This includes the confidence of staff to be able to flag with issues without fear of repercussion; the Charter could potentially help support this by explicitly emphasising the right and responsibility of staff to highlight concerns.

20. We consider that these shifts are achievable over coming years – and set out below what agencies will need to do to achieve them (seeking your agreement to respective roles and responsibilities), as well as a proposed path to achieve them over time as reforms embed.

Roles and responsibilities of health agencies

21. You have already made a number of fundamental decisions which govern which agencies will hold which functions in our future quality system. The system operating model makes Health NZ and the Māori Health Authority the system's primary commissioners, and so responsible for core quality control, including developing and maintaining a quality-focused workforce culture; the Ministry of Health will be the system's overall steward with policy, funding and regulatory functions; and HQSC's quality monitoring and improvement remit has been expanded to explicitly include consumer and whanau voice and experience.

22. What we set out below is more detail on what each of these agencies will need to do, and lead, to deliver on the quality system outlined above. We also set out a summary diagram at Annex B, which lays out the relative responsibilities of the agencies and the intersection between their roles and responsibilities.

Health NZ and Māori Health Authority

23. In the future health system, Health NZ and the Māori Health Authority's national roles and responsibilities will provide the opportunity to standardise best practice across the country, reduce variation in the quality of healthcare and embed consistent processes to engage and partner with people, whānau and communities.

24. Health NZ will be the main provider of services, and both Health NZ and the Māori Health Authority will be the main commissioners, giving both agencies primary responsibility for frontline quality assurance and improvement on a day-to-day basis. This is because primary activity to assure and improve the quality of health services should take place as close to the consumer as possible, drawing on all available data and information.

25. Ideally, quality issues will be identified before they emerge or as they begin to emerge, rather than once they are already embedded in practice and/or have impacted patient outcomes. The right culture, one of trust and openness, is a key enabler which will allow excellent metrics, data, monitoring, consumer insights and provider relationships to drive early intelligence on quality issues.

26. To this end, both agencies should adopt approaches which balance rapid responses to quality issues being a normal part of business procedures with appropriate accountabilities to ensure quality issues do not slip through the cracks. Devolution of quality control and improvement responsibility should extend to national, regional and locality commissioners and managers. This is well aligned to the locality model, and ensures that those commissioning care and managing services are also responsible for ensuring it is always being improved on. This will incorporate regular monitoring of performance data and information from the frontline, evaluating contracting arrangements, and ensuring consumer intelligence is reflected in planning and commissioning – with appropriate escalation of quality issues which are more ambiguous, severe, or widespread.

27. Health NZ, with its funding and commissioning role, will be responsible for operational leadership and delivery of research and innovation across the health system. The Māori Health Authority will be a key partner in co-commissioning any research and innovation that is focused on reducing existing health disparities, delivering to Māori aspirations, capacity and capability building, and providing oversight of kaupapa Māori and mātauranga Māori methodologies.

28. However, as noted above, frontline commissioners and managers will not always be best placed to address quality issues because of a combination of competing workloads, lack of skill or capability, closeness to services (which is both an advantage and a potential vulnerability), or their own involvement in how quality issues might have arisen (e.g. due to commissioning or management processes or decisions). To augment this primary responsibility:

    a. the agencies – particularly Health NZ – will need dedicated quality improvement, control and assurance expertise which can be drawn on by commissioners, particularly where quality issues go beyond a single locality, become complex or require innovative thinking; and

    b. an inclusive escalation principle should be adopted to ensure that both communities (including Māori) and managers have visibility of emergent quality challenges.

29. While quality is everyone's business, specialist quality teams within agencies can help provide additional focus and impetus. These should, at least initially, focus on growing the ability to:

    a. undertake and support diagnostic review to understand what is happening, why it is happening, and whether there is local capability to address the problem; and

    b. undertake and support responses to specific problems – including building relationships with the Ministry and HQSC to ensure levers within their powers are available to solve tough quality problems, and to escalate issues to Ministers when required.

30. Critical to the leadership and support for quality in the future system will be the role of clinical governance at each level of Health NZ, and how this is shared with the Māori Health Authority. This should encourage the participation of all clinicians and health workers at each level of system, so that there is a culture that promotes quality and shared accountability for its achievement. Effective clinical governance will also foster partnerships between the clinical and non-clinical workforce, and with consumers and whānau.

