OIA request – Committees managed by the Commission

Ahuahu Kaunuku

Committee name: Te Roopū
Members: Ria Earp (Chair), Dr Fiona Cram, Marama Parore, Muriel Tunoho, Prof Denise Wilson, Hingatu Thompson
Term of appointment: Membership of Te Roopū Māori will be reviewed every four years and membership on Te Roopū will not exceed two election cycles (unless agreed by the Board).
Terms of reference below.

Quality Systems

Committee name: Strategic Infection Prevention and Control Advisory Group (SIPCAG)
Members: Andi Shirtcliffe, Anne Hutley, Arthur Morris, Claire Doyle, Greg Simmons (Chair), Janine Ryland, Jocelyn Peach, Jo Stodart, Joshua Freeman, Lyn Downing, Max Bloomfield, Ngāpei Ngatia, Sally Roberts, Susan Barnes, Susan Wood
Length of term for each member: the term of membership is three years with renewal for another three years
Terms of reference below.

Committee name: Integrated advisory group (IAG)
Members: Nick Chamberlain (Chair), Les Toop, Peter Jones, Sue Wells, Rawiri Jansen, Marlene Whaanga-Dean, Chiquita Hansen, Jean Mitaera, Bryan Betty, Kristina Sofele, Justine Mesui, Rawiri Keenan
Length of term for each member: Three years with renewal another three years
Terms of reference below.

Committee name: Aged Residential Care Quality Leads
Members: Julie Daltrey, Heather Harlow, Katherine Foulkes, Pam Walker, Jane Watson, Virginia Sisson, Lynda Irvine, Tanya Bish, Jane Smart, Karen Lake, Nikki Close, Joy Tlapi, Sharmila Devaraj
Length of term for each member: No set term
Link to Terms of reference: No TOR

Committee name: Aged Residential Care Leadership Group
Members: Richard Scrase (Chair), Rhonda Sherriff, Ruihua Gu, Bev Nicolls, Brigette Meaghan, Jon Schapleski, Maree Todd, Jessica Buddendijk, Andi Shirtcliffe, Karen Browne, Tiakina Te Kare, Kelly Te Kare
Length of term for each member: Two years with renewal another two years
Terms of reference below.

Committee name: Adverse Events Reporting Policy Working Rōpū
Members: Jeanette MacKenzie, John Peek, Carmel Conaghan, Brendon Clark, Julia Abbott, Charmaine Pene, Ruihua Gu, Liang Huang, Rosie DeGregorio, Kirsten Lassey, Janet Cuthers, Angela Smith, Naomi Cowan, Maine Mareko-Johnson, Michelle Wise, Peter Godden-Steele, Ria Earp, Luatupu Ioane-Cleverley, Chris Sorensen, Peter Twamley, Elizabeth Wood, Ayshea Green, Bella Atherton, Susan Barnes, Sue Wood, Jacky Bush,

Lesa Freeman, Erika Hunt, Cherie Buchanan, Cristina Ross, Riani Albertyn, Jane Watson, Victoria Brevoort, Jacqui Tuffnell, Christina Curd, Joan Burns, Cheryl des Landes, Alana Harper, Tangi Noomotu, Julia Mitchell, David Hughes.
Length of term for each member: Until June 2022
Terms of reference below.

Committee name: System Safety Rōpū
Members: David Hughes, Carl Horsley, Tanya Maloney, Jo Wailing, Erin Downs, Anne Stewart, Julie Williamson, Sheila Beckers, Brenda Hall, Kate Coley, Rose Wall, Denys Court
Length of term for each member: Until June 2022
Terms of reference below.

Mortality Review Committees

Committee name: Child and Youth Mortality Review Committee
Members: Dr Matthew Reid (co-chair), Dr Alayne Mikahere-Hall (co-chair), Fale (Andrew) Lesa, Dr Rebecca Hayman, Rob Thomson, Linda Bowden, Dr Collete Muir
Length of term for each member: Members of the Committee are appointed by the Commission for a term of up to three years. Members may be appointed for further terms.
Terms of reference below.

Committee name: Family Violence Death Review Committee
Members: Dr Fiona Cram (chair), Dr Jacqueline Short, Assoc Prof Nicola Atwool, Dianne Cooze, Stormie Waapu, Shayne Walker, Dr Michael Roguski
Length of term for each member: Members of the Committee are appointed by the Commission for a term of up to three years. Members may be appointed for further terms.
Terms of reference below.

Committee name: Perinatal and Maternal Mortality Review Committee
Members: John Tait (chair), Robin Cronin, Lisa Paraku, Dr Rose Elder, Claire MacDonald, Dr Kasey Tāwhara, Dr Liza Edmonds
Length of term for each member: Members of the Committee are appointed by the Commission for a term of up to three years. Members may be appointed for further terms.
Terms of reference below.

Committee name: Perioperative Mortality Review Committee
Members: Dr Dick Ongley (chair), Stephanie Thomson, Prof Andrew Hill, Dr Kerry Gunn, Dr Jason Gurney, Prof Jonathan Koea
Length of term for each member: Members of the Committee are appointed by the Commission for a term of up to three years. Members may be appointed for further terms.
Terms of reference below.

Committee name: Suicide Mortality Review Committee
Members: Dr Sarah Fortune (chair), Prof Roger Mulder, Taimi Allan, Denise Kingi-'Ulu'ave, Tania Papali'i
Length of term for each member: Members of the Committee are appointed by the Commission for a term of up to three years. Members may be appointed for further terms.
Terms of reference below.

HQI

Committee name: Patient Experience of Care Governance Group
Members: Amanda Dudding, Apisalome Talemaitoga, Carin Hercock, Catherine Gerard, Nicola Russell, Christine Walsh, Dean Rutherford, Fiona Thomson, Joanna Swanson, Marcia Walker, Marj Allan, Martin Carrell, Mataroria Lyndon, Rawiri Keenan, Ron Dunham (Chair), Sharon Kletchko, To'a Fereti
Length of term for each member: Two years with possible extension for continuity
Terms of reference below.

Trauma

Committee name: Trauma Rehabilitation Project Expert Advisory Group
Members: Lee Taniwha, Tim Dunn, Jonathan Armstrong, Gina Marsden, Alice Theadom, Martin Chadwick, Sean Gray, Christine Howard-Brown, Subramanya Adiga, Ian Winson, Sarah Hawkins, Katherine Winson, Trish Fredericksen, Roxanne Waru, Fraser Wilkins, Te Rina Ruru
Length of term for each member: until end of 2021
Terms of reference below.

Committee name: Severe traumatic brain injury project – Acute Expert Advisory Group
Members: Alex Browne, Casey Drum, David O'Bryne, Grant Christey, Jason Wright, Katherine Townend, Kerry Harrington, David B Harrington, Kevin Henshall, Reuben Johnson, Sharlene Olsen
Length of term for each member: until December 2022
Terms of reference below.