31. While the design of the approach to clinical governance will be a matter for Health NZ to determine, we would expect it to provide for clear roles at each level, with mechanisms for organising clinical leadership and engagement, disseminating best practice and generating insights on quality issues. We expect that this would include:

    a. a series of national clinical networks, perhaps arranged according to key clinical pathways or specialisms (e.g. cancer, diabetes, mental health), which would encourage engagement with all clinicians working across Health NZ at all levels. These would build on clinicians' own professional bonds within their chosen specialism and link between areas to support formal and informal sharing of information. There may also be a case for regional networks for some pathways;

    b. using clinical networks as a vehicle for maintaining the national picture of clinical practice in that area, with the capacity and capability to identify good practice, to develop tools to benchmark and implement evidence-based pathways consistently, and to provide early warning of possible quality issues;

    c. leadership of clinical networks through national clinical directors, who would provide an important whole-system leadership role and may be a shared resource with the Māori Health Authority and Ministry of Health; and

    d. a mechanism for bringing together the different clinical networks into a single national quality board or senate, to develop a clear clinically-led voice on quality within Health NZ. This would then partner and engage across the system, including with the cross-agency National Quality Forum which is noted below.

32. Inclusive escalation implies that there is management oversight over quality issues: that localities understand service specific issues; regions understand more widespread and complex local issues; and the national executive understand the most widespread and serious issues and host specialist quality teams. It also implies that consumers, whānau and communities – including IMPBs – partner in quality activities. This ensures that if a response to a quality issue is unsuccessful, it is visible and can be addressed in a timely way. By working towards automation of de-identified reporting into national collection systems, emergent quality issues across multiple localities can be addressed with appropriate collective action, instead of driving localities to always respond in isolation.

33. Where the system is working well, this infrastructure acts to both involve the community in identifying and solving quality issues, and ensures visibility through Health NZ and the Māori Health Authority. Such principles also ensure proportionality: nation-wide quality issues are likely to be escalated to senior executives, while localised problems may only require regional oversight day-to-day. Where quality issues pose more significant risks to people's health or the integrity of the health system, agencies will be well-placed to advise and inform Ministers.

34. While failure for a quality improvement effort can manifest itself in different ways, they ultimately aggregate into two main types – that the approach was correct but there was a lack of capability or capacity to implement it successfully (the right thing was done badly); or the analysis of the cause was incorrect so the wrong approach was used (the wrong thing was done). In instances where solving problems is more difficult, inclusive escalation is designed to ensure transparency and gain internal organisational support to improve how quality issues are being tackled – including providing access to stronger levers where needed.

35. In a system performing well, local Health NZ clinical governance groups should be regularly making the regional levels of Health NZ and the Māori Health Authority aware of quality issues and progress in addressing them, including escalating where they do not reasonably have the capability to resolve them (or where the issue is more widespread than within just one team, department or service). Similarly, they need to be partnering through consultation or co-design with consumers and IMPBs on such issues, and others as appropriate (for example maternity issues in some part of the country should involve Pacific health care providers). A similar approach to diagnostic reviews of quality risks and issues, and responses according to capabilities and roles, needs to be in place at the Health NZ and Māori Health Authority regional level, with escalation to national leadership or the Board of Health NZ where required.

36. We would anticipate the Māori Health Authority developing similar functions to Health NZ to oversee and respond to widespread or significant quality issues within Māori services which they take a lead role in commissioning – though they may share a centre of expertise and clinical leadership with Health NZ at the agencies' discretion. We would expect that this should include a shared data platform between the two agencies, with quality data hosted by each entity but accessible to each other so trends and common issues can be identified early. Similar to Health NZ, the MHA has a critical role in both highlighting quality issues that specifically affect Māori within Health NZ provided and commissioned services; in which we anticipate the Authority's monitoring function to have close relationships with both the Ministry, HQSC and the HDC among other agencies.

Health Quality and Safety Commission

37. HQSC has two specific current roles that support our future quality system: monitoring, and supporting quality improvement.