Committee name: Severe traumatic brain injury project – Rehabilitation Expert Advisory Group
Members: Alice Theadom, Christine Howard-Brown, Fraser Wilkins, James McKay, Lisa Starnes, Melanie Cheung, Renate Donovan, Richard Seemann, Suzanne Gudgeon, Toni Auchinvole
Length of term for each member: until December 2022
Terms of reference below.

Partners in Care

Committee name: Te Kāhui Mahi Ngātahi / Consumer Advisory Group (CAG)
Members: Delphina Soti, Frank Bristol, Maine Johnson, Mary Schnackenberg, Muriel Tunoho, Rowena Lewis, Russ Aiton
Length of term for each member: three years with possible extension to six
Terms of reference below.

Committee name: Kōtuinga Kiritaki / Consumer Network
Members: Amanda Stevens, Angie Smith, Bernadette Pereira, Edna Tuitupou, Hyejung Kim, Jennie Harre Hindmarsh, Joanne Neilson, Mark Rogers, Marlene Whaanga-Dean, Mary

Schnackenberg, Oliver Taylor, Renee Greaves, Ricky Ngamoki, Russ Aiton, Vishal Rishi, Zechariah Reuelu

Length of term for each member: three years with possible extension to six
Terms of reference below.

Mental Health and Addiction Quality Improvement Programme:

Committee name: Consumer Advisory Group (CAG)
Members: Penelope Jane Saunders-Francis, Egan Bidois, Leo McIntyre, Martin Burke, Suzana Baird.
Length of term for each member: Terms of appointment are for a maximum of 3 years with the ability to re-appoint for a further term.
Terms of reference below.

Committee name: Māori Advisory Group (MAG)
Members: Guy Baker, Jason Haitana, Joanne Henare, Johnnie Potiki, Aaryn Niuapu, Dean Rangihuna, Millie Berryman, Robert Walker, Rangimokai Adrienne Fruean.
Length of term for each member: Terms of appointment are for a maximum of 2 years with the ability to re-appoint for a further term.
Terms of reference below.

Committee name: MHA Leadership Group
Members: Rees Taspell (Co-Chair), Peter Bramley (Co-Chair), Alison Masters, Clive Bensemann (Clinical lead), David Codyre, Graham Mellsop, Heather Casey, Joanne Henare, Peta Rowden, Emma Wood, Ian McKenzie, Phyllis Tangitu, Suzie Baird, Philip Grady, Naomi Cowan, To'a Fereti
Length of term for each member: Terms of appointment are for the current contract with DHBs (until 30 June 2024).
Terms of reference below.

Committee and Advisory Group Fees Policy

Purpose

The Commission needs to be able to access expertise and input into work programme development and decision-making. It is important that fees are available for participants in line with the State Service's Commission fees framework and sector best practice.

This policy outlines the approach to the payment of fees for participation in Commission working groups, advisory groups and committees.

Policy

For Commission Board remuneration and expenses, see the Commission Governance Manual.

- Groups that are formed by the Commission, and operating under an approved Terms of Reference,[3] are eligible for fees in accordance with State Services Commission guidelines ('Fees and allowances for statutory and other bodies') and *Cabinet Office Circular CO (19) 1 , dated 17 June 2019.*

Budget managers are responsible for ensuring the Terms of Reference clearly outlines:

- the fee to be paid, including preparation time
- the meeting frequency and anticipated duration
- the approach to expenses.

The budget manager in charge of the committee and/or subcommittee must be satisfied that all fees and payments made to committee or subcommittee members are in accordance with the State Services Commission guidelines prior to authorising payment. Members should be reminded of their obligations in any letter inviting participation in a committee or group. Please refer to the Template for Membership Appointment and Fee Payment.

[3] Approved Terms of Reference are those approved by the Chief Executive or General Manager.

On appointment to a group or committee, members will be asked to confirm whether they are:

- employed full time by a public sector organisation
- not employed by a public sector organisation
- GST registered.

All expenditure incurred on Commission business, by committee members, for which the Commission is liable or reimbursement will be sought, must comply with all relevant Commission policies and procedures including the Commission's financial delegations.

All expenditure must satisfy the reasonable person test. Clarification of the validity of expense items or interpretation of policies and procedures should be sought from the CFO, if required.

Payment of committee fees

Fees for Commission committees are paid within the CO (19) 1 *Group 4* . In most cases this will be set at $330 [4]per day for members and $463 per day for Chairs of the committees.

In exceptional circumstances budget managers may seek approval from the General Manager for a higher or lower rate within the *Group 4 band* to be paid. Ministerial approval is required for fees above this band to be paid.

Members are also entitled to preparation and travelling time where appropriate. Preparation time will generally be half a day for every full meeting day. In some cases more or less may be appropriate depending upon the nature of the work to be undertaken.

Reimbursement of expenses

Accommodation and incidental costs

The policy of the Commission is to reimburse committee members' actual and reasonable costs that relate to the committee meeting. Prior approval must always be obtained from the Budget Manager in charge of the committee for any expenditure prior to the expense being incurred.

All accommodation, air travel and rental car bookings must be booked through the Commission's preferred travel provider. Only on an exceptional basis is a committee member to book through any other travel agent and charge back to the Commission.

Travel

All committee members' travel should be coordinated by the person/staff member responsible for the committee. Travel arrangements are to be made through the Commission's preferred travel provider where preferential rates are provided to the Commission for both air travel and rental vehicle.

---

[4] From 1 Jan 2020

All committee members travelling on behalf of the Commission are expected to follow the Commission Travel Policy and Guidelines, part of the Operational/Administration Policy Manual.

Motor vehicle reimbursement/allowances

Mileage will be refunded at the current IRD rate of 76 cents per kilometre. Mileage reimbursements are no longer subject to withholding tax.

Claiming expenditure

All committee expenses must be submitted on the appropriate commission claim form and approved by the budget manager.

Tax implications for fees

Withholding tax (schedular payments)

Members are responsible for ensuring they meet their tax obligations.
Committee fees are categorised as honoraria and as such are subject to withholding tax pursuant to Schedule 4 Part B of the Income Tax Act 2007 No 97.

Managers must ensure an individual receiving withholding payments from the Commission for the first time has completed an IR330 form and forwarded it to the CFO before he/she is paid, or alternatively has provided the Commission with an exemption certificate IR331 form.

Goods and Services Tax

Where a tax invoice is provided by an individual (not a limited liability company), the invoice value including goods and services tax should be paid, less withholding tax calculated on the GST exclusive value of the invoice.

Te Roopū Māori
Te Kaupapa, ngā kawa me ngā tikanga
October 2021

Tuatahi: Te Tiriti o Waitangi

1. Te Tiriti o Waitangi provides the basis for shared partnership between tangata whenua and the Crown. Te Tiriti also provides the settings for the work of the Health Quality and Safety Commission (the Commission) and this is echoed in our Statement of Intent (SOI) 2017-2021. As part of the Commission's commitment and responsibilities towards enacting Te Tiriti o Waitangi including strengthening Māori Crown relations, the Commission's Governing Board (the Board) has continued established Te Roopū Māori.
2. Te Roopū Māori recognise the need for agility and flexibility given the context of significant health reforms over the next five – ten years. Te Roopū Māori will ensure that as the Commission moves towards its extended functions it will ensure its advice is cognoscente of Te Tiriti o Waitangi obligations and responsibilities.

Tuarua: Our Values

3. Te Roopū Māori operates under a korowai of shared values to support the Commission. These values include:

Kaitiakitanga / Guardianship – to care for and look after the quality and safety of our health system	**We share responsibility to look after and care for (in accordance with tikanga Māori) the mana and the mauri of the Commission in its role to contribute to a quality and safe health system**
Kotahitanga / Unity – maintaining a collective purpose and direction	**We support the Commission to achieve unity through discussion and debate in a way that is mana enhancing and achieves collaboration and harmony**
Manaakitanga – the ethic of caring for others through hospitality and hosting	**We support the Commission to express manaakitanga towards each other and to other colleagues while taking care not to trample another's mana**
Rangatiratanga – expression of humility, self-determination, leadership, generosity, and altruism	**We respect the right of Māori to make decisions about their health and wellbeing and to be self-determining - often expressed through the attributes of leadership, humility, diplomacy and the sharing of knowledge**

Te reo me ngā tikanga Māori – sustaining our Māori language and doing things the "right way"	**We value and support the mana and use of te reo me ngā tikanga Māori throughout the work of the Commission**
Wairuatanga / Spirituality – the belief in spiritual existence along side the physical world	**We value the nourishing and nurturing of the Commission's spiritual connectedness through the practice of karakia, mihimihi and wānanaga**
Whakawhanaungātanga / Relationships – the view that we are part of a larger whole of the collective	**We support and will enable the Commission's ability to maintain its own sense of belonging and ownership through its connectedness to the wider health system**

Tuatoru: Purpose

4. The purpose of Te Roopū Māori is to advise, guide and provide direction to the Board and Chief Executive on strategic issues, priorities and some operational matters regarding Te Tiriti o Waitangi enactment. This will be achieved through the quality and safety work of the Commission across the health system. Te Roopū brings Māori worldview knowledge and advice to the Commission and perspectives of Māori consumer, whānau, hapū, and Iwi to improve the quality and safety of the health system to better meet the needs of Maōri.

Tuawha: Role & Responsibilities

5. Te Roopū Māori will support the Commission through the provision of advice, guidance and direction on the Commissions strategic intent and work programme to influence, involve and reach Māori health consumers, whānau, hapū and Iwi by:
   5.1. Proactively recognise Te Tiriti enactment and Māori worldviews in the design and implementation of quality improvement initiatives;
   5.2. Reviewing Board papers, out of cycle, that have strategic implications to improve Māori health outcomes;
   5.3. Identifying key quality and safety issues that impact on the delivery of quality and safety for Māori consumers, whānau, hapu and Iwi;
   5.4. Ensuring the voice of Māori consumers, whānau, hapū and Iwi are involved, inform and influence health quality and safety improvements across the health system;
   5.5. Advising on qualitative and quantitative methods for measuring and monitoring health quality and safety for Māori;
   5.6. Consider Whakamaua: The Māori Health Action Plan within the Commission's work to improve the quality of the Health System;

5.7. Engage and work with clinical advisory groups and international groups as requested by the Board or Chief Executive, and as time allows;

5.8. Engage with their own networks of kuia and kaumatua, community leaders, clinicians, advisers, researchers and specialists on the Commission's activities and interests as requested by the Board or Chief Executive; and

5.9. Supporting the Board and Chief Executive in building and sustaining Māori Crown relations.

Tuarima: Accountability

6. Te Roopū Māori is accountable to the Board.
7. Te Roopū Māori is advisory only although the Board may specifically delegate to Te Roopū Māori the authority to make decisions and take actions on its behalf in relation to certain matters.
8. Any recommendations or decisions of Te Roopū Māori will be brought to the Board through the Chair of Te Roopū Māori and ratified by the Board accordingly (unless authority has already been delegated to Te Roopū Māori).
9. Te Roopū Māori may only give advice or release information to other parties under authority of the Board or Chief Executive.
10. Meetings should comply with the same statutory and best practice requirements that apply to Board meetings.

Tuaono: Membership

11. The Board of the Commission will appoint the Chairperson of Te Roopū Māori
12. Te Roopū Māori consists of eight Māori health sector experts who are networked, known, respected and knowledgeable about issues and priorities for whānau, hāpu and Iwi Māori in regard to advancing Māori health and achieving health equity
    12.1. Up to two other members may be co-opted onto Te Roopū Māori from time to time
13. Members will have recognised range of skills and knowledge in health, in particular Māori health issues across a range of areas.
14. Members will be people who are acknowledged by their peers as having the ability to represent Māori issues to the Commission and to assist the Commission in its deliberations and commitment to addressing these issues
15. Members will come from a range of backgrounds (e.g. the private and public sector, DHBs or equivalent agencies, aged care, primary care, disability, social services etc) and will have knowledge of the health sector through engagement with central, regional and local agencies

16. One of the membership seats will be reserved specifically for a Māori consumer and/or whanau representation
17. One of the membership seats will be reserved for Mortality Review Committee respresentation
18. The Commission Chief Executive, in consultation with the Executive Leadership Team and the Chair of Te Roopū or other advisors as required, shall appoint members to Te Roopū Māori
19. Membership of Te Roopū Māori will be reviewed every four years and membership on Te Roopū will not exceed two election cycles (unless agreed by the Board).

Tuawhitu: Fees and allowances

20. Members of Te Roopū Māori who are employed by a New Zealand public sector organisation including public service departments, state-owned enterprises, or crown entities are not entitled to claim fees for meeting attendance
21. Attendance fees may be claimed by members not included in clause 20 above.
22. The level of attendance fees will be set in accordance with the State Services Commission's framework for fees for statutory bodies (2006) and the Cabinet Office circular CO (09)
23. In addition to the daily rate for meetings, there will be a half day's preparation fee. The Chair will be entitled to an allowance of two extra days per month to cover additional work undertaken.
24. Where Board papers are reviewed out of cycle (and up to five times a year according to the Board meeting cycle) Te Roopū Māori members will be entitled to an additional half days preparation fee per (Board) meeting
25. The attendance fee for meetings and teleconferences is calculated on a pro rata basis (the hourly rate will be calculated at one seventh of the daily rate)
26. Actual and reasonable travel and accommodation expenses of all members of Te Roopū Māori will be met by the Commission.

Tuawaru: Quorum

27. If the total number of members of Te Roopū Māori is an even number, half that number; but if the total number of members is an odd number, a majority of the members.
28. Te Roopū Māori will meet up to five times a year and as required on specific issues.

Iwa tekau: Reporting

29. The Chair of Te Roopū Māori will attend the open part of all Board meetings, as their availability allows.
30. Te Roopū Māori will regularly, through the Te Roopū Chair, report to the Board on its activities during the year.
31. Te Roopū Māori may, at any time, report to the Board or Chief Executive on any other matter it deems of sufficient importance. This may be written or via the Te Roopū Chair through attendance at Board meetings.