38. HQSC's monitoring will be provided to the Ministry of Health, Accident Compensation Corporation (ACC), Health NZ and the Māori Health Authority using a range of its metrics – including quality alerts which form part of the early warning system, the system quality dashboard, and the Atlas of Healthcare Variation. This will support the Ministry to act as system steward, and Health NZ and the Authority to identify opportunities for service improvement and quality intervention. Essential to support this monitoring role is the ability to stand outside of the system far enough to provide a sufficiently independent view, that quality successes and challenges can alike be identified with credibility. This ensures a fresh and unbiased perspective on quality challenges, and creates space for deliberate and proactive evaluation of system quality – free from reactive distractions of day-to-day system management. Where HQSC's monitoring suggests that there is a major systemic issue, they will work closely with the relevant agencies to ensure a system wide response, and you will be informed of on-going progress to address the issue.

39. HQSC's role in supporting quality improvement will operate in four ways:

    a. It can lead national quality improvement programmes where this is clearly the most effective and appropriate response. Given that HQSC will have significant quality capability and knowledge, as well as a degree of distance from operations, this role is likely to be most appropriate for large national or regional endeavours where agencies either lack capability, or may not be seen as impartial (e.g. where there is a measure of public criticism of agencies' handling of quality).

    b. It can support local and regional quality improvement efforts through providing 'library' services which facilitate sharing of good practice and expertise. HQSC has a strong position to act as a broker and a more independent conduit for support to providers. HQSC already does this today, but we expect it will need to expand its capacity and capability as the system is implemented.

    c. It can operate as a centre of excellence to support building quality capability within Health NZ, the Māori Health Authority, ACC and commissioned providers through a series of education programmes.

    d. In its increasing role in developing and supporting consumer and whānau engagement and partnership throughout the system.

40. The nascent National Quality Forum (NQF) can play a pivotal role in how this system works. It provides a mechanism for sharing, investigating, diagnosing and addressing emergent and cross-agency concerns at a national level. It can also be a mechanism to address entrenched and normalised quality issues. By having agencies (including the HDC and ACC), consumers and professional organisations involved, it has access to most sources of intelligence and all potential responses. Further development of the NQF model will continue over the next six months, but this has the capacity to operate as an exemplar for the sort of operating that the system requires at all levels. HQSC will brief you further on the NQF as work progresses.

The Ministry of Health

41. As the steward of the future health system, the Ministry of Health holds overall responsibility for system quality. We envisage that:

    a. Health NZ and the Māori Health Authority will provide regular information to the Ministry about quality risks and issues, including progress in addressing them;

    b. HQSC would provide quality monitoring data with the Ministry regularly, with shared analysis and identification of areas of potential systematic threat;

    c. the Ministry would be an active participant in the National Quality Forum; and

    d. the Ministry will, in addition to its work as a monitor, make active use of levers such as policy, regulation, funding and advice on Ministerial powers to address quality risks and issues as appropriate to improve the quality of the system – noting that these levers will typically be used for more serious issues or those with more than just a local dimension, usually involving a cross-agency response.

42. Finally, as system steward, the Ministry will have ultimate responsibility for assuring that all parts of the overarching quality response system are in place, fit for purpose and working well. We anticipate that the Ministry and HQSC will work together closely to

deliver on this feature of stewardship, and to provide you with regular updates on system quality performance.

43. We set out below two examples of how agencies might work together to deliver on desired outcomes in different scenarios – noting that different combinations of actors will be needed depending on severity and localisation to address quality issues well.

SCENARIO 1: A simple, very localised quality issue

Routine day-to-day monitoring and information from a patient experience survey suggests that time spent in the waiting room inside a specific outpatient clinic is too long.

This very specific and local problem is reviewed under local clinical governance processes with both lack of capacity and process inefficiencies considered. Through comparing existing processes with examples of best practice, process inefficiencies are identified as the problem.

By using service redesign processes such as process and value stream mapping, a better process is designed and implemented, drawing on best practice available to the hospital provider executive and the service. Routine monitoring and patient experience surveys will then show that this has indeed succeeded in reducing time spent in the waiting room. The example is written up and shared in a national library of successful service redesign projects.

SCENARIO 2: A complex, multi-agency and systemic quality issue.

A range of data shows long standing inequitable maternity outcomes for Māori, Pacific and Indian mothers. This is a systemic problem, where the response of the health system is one element of the problem though not necessarily the primary driver – and where this complexity can put off tackling root causes.