Iwa tekau mā tahi: Secretariat Support

32. The Commission will provide secretariat support to Te Roopū Māori through Ahuahu Kaunuku (the Māori Health Outcomes Team)
33. This will include ensuring that the agenda and supporting papers are circulated, minutes are recorded, and that additional information and/or context is available to enable meaningful review, input and discussion
34. Should additional support be required to carry out its functions, this will be agreed with the Chief Executive

Iwa tekau mā rua: Conflicts of interest

35. The Commission will maintain a Conflicts of Interest register to be reviewed before each meeting. Te Roopū members will keepthe register updated and declare any conflicts of interest that would preclude them from any discussions to held at the meetings or any changes that would preclude them being members of Te Roopū Māori
    35.1. Members must declare any conflicts of interest at the start of each meeting or before discussion of the relevant agenda item or topic. Details of any conflicts of interest should be appropriately recorded in the minutes.
    35.2. Where any member is deemed to have a real, or perceived, conflict of interest at a meeting, it may be appropriate that they are excused from deliberations on the issue where the conflict of interest exists.

Iwa tekau mā toru: Review

36. At least once every three years, the Board and the Chair of Te Roopū Māori will jointly review the Terms of Reference
37. The next review will be in October 2024.

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

STRATEGIC INFECTION PREVENTION AND CONTROL ADVISORY GROUP

TERMS OF REFERENCE – September 2019

Background

The Health Quality and Safety Commission (the Commission) has led a national Infection Prevention and Control (IPC) programme in partnership with others since 2011. This includes:

- an initial focus on Central Line Associated Bacteraemia (CLAB), resulting in the incidence of CLAB in intensive care units reducing by 81 percent to 2014
- the NZ Surgical Site Infection Improvement (SSII) programme being established, resulting to date in a reduced infection rate for both orthopaedic and cardiac surgery
- an ongoing focus and approach for working with hospital health care staff to make significant strides in hand hygiene practice.

In November 2018 DHB Chief Executives agreed to provide an ongoing and increased funding contribution for an effective and sustainable whole-of-sector approach to HAI, to fund:

- leadership and expert advice
- shared data and information systems
- team capability
- nationally funded quality improvement support.

The ongoing and increased funding from DHBs from July 2019 has expanded the capacity of the HAI programme for an effective and sustainable whole-of-sector approach in New Zealand.

Key functions

The Strategic IPC Advisory Group (SIPCAG) has been established by the Commission to:

- agree and advise the Commission on strategic priorities for infection prevention and control improvements to promote and protect the health of people and communities
- provide clinical leadership in healthcare associated infections (HAI) to the sector and be champions for IPC safety activities
- provide active leadership in building collaboration and co-operation between the entities represented, and to facilitate an integrated approach to local, regional, and national infection prevention and control quality improvement programmes
- work with the sector to support, encourage and develop innovation and identify new evidence and directions for national infection prevention initiatives
- provide oversight of the work programme.

Accountability

SIPCAG is accountable to the Commission. The Commission is accountable to the Crown. SIPCAG's approach is to:

- provide evidence-based advice and strategic direction for the improvement approaches and implementation of projects aimed at reducing harm to consumers from HAI
- monitor the impact of the individual IPC projects through both process and outcome measurement.

Annual review and power to co-opt

There is a need for flexibility of the group to respond to changing priorities and work over time:

- there will be an annual review of membership to make sure membership relates to the national priorities as they evolve, and that greater consideration is given to short term co-option of members where specific expertise is needed
- the term of membership is three years with renewal for another three years and the terms of members will be staggered to ensure continuity of membership
- any member may at any time resign as a member by advising the Chair in writing.

Reporting requirements

SIPCAG is required to keep a record of all meetings, outling the matters discussed, noting all decisions taken, action points agreed, and recommendations made.

Meetings

The timing and frequency of meetings will aim to ensure the most efficient use of members' time. The timing and frequency of meetings can be changed by agreement among the Advisory Group members. All meetings of the Advisory Group will:

- be convened by the Chair or delegated person.
- take place quarterly, unless determined otherwise by the Commission's HAI team and Chair
- be a full day between 9.30am to 3:30pm, and will usually be held at an agreed Wellington venue. Where necessary, members will be able to join the meeting via video/teleconferencing facilities.
- have a quorum of fifty percent of the members, plus one, in addition to the Chair. If a member is unable to attend, a fully briefed alternate representative may participate subject to prior agreement of the chair at least five days prior to a meeting
- record attendance / apologies in the minutes, the alternate representative will be required to disclose their interests at the meeting
- determine agreement to items at a meeting by consensus. Where a consensus cannot be reached, a majority vote will apply. Any individual can absent him or herself from the group decision making process, subject to a residual quorum remaining after this process.

Duties and responsibilities of members

SIPCAG has an obligation to conduct its activities in an open and ethical manner. Members are expected to:

- have a commitment to work for the greater good of the health and disability sector with a strategic national focus
- attend meetings and undertake activities as independent persons responsible to the group
- make every effort to attend all meetings and become familiar with IPC issues, challenges and emerging opportunities
- identify when they have a conflict of interest on a subject that will prevent them from reaching an impartial decision or undertaking an activity consistent with the group functions (they must declare that conflict of interest prior to a meeting and withdraw themselves from

the discussion and decision-making processes). Members may question other members if they consider that there is a potential conflict of interest
- convey, where feasible the consensus view of the organisation if such a view exists
- reporting back to their organisation, or stakeholder group whose perspective they represent, as appropriate.

Attendance fees

- Members of SIPCAG who are staff of New Zealand public sector organisations including public service departments, state-owned enterprises, or crown entities, are not permitted to claim costs to attend SIPCAG meetings.
- Claims for costs in attending meetings may be claimed by a member not included in the above groupings. A process for agreeing fair and reasonable costs for meeting attendance shall be agreed by the Chair.

The Secretariat

SIPCAG will have a secretariat provided by the Commission:

- the responsibilities of the secretariat include preparing and distributing the agenda and associated papers at least five working days prior to meetings; recording and circulating of minutes for approval; managing the organisational arrangements for meetings, including the provision of rooms and audio-visual support
- members have two weeks following receipt of the draft minutes to comment on the factual accuracy of the draft minutes
- once the two-week deadline for correcting factual accuracy of the draft minutes has passed, the chair will approve the draft minutes for publication on the Commission's website.

Membership

The current membership of SIPCAG includes IPC, microbiology and infectious disease clinical expertise, central agencies, private hosptial sector, DHB management, and consumer representatives. Some members represent more than one area of expertise.The Commission Clinical Leads and the National Monitor host are SIPCAG members. The group is attended and supported by the Commission team.

The new composition of the group is:

	Membership of Strategic Infection and Prevention Control Advisory Group (SIPCAG)	**Position/s**
DHB Management	Chair - a DHB CE	1
	DHB Executive member – Director of Nursing and/or Infection Control Chair	1
	DHB Quality and Risk Managers	2
Clinical	Infection Prevention and Control Nurses College – IPC nurses	2
	Infectious Disease physician	1
	Clinical microbiologist	1

	Commission Clinical leads	2
Private Surgical Hospitals	Private Surgical Hospital Association representative	1
Professional college	Royal Australian College of Surgeons*.	1
Central Agencies	Senior managers with decision-making authority and clinical knowledge to be represented – Health, ACC	2
Consumer	Strong consumer perspective, to balance clinical and management perspectives, and ensure that the voice of patients, family and whanau is strong.	2
	TOTAL	**16**
Health Quality and Safety Commission	Secretariat Senior Portfolio Manager, Chief, Quality and Safety, IPC Specialist, Project Manager, Quality Improvement Advisor, Programme Coordinator, Analyst (as required)	5

* Specialist orthopaedic and cardiac surgeon input is currently provided to the programme via the Expert Faculty Groups

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

Terms of Reference

Integrated Advisory Group (Primary and Community Care)

1. Context

The Health Quality and Safety Commission has a number of internal groups through which it's programme of work is delivered. These groups include Quality Systems (QS), Health Quality Intelligence (HQI), Ahuahu Kaunuku and Partners in Care who work closely together and have activities spanning the whole health sector. The integrated advisory group (IAG) has been established by the Commission to support and provide advice on the primary / community care activities of the Commission's work. This group will have a remit to consider intelligence (including variation), improvement, innovation and integration within its terms of reference. The group will be supported by the internal operational teams within the QS and HQI groups and others as required.

2. Purpose

The purpose of the IAG (Primary and Community Care) is to:

a. provide **sectoral leadership** to support quality improvement activities and the development of measures (including Atlas topic selections) to inform the Commission's work
b. provide **strategic insight** to ensure the Commission's approach is aligned with other primary and community care sector priorities
c. proactively support effective **relationships** between the primary / community care sector and the Commission
d. provide **expert advice** and make evidence based recommendations to the Commission on strategies to improve primary / community healthcare services
e. **share information** that supports a national approach to primary / community care quality and safety improvements
f. foster an **integrated approach** to improving the quality and safety of health and disability services with other Commission programmes
g. **influence** the appropriate use of intelligence (e.g. Quality Alerts) and data to identify priorities for action with a focus on equity.
h. champion **capability building** within primary care and the community to sustain quality improvement, and the use of data for analysis and improvement
i. identify actions that **give effect to the Commission's priorities**: improving consumer and whānau experience, embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake, achieving health equity, and strengthening systems for quality services.
j. improve health outcomes for Māori.

3. Governance

The Directors of the QS and HQI groups have the key accountability for the IAG and there will be significant representation from the Executive Leadership Team at meetings. As a result, advice and recommendations from IAG will be to the most senior members of the Commissions operational team.

4. Membership

The IAG will comprise up to 18 members with significant representation from Māori. The Commission's work is underpinned by a Te Tiriti o Waitangi partnership and membership will

reflect that relationship. The work is also reflected in the Commission's strategic priorities including equity.

The Chair will be appointed by the Commission. The membership will comprise respected leaders and influencers across the sector who are actively engaged in the community or group/s they seek to represent. They will be well connected and respected by their peers and other sector leaders. Members will be selected to ensure broad geographic representation and professional skill sets and may include:

i. Clinicians from primary / community / secondary care settings, across professional disciplines.
ii. The Ministry of Health, including representation for the primary care teams and aligned quality improvement work programme.
iii. Primary health organisations, district health boards and public health system funders.
iv. Professional bodies such as Pharmac and the Royal New Zealand College of General Practitioners (RNZCGP)
v. Two (minimum) consumer representatives who can demonstrate their links to consumer groups and can engage with other consumers and their networks as needed.
vi. At least two members with a Māori perspective.
vii. At least two members with a Pacific perspective.
viii. At least one member with a public health perspective.

5. Responsibilities

The IAG has an obligation to conduct its activities in an open and ethical manner. Members are expected to work in partnership with the Commission, and to:

a. work strategically contributing to a sustainable system of improvement
b. work co-operatively, respecting the views of others with a focus on improving health outcomes and overall system performance as well as improving the experience for health care for consumers, whānau and family
c. act, as a collective group, in the best interests of quality and safety initiatives locally, regionally and nationally
d. be a point of liaison with the relevant regional groups and bodies across the primary / community care sector
e. make every effort to attend all meetings and devote sufficient time to become familiar with the priorities of the group and the wider environment within which it operates
f. identify and declare any conflicts of interests and proactively manage any conflicts
g. refer requests for media comments to the Chair of the IAG or the Commission's Chief Executive.

6. Meetings and decision-making

Recommendations to the Commission will be made at the IAG meetings and ratified through the Chair. Decisions will be made by consensus.

a. The IAG will meet up to four times each year, involving a mix of face to face and virtual.
b. Additional meetings outside of this will be organised, if required.
c. A quorum will be a minimum of 9 members plus the Chair.
d. All members will be given the opportunity to speak and contribute to decisions or recommendations.

7. Secretariat

The IAG will have a secretariat provided by the Commission. The responsibilities of the secretariat will include:

a. preparing and distributing the agenda and associated papers at least five days prior to meetings
b. recording and circulating the minutes no later than a fortnight following the meeting date
c. managing the organisational arrangements for meetings, including flight bookings, the provision of rooms and audio-visual equipment
d. managing the membership appointment process.

8. Reporting and Communication

Key messages for public dissemination from the IAG will be communicated via the Commission's communication networks and mechanisms such as the website and e-digest newsletter. Other dissemination channels will also be developed relevant to the primary / community care sector.

9. Terms and Conditions of Appointment

Members will be invited to join the IAG or be identified through a nomination process.

Terms of appointment will be for a period of up to three years with the ability to re-appoint for a further term. As members come up for renewal each will be considered on their merits, and informed by the needs of the programme, knowledge continuity and expertise required on the IAG.

Any member may at any time resign by advising the Chair in writing.

If any member is absent, without the agreement of the Chair, for 3 or more consecutive meetings then that member may be deemed to have resigned from the IAG.

10. Fees

Members who are employed by a New Zealand Public Sector Organisation including public service departments, state-owned enterprises, or crown entities are not entitled to claim fees for meeting attendance. Attendance fees may be claimed by members not included in the above clause.

The level of attendance fees will be set in accordance with the State Services Commission guidelines ("Fees and allowances for statutory and other bodies") and the Cabinet Office circular CO (12) 6. In addition to the daily rate for meetings, there will be a half day's preparation fee. Actual and reasonable travel and accommodation expenses will be met by the Commission for meeting attendance, as appropriate.

11. Review

The terms of reference for the group will be reviewed and updated as required, but no later than two yearly.