In this scenario, some precise issues are likely to be local (e.g. differential access to culturally-appropriate midwifery care in different parts of the country), therefore diagnostic processes need to involve local consumers, professionals, managers and broader stakeholders with regional support as required. Through this, a range of potential causes are identified, including lack of culturally safe practice and general system weaknesses such as too few midwives and a lack of integration of maternity services. This promotes three types of responses:

- Addressing culturally unsafe care through a mix a capability building and firm accountability to increase the cultural safety of maternity practice across organisations and professions (using both quality improvement and quality control approaches).
- Addressing system weakness by enabling inventive local solutions which break down lack of integration between different professional groups (GPs, midwives, obstetricians) and settings (practices, hospitals, community-based care, birthing centres). Flexible policy settings and funding models are employed to promote emergent innovation, but with support designed to encourage scaling of successful models as appropriate.
- Agencies integrate the issues into their approaches to strategic issues and policymaking, such as in strategic workforce.

These types of innovations need robust piloting and targeted evaluation and, if successful, consideration of how best to seek spread and scale of these (simple "lift and shift" is unlikely to be an appropriate approach).

Phasing and transition

44. Our ideal future state for the quality system cannot be fully realised by July 2022. Some features required to deliver that system will require substantial work and investment by the future entities, and will need targeted funding in future Budgets.

45. However, there are things that can be done now and over the next two years to set the reformed health system up for success. These early steps should leverage off the systems and processes already in place in DHBs to harness best practice and the opportunity of common leadership within Health NZ.

For Day 1

46. The most essential components of the quality system will be needed by July 2022 to ensure that when problems arise, they can be addressed. Further components can then be built on in the years that follow. Many of these critical elements exist, and can be adapted to fit the new structures.

47. All health agencies will need to be clear on their roles and responsibilities for quality (as outlined above) and have clearly defined expectations and processes for working together in response to a quality issue. This is particularly important with the system still responding to COVID-19, to ensure agencies can work together to respond to complex issues that are impacting the entire system.

48. Ahead of Day 1, we recommend that Health NZ and the Māori Health Authority focus on building the internal mechanisms to deliver on the above quality system. In particular, this means:

    a. establishing a function to oversee quality within Health NZ, with close links to other agencies, which is internally accountable for quality improvement, assurance and planning;

    b. developing operational mechanisms, as part of putting in place commissioning and service management arrangements, to link teams expert in quality improvement and service redesign to routine operational management and clinical governance; and

    c. agreeing how quality will be evaluated, in particular how agencies will ensure the needs and aspirations of Māori, Pacific peoples, disabled people, the LGBTQI+ community and other historically underserved communities will be reflected in how we conceive of quality. This will need to align closely with system-level outcomes and priorities, including those which you agree for inclusion in the Government Policy Statement.

49. Alongside this, early priorities for HQSC include:

    a. further developing its monitoring and measurement role including development of the National Quality Forum;

    b. supporting Health NZ and the Māori Health Authority to develop skill and capability where required;

    c. expanding its library of evidence-based resources, and making them more visible and accessible across the system;

d. commencing development of programmes to increase skills in quality improvement science and service redesign; and

e. further advancing consumer/whānau engagement work in line with the agreed work programme.

50. Early priorities for the Ministry of Health should include:

a. developing an independent monitoring system to synthesise insights collected from the health system, in line with the interim Government Policy Statement (iGPS), interim New Zealand Health Plan (iNZHP) and monitoring frameworks;

b. building relationships with Health NZ and the Authority's quality teams, commissioners and planners to derive on-the-ground insights, and ensure escalation where more systemic responses (e.g. using policy levers) are needed; and

c. working with Health NZ, the Māori Health Authority and HQSC to identify priority targets for quality improvement in the system which must be tackled in the short-term, including for effective clinical governance.

By June 2024

51. The period between June 2022 and June 2024 will allow agencies to build on early foundations, and ensure the quality system aligns with wider system priorities articulated through the iGPS and the iNZHP. Priorities for quality system improvement will need to be underpinned by investment in internal capability and shifting practice day-to-day as services are improved and the locality approach and hospital networks are rolled out.