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

Terms of Reference - Leadership Group (LG)

Quality Improvement Programme - Aged Residential Care (ARC)

[Approved 18 May 2018]

1. Purpose

The purpose of the Aged Residential Care (ARC) quality improvement programme Leadership Group (LG) is to provide sector leadership and support to the Health Quality & Safety Commission (the Commission) to lead the national ARC quality improvement programme (the programme).

This LG will inform all aspects of the programme and contribute to developing strategies to improve aged-residential care services to positively impacting on residents' experience of care.

The LG will actively contribute to achieving the Commissions strategic intent, namely:

New Zealand will have a sustainable, world-class, patient-centered health care and disability support system, which will attract and retain its workforce through its commitment to continually improve health quality, and deliver equitable and sustainable care.

The key purpose of this LG is to:

a. **provide advice** and make recommendations to the Commission that are informed by evidence and international, national and local knowledge, and focused on strategies to improve aged-residential care services and improve the resident experience of care
b. provide **sector leadership** in the development and implementation of the ARC quality improvement programme and achieving improved outcomes, in collaboration with other groups
c. proactively support effective **relationships** between the ARC sector and the Commission
d. **share** information that supports a national approach to ARC quality and safety improvements
e. **foster** an integrated approach to improving the quality and safety of health and disability services with other Commission programmes
f. provide **strategic insight** to ensure the Commission's approach is aligned with other ARC sector priorities

The LG will provide guidance on the ARC quality improvement work programme consistent with evidence.

The LG priorities are to:

a. ensure the programme gives effect to the Commissions priorities: increasing consumer and whānau experience, improving health equity, reducing harm and mortality, and reducing unwarranted variation
b. support sector engagement and raise awareness of the programme
c. inform the development of the interventions within the programme
d. promote the work of the programme and influence uptake across the ARC sector.

2. Governance

The LG provides sector leadership to the Commission through the ARC quality improvement programme team, which is part of the Commission's Improvement Hub, and the Learning and Improvement Group that supports the activity of the Hub.

3. Membership

The Chair will be appointed by the Commission.

The membership will comprise respected leaders and influencers across the sector, and actively engaged in the community or group/s they seek to represent. They will be well connected and respected by their peers and other sector leaders. They will have a close alignment with service provision across the ARC sector, and bring this perspective to the LG to ensure the group has a diverse range of views connected into the sector's priorities for action.

Membership will include, but is not limited to, representatives of:

a. consumers who can demonstrate their links to other community / consumer networks with experience (directly or indirectly) of ARC services, and representing cultural diversity
b. Māori as tangata whenua
c. clinicians representative of the multi-disciplinary teams forming the "care team" for ARC service users
d. people with influence, expertise and experience in aged-residential care (including but not limited to knowledge of quality improvement, and those with academic backgrounds)
e. professional colleges / bodies
f. district health boards
g. agency / stakeholder representative
h. non-government organisations

There is no set number of members. Given the nature of the leadership group, and the complexities of the ARC sector, additional members may be co-opted to provide specialist advice or support as and when required, aligned with programme priorities. The LG membership and structure may be reviewed to reflect the developing nature of the programme.

The programme is committed to undertaking a variety of engagements across the sector to support a sustainable approach to continuous quality improvement. This will see us creating connections with diverse groups of aged residential care service providers (large and small).

Due to manageability of size, we cannot have all provider voices directly represented on this LG so our approach will be to ensure all providers have opportunities to inform and engage in the programme through the range of networks being established.

4. Responsibilities

The LG has an obligation to conduct its activities in an open and ethical manner. Members are expected to work in partnership with the Commission, and to:

a. work strategically contributing to a sustainable system of improvement
b. work collaboratively, respecting the views of others with a focus on improving health outcomes and overall system performance as well as improving the experience for health care consumers, whānau and family

c. act, as a collective group, in the best interests of quality and safety initiatives locally, regionally and nationally
d. be a point of liaison with the relevant regional groups and bodies across the ARC sector
e. make every effort to attend all meetings and devote sufficient time to become familiar with the priorities of the group and the wider environment within which it operates
f. identify and declare any conflicts of interests and proactively manage any conflicts
g. refer requests for media comments to the Chair of the LG or the Commission's Chief Executive.

5. Meetings and decision-making

Recommendations to the Commission will be made at the LG meetings and ratified through the Chair. Decisions will be made by consensus.

a. The LG will meet quarterly by tele/videoconference or face to face.
b. Additional meetings outside of the quarterly cycle will be organised, if required.
c. A quorum will be a minimum of five members, plus the Chair.
d. All members will contribute to substantive decisions or recommendations.

6. Secretariat

The LG will have a secretariat provided by the Commission. The responsibilities of the secretariat include:

a. preparing and distributing the agenda and associated papers at least five days prior to meetings
b. recording and circulating the minutes no later than a fortnight following the meeting date
c. managing the organisational arrangements for meetings, including flight bookings, the provision of rooms and audio-visual equipment

7. Reporting and Communication

Key messages for public dissemination from the LG will be communicated via the Commission's communication networks and mechanisms such as the website and e-digest newsletter. Other dissemination channels will also be developed relevant to the ARC sector.

A communication and stakeholder engagement plan for the programme will be developed and implemented.

8. Terms and Conditions of Appointment

Members will either be invited to join the LG or appointed following an "Expressions of Interest" process. Nominations may also be sought from organisations and professional bodies across the New Zealand health sector. Where expressions of interst are sought, applications will be reviewed by a selection panel with recommendations for appointment made to the Commission, and endorsed by the Chair of the LG and / or Clinical Lead for the programme.

Terms of appointment will be for two years with the ability to re-appoint for a further term. As members come up for renewal each will be considered on their merits, and informed by the needs of the programme, knowledge continuity and expertise required on the LG. Any member may at any time resign by advising the Chair in writing.

9. Fees

Members who are staff of a New Zealand public sector organisation including public service departments, state-owned enterprises or Crown entities are not permitted to claim a fee to attend the LG meetings. The Commission has a fees framework that applies to members who are not included in the above groupings.

The terms of reference for the group will be reviewed and updated as required, likely to be at the six month interval to align with the LG approval of the Programme Charter, Programme Plan and emerging vision for the future.

Beyond that date review will be on a two yearly cycle.

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

Adverse Events Policy Review Working Rōpū terms of reference

The Adverse Events Policy Review Working Rōpū focuses on a review of the current Health Quality & Safety Commission (the Commission) 2017 Adverse Events Policy. The Commission has committed to reviewing the policy at least every five years and is working towards releasing an updated version of the policy in 2022.

The rōpū will contribute to achieving the Health Quality & Safety Commission's vision, 'Hauora kounga mō te katoa | Quality health for all'.[1]

The rōpū collectively recognises the Commission's enduring priorities based on Te Tiriti o Waitangi and will embed these within the agreed mahi:

- kāwanatanga – partnering and shared power decision making
- tino rangatiratanga – recognising Māori authority
- ōritetanga – equity
- wairuatanga – upholding values, belief systems and worldviews.

The Commission is committed to Te Tiriti o Waitangi and demonstrates this through partnership and the facilitation model of this rōpū, which will apply the 'three-house model' to enable and build positive relationships between all. The 'three-house model is inclusive of both te ao Māori and Western approaches to governance'.[2] This enables respectful discourse to occur from both the Whare Iwi and Whare Tauiwi through to the Whare te Tiriti (collective systems safety whare).

Purpose

This rōpū will lead the review of the National Adverse Events Reporting Policy. The revised version needs to be based on the articles of the Te Tiriti o Waitangi and supporting material needs to be grounded in te ao Māori when required.

The review will be informed by a review of the literature from 2016 (the previous literature reveiw date) and will incorporate:

- a Safety II paradigm
- addressing equity
- consumer-initiated adverse events reporting

[1] Health Quality & Safety Commission. 2020. *Tauākī Koronga | Statement of Intent 2020–24.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/publications-and-resources/publication/4048.

[2] Webster K, Cheyne C. 2017. Creating Treaty-based local governance in New Zealand: Māori and Pākehā views. *Kōtuitui: New Zealand Journal of Social Sciences Online* 12(2): 146–64. DOI: 10.1080/1177083X.2017.1345766.

- reflect the Commission's promotion of resilent healthcare, including restorative practice and a safety II approach.

The rōpū will engage with key stakeholders across the sector focusing on transparency, a combined understanding and collective responsibility to improve systems safety.

The function of this rōpū is driven by the Commission's mission statement to:

- whakauru – involve
- whakamōhio – inform
- whakaawe – influence
- whakapai ake – improve.

Throughout this review process we will:

- whakauru – involve key stakeholders across the sector
- whakamōhio – inform the systems safety rōpū of progress and produce final draft policy
- whakaawe – influence rōpū members on updated evidence regarding adverse event reporting and review processes
- whakapai ake – improve the health & disability approach to the opportunities to improve through understanding work-as-done

Membership

The Adverse Events Working Policy Review rōpū will comprise a minimum of service providers where adverse event report is required by Ngā Paerewa Health and Disability Services Standard 2021[3].

There are two chairs, one of which must come from the Whare Iwi. The position of co-chair is appointed by the Commission in discussion with the rōpū. The rōpū is supported by members of the Commission's quality systems group. This support includes, but is not limited to, arranging meetings and recording minutes. Ex-officio status extends to the following Commission staff:

- Ahuahu Kaunuku
- senior manager system safety and capability
- clinical lead system safety
- clinical lead adverse events
- specialist system safety
- safety systems advisor
- Partners in Care

The members are representatives of their respective organisations/sectors, and will be a conduit for information to and from their respective organisations/sectors. Each organisation is to ensure they have two members one of whom is Māori.

- Abortion services
- Aged residential care services
- Ambulance services

[3] https://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standards/standards-review-2019-2021

- ARC Leadership Group
- Assisted reproductive technological services
- Consumers x2
- Home and community support services
- Hospice services
- National Quality & Risk Leads
- Pacific People
- PHO Quality Improvement Network
- Private overnight hospital inpatient services
- Residential disability support services
- Residential mental health and addiction services
- Te Puni Kōkiri

Responsibilities

The rōpū has an obligation to conduct its activities in an open and ethical manner. Members are expected to:

- work in partnership, embedding the articles of Te Tiriti o Waitangi
- work collaboratively, share work activities and contribute to collective sustainable system improvement
- work cooperatively, respecting the views of others, with a focus on improving health outcomes and overall system performance as well as improving the experience for consumers, whānau and health care providers
- make every effort to attend all hui and devote sufficient time to become familiar with the kaupapa of the rōpū and the wider system within which it operates
- identify and declare any conflicts of interest and proactively manage any conflicts. Any conflicts of interest can be raised in meetings and will be recorded in the minutes
- refer requests for media comments to a co-chair or the Commission's director of communications.

Meetings

- The rōpū will meet via zoom or via kanohi ki te kanohi if required
- A quorum will be a minimum of one co-chair and 10 external members, in addition to Commission staff.
- The rōpū will focus on enabling a transparent, combined understanding and responsibility for adverse event reporting within the wider health sector.
- Actions will be agreed through consensus.
- Where an urgent matter arises out of meeting times, an 'out-of-hui' decision may be made via Zoom or other means.

Communication

Key messages from the rōpū will be communicated via the Commission's communication networks and mechanisms such as the website and e-digest. Members should represent the agreed view of the rōpū when communicating as a member of the rōpū.

Terms and conditions of appointment

The terms of appointment are until the end of June 2022, at which time the rōpū and its membership will be disbanded.

Any member may at any time resign by advising the co-chairs in writing.

Reporting

The rōpū will report to the Systems safety rōpū who provide governance for this mahi.

Fees

Members who are staff of a New Zealand public sector organisation, including public service departments, state-owned enterprises or Crown entities, are not permitted to claim a fee to attend the hui. The Commission has a fees framework that applies to members who are not included in the above groupings.

Systems safety rōpū terms of reference

The systems safety rōpū is a leadership collaborative with a strategic focus on facilitating systems safety across the health and disability sector. It incorporates an emphasis on a resilient health care | tiaki hauora pakari approach that includes systems thinking and human factors to strengthen safe provision and receipt of care'. The rōpū will contribute to achieving the Health Quality & Safety Commission's vision, 'Hauora kounga mō te katoa | Quality health for all'.[1]

The rōpū recognises the Commission's enduring priorities based on Te Tiriti o Waitangi and will embed these within the agreed mahi:

- kāwanatanga – partnering and shared decision making
- tino rangatiratanga – recognising Māori authority
- ōritetanga – equity
- wairuatanga – upholding values, belief systems and world views.

The Commission is committed to Te Tiriti o Waitangi and demonstrates this through partnership and the facilitation model of this rōpū, which will apply the 'three-house model' to enable and build positive relationships between all. The 'three-house model is inclusive of both te ao Māori and Western approaches to governance'.[2] This enables respectful discourse to occur from both Te Whare Iwi and Whare Tauiwi through to the Whare te Tiriti (collective systems safety whare).

Purpose

This rōpū will lead the establishment and embedding of systems safety and a resilient health care approach within Aotearoa New Zealand. The rōpū will engage with key stakeholders across the sector focusing on transparency, a combined understanding and collective responsibility to improve systems safety.

The function of this rōpū is driven by the Commission's mission statement to:

- whakauru – involve
- whakamōhio – inform
- whakaawe – influence
- whakapai ake – improve.

---

[1] Health Quality & Safety Commission. 2020. *Tauākī Koronga | Statement of Intent 2020–24.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/publications-and-resources/publication/4048.

[2] Webster K, Cheyne C. 2017. Creating Treaty-based local governance in New Zealand: Māori and Pākehā views. *Kōtuitui: New Zealand Journal of Social Sciences Online* 12(2): 146–64. DOI: 10.1080/1177083X.2017.1345766.

In the first 12 months we will:

- whakauru in how we collectively support the sector's understanding of human factors and restorative practice approaches
- whakamōhio through focused human factors and restorative practices capability building
- whakaawe the sector to consider a resilient health care approach
- whakapai ake quality care through the development of an Aotearoa systems safety action plan.