52. We consider the top priorities for Health NZ and the Māori Health Authority for the first two years of the reformed system should include:

a. Developing metrics of performance at a local, regional and national level that can be used to drive improvement – both across the system as part of the development of a full outcomes framework, and at a more granular level for specific localities and services. This should include consumer and whānau-centred quality measures wherever possible.

b. Developing approaches to spread and scale successful interventions, including to share lessons learned from addressing complex systemic quality problems and applying national and international evidence.

c. Ensuring fit for purpose clinical governance models and capability, including ensuring representation of Māori and Pacific clinical voices.

d. Developing processes to leverage existing mechanisms such as consumer councils and new mechanisms such as the emerging consumer health forum to engage with consumers when diagnosing and responding to quality problems at every level of the system.

e. Setting cultural safety standards and policies for all services, including expectations (and support to lift capability) for the health workforce in their understanding of te Tiriti o Waitangi, culturally safe practice, and te ao Māori.

f. Integrating requirements for quality within contracts and commissioning, including agreed ways to measure success. An intervention framework for commissioned services should also be developed as a guide for how to address quality issues.

53. Along with continuing to support the system where needed (less so than in the first two years), HQSC will have developed a measures library to support greater consistency in available indicators, creating a knowledge centre and building its base of consumer experience sources, including surveys and patient-reported outcome measures (PROMs). Additionally, the quality improvement and service redesign programmes developed should be ready to implement across the system.

Implications

Fiscal implications

54. We consider that the roles, functions and system features outlined above are deliverable within current system settings and parameters, subject to sufficient funding for system stability being agreed through Budget 2022.

55. In the short-term, it will be important for Health NZ to undertake a stocktake of the system's capacity which is currently focused on quality improvement, to understand the starting point and identify good practice and areas to address. This will help to target early investment towards developing the quality approach.

56. Longer-term improvement and expansion of roles and capability will require additional investment in future Budgets and prioritisation in the next GPS and full NZ Health Plan. For instance, HQSC have highlighted that to meaningfully lift system performance across services, materially more investment in quality will be needed than is the norm in today's system – while noting that the above operating model and the system operating model more generally offer opportunities for significant efficiencies. We anticipate that as Health NZ and the Māori Health Authority settle into new roles, and the necessary spread of resourcing across agencies becomes apparent, agencies may provide you with further advice ahead of future Budget cycles to inform decisions about where resourcing is invested, and in what quantum. It will be clearer by FY2024/25 whether funding can be reallocated from within current baselines to sustain a stronger quality function, or whether further ongoing investment will

Agency implications

57. You have also received advice from HQSC regarding their level of independence in the health system, and the potential impact of their current legal form (i.e. a Crown agent) on their ability to operate effectively in the manner described in this paper. We have considered this further in the content of developing this advice.

58. We agree that to achieve the role outlined above, the HQSC needs to be seen and respected across the health system as an independent voice and champion for quality. The HQSC has a unique role, removed from the competing pressures and mixed incentives of being a service commissioner and provider, which allows it to focus on providing a more neutral and evidence-based perspective on what works, what may be failing, and where systemic action may be necessary. For this role to be effective, HQSC needs to have autonomy to make judgments and provide early warning.

59. We also agree that the current practical level of HQSC's independence needs to be strengthened. The level of HQSC's independence, and crucially the perception of its autonomy both within the Commission and across the health system, has been hampered by processes and ways of working. These include, for instance, HQSC's views on priorities for investigation being subject to agreement with the Ministry of Health, and a lack of a clear channel for escalating concerns.

60. It is not clear the extent to which HQSC's legal form acts as a barrier to greater independence. While a move to a more autonomous form (e.g. an autonomous Crown entity) would provide greater operational freedom, many of the barriers which have been highlighted are the result of embedded processes which are not matters of law, but of practice. The reformed health system, with new roles for the Ministry and health entities, offers a rare opportunity for a reset of relationships and a rebalancing of ways of working.

61. There would also be a risk that a more autonomous legal form for the HQSC would remove it from the scope of the Government Policy Statement and NZ Health Plan and therefore Ministers' ability to set a common policy direction for core health entities. There may be advantages to the HQSC of acting a further step removed from Government, but it is too soon to say whether these would outweigh the risk to a "one system" policy approach to quality.

62. On balance, we recommend that the case for a change in the legal form of the HQSC is kept under review as the new system builds and consolidates in the coming two years. If the new system structures and relationships do not succeed in providing the platform for the HQSC to strengthen its role as envisaged, together with the actions which the Commission should take itself, then it may then be necessary to recommend a change of status to support this. However, we believe that there is significant capacity to improve without change to legislation, and a clear desire from all agencies to support the direction.

63. This would be consistent with other potential changes to legislation which are not included in the Pae Ora Bill, but where there is likely to be a case for further amendment through subsequent bills – including, for example, workforce regulatory reform and reviewing the Health Act. It also recognises that the timetable for amendment to the Pae Ora Bill is limited.

Consultation

64. We have worked closely with HQSC to develop this advice. Treasury and the Ministry of Health have been consulted on this paper.

Next steps

65. In the immediate term, it will be important to communicate the direction and expectations clearly to agencies, so that necessary development work ahead of Day 1 is focused appropriately and supports common goals. We recommend that:

    a. Based on your feedback and decisions, we communicate your expectations for the future system quality framework to the interim agencies to set a clear benchmark and level of ambition. This might be achieved by sharing the advice in

this paper in board papers for the agencies. These should also be shared with HQSC and the Ministry.

b. You include high-level expectations in the iGPS to reinforce the direction of travel and make clear requirements on the new entities to develop the necessary functions and processes over the first two years. We would then expect similarly to see this focus, and associated, tangible actions in the interim NZ Health Plan.

66. Subject to your agreement, we will take steps to brief the Boards of interim Health NZ and the interim Māori Health Authority on the above framework, and work with HQSC and the Ministry of Health to provide the Boards with further operational detail about how they might operationalise the above priorities.

67. We are available to discuss this with you at our regular meeting this coming week.

Annexes	
Annex A	Framework for a high performing quality system
Annex B	System monitoring diagram

DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

ANNEX A: FRAMEWORK FOR A TIRITI-ALIGNED, HIGH PERFORMING QUALITY SYSTEM (RIGHT CARE, RIGHT PLACE, RIGHT TIME)

	Kāwanatanga: Partnerships	**Tino rangatiratanga: self-determination**	**Ōritetanga: equity**	**Active protection**	**Options**	**Wairuatanga: upholding values, belief systems and worldviews**
Whānau	Whānau, consumers and providers share information and partner in care.	Whānau and consumers are able to exercise their right to self-determination.	Health care is provided equitably, to deliver equitable health outcomes for Māori and other groups.	Effective, clinically and culturally safe healthcare is delivered to meet whanau and consumers' needs.	Quality, safe, equitable care for Māori whānau is accessible through both Kaupapa Māori and general services. Culturally appropriate options are available for all health service users and their families.	Te ao Māori, Māori worldviews and mātauranga Māori are upheld. The worldviews of all consumers and their communities are respected and upheld.
Population	Partnerships with Māori and other relevant groups of consumers and populations determine processes and outcomes sought from our health system.	Māori self-determine what quality and safety looks like for Māori. Consumers self-determine what quality and safety looks like for them.	Health care is provided equitably, to deliver equitable health outcomes for Māori and other groups.	Culturally safe and appropriate healthcare is delivered, to meet whānau and consumer needs.	Quality, safe, equitable care for whānau is accessible through both Kaupapa Māori and general services. Culturally appropriate options are available for all groups.	Te ao Māori, Māori worldviews and mātauranga Māori are upheld, across services and the system. The world views of all consumers and their communities are respected and upheld.
System	Partnerships with Māori as well as other relevant groups of consumers and populations ensure equitable and sustainable distribution of health resources to meet need.	Māori determine the use of system resource for Māori. Other population groups determine use of system resource for them.	Addressing health inequity is a system priority.	Crown obligations under Te Tiriti are prioritised.	Quality, safe, equitable care options are well resourced across the health system	Te ao Māori, Māori worldviews and mātauranga Māori are upheld. The world views of all consumers and their communities are respected and upheld.

Workforce	A safe and effective health workforce reflects the aspirations of Māori and other relevant groups of consumers and populations. Māori leadership is evident at all levels of the health system	Iwi- and Māori-led professional pathways and models of care are in place and accessible. Professional pathways relevant for other groups are in place and accessible.	Our workforce is representative of the populations it serves, and is competent to meet the specific needs of whānau.	A culturally safe working environment supports the health workforce.	A range of training and development options, including Māori worldview options, support the growth and retention of our workforce.	The system ensures te ao Māori, Māori worldviews and mātauranga Māori expertise is valued in our workforce. Cultural safety is practiced across the workforce for the benefit of all groups.

ANNEX B: SYSTEM MONITORING