Membership

The systems safety rōpū will comprise a minimum of 13 members who are external to the Commission. There are two chairs, one of which must come from the Whare Iwi. The position of co-chair is appointed by the Commission in discussion with the rōpū. The rōpū is supported by members of the Commission's quality systems group. This support includes, but is not limited to, arranging meetings and recording minutes. Ex-officio status extends to the following Commission staff:

- medical director/executive lead quality systems
- director Ahuahu Kaunuku
- senior manager system safety and capability
- clinical lead patient safety
- clinical lead adverse events
- specialist patient safety
- specialist adverse events.

The membership will comprise experts in their respective fields. They are not official representatives of their respective organisations/sectors, however, they will be a conduit for information to and from their respective organisations/sectors. Membership will be drawn from, but not be limited to:

- Māori and Pacific consumers who have links to their communities
- Ministry of Health (Health New Zealand and Māori Health Authority as of July 2022)
- Health and Disability Commissioner or their delegate
- Chair National Quality Leaders Group
- Accident Compensation Corporation
- WorkSafe
- Centre for Restorative Justice – Victoria University of Wellington
- Mental Health and Wellbeing Commission
- TAS
- Chair General Managers Human Resources
- those with clinical expertise in systems safety thinking.

Responsibilities

The rōpū has an obligation to conduct its activities in an open and ethical manner. Members are expected to:

- work in partnership, embedding the articles of Te Tiriti o Waitangi
- work collaboratively, share work activities and contribute to collective sustainable system improvement
- work cooperatively, respecting the views of others, with a focus on improving health outcomes and overall system performance as well as improving the experience for consumers, whānau and health care providers
- make every effort to attend all hui and devote sufficient time to become familiar with the kaupapa of the rōpū and the wider system within which it operates
- identify and declare any conflicts of interest and proactively manage any conflicts. Any conflicts of interest can be raised in meetings and will be recorded in the minutes
- refer requests for media comments to a co-chair or the Commission's director of communications.

Meetings

- The rōpū will meet kanohi ki te kanohi quarterly or as otherwise agreed.
- A quorum will be a minimum of one co-chair and six external members, in addition to Commission staff.
- The rōpū will focus on enabling a transparent, combined understanding and responsibility for systems safety with the wider health sector.
- Actions will be agreed through consensus.
- Where an urgent matter arises out of meeting times, an 'out-of-hui' decision may be made via Zoom or other means.

Communication

Key messages from the rōpū will be communicated via the Commission's communication networks and mechanisms such as the website and e-digest. Members should represent the agreed view of the rōpū when communicating as a member of the rōpū.

Terms and conditions of appointment

The terms of appointment are until the end of June 2022, at which time the rōpū and its membership will be reviewed. Membership will change to reflect the changes from the New Zealand Health and Disability System Review after 2022.

Any member may at any time resign by advising the co-chairs in writing.

Fees

Members who are staff of a New Zealand public sector organisation, including public service departments, state-owned enterprises or Crown entities, are not permitted to claim a fee to attend the hui. The Commission has a fees framework that applies to members who are not included in the above groupings.

Child and Youth Mortality Review Committee Terms of Reference

May 2021

Background

1. The objectives of Health Quality & Safety Commission (the Commission) are to lead and coordinate work across the health and disability sector for the purposes of:

    a. monitoring and improving the quality and safety of health and disability support services; and

    b. helping providers across the health and disability sector to improve the quality and safety of health and disability support services.

2. Under the New Zealand Public Health and Disability Act 2000 (the Act), the Commission may appoint mortality review committees (MRC) to carry out any of the functions specified in section 59E(1) of the Act, notified by the Commission to the MRC.

MRC Functions and Scope

3. These terms of reference constitute notice under Section 59E(1) of the Act, that the Commission appoints an MRC to be known as the Child and Youth Mortality Review Committee (the Committee).

4. The functions of the Committee are to (the Functions):

    a. review and report to the Commission on specified classes of deaths of persons, or deaths of persons of specified classes, as set out in section 5 (the Scope);

    b. advise the Commission on ongoing quality assurance programmes to support continuous quality improvement in health and disability support services; and

    c. advise the Commission on any other matters related to mortality that the Commission specifies in a notice to the Committee.

5. The Committee's Scope is to consider child and youth mortality and other mortality and morbidity as directed by the Commission in writing, or as specified within the Committee's agreed Work Plan.

6. For the purpose of these Terms of Reference, child and youth mortality is all deaths of children and young people aged 28 days to 24 years.

7. The MRC is an independent advisor to the Commission. It will obtain information and undertake independent analysis, based on strategies and methodologies it designs, to inform and assist the Commission to reduce morbidity and mortality, within the Scope.

Approach to performing its Functions

8. In performing its Functions, the Committee will:

a. provide independent advice to the Commission with a view to reducing the numbers of deaths within the Scope;

b. give effect to the Commission's responsibilities under Te Tiriti o Waitangi and ensure its review methodology, reports and recommendations contribute to achieving equitable outcomes for Māori by:

   i. implementing *Te Pou, Māori responsive rubric and guidelines*[1]

   ii. considering advice from Ngā Pou Arawhenua and other Māori stakeholders.

c. consult and engage with an appropriate range of stakeholders (including relevant Māori, and consumer representatives) in relation to informing and carrying out its Functions; and

d. ensure its advice and recommendations comply with the laws of New Zealand.

Work Plan

9. In accordance with section 59E(2) of the Act, the Committee is required to develop a strategic plan and methodologies that:

   a. are designed to reduce morbidity and mortality; and

   b. are relevant to the Committee's Functions.

10. By March of each year, the Committee will submit to the Commission for its approval, a proposed programme of work for the following financial year that sets out the Committee's:

   a. strategic plan, methodologies and activities to undertake its activities in accordance with these terms of reference and achieve the Commission's expectations communicated to the Committee in Letters of Expectation;

   b. approach to delivering the Commission's reporting requirements;

   c. plan to disseminate (including publish) the Committee's recommendations; and

   d. budget for undertaking the programme of work.

11. If the Commission approves the proposed programme of work (the Work Plan), it will allocate a budget to it. The Committee must achieve the Work Plan within the assigned budget (the Committee's Budget).

12. In any case where the Budget is insufficient to achieve the Work Plan (e.g. due to unexpected higher costs), the Committee will discuss and agree with the Commission a variation to the Work Plan.

[1] https://www.hqsc.govt.nz/publications-and-resources/publication/3903/

Data collection, reports and other activities

13. The Commission will, in accordance with the Work Plan and from the Committee's Budget fund mortality data collection, analysis, and review activities relevant to the Scope, to inform the Committee and assist it to perform its Functions.

14. The Committee will oversee the activities described in section 13 to ensure its advice to the Commission is relevant, evidence-based and provided as quickly as practicable.

15. The Committee will provide advice to service providers in the health (including DHBs) and social sectors, on developing and enhancing systems to:

    a. collect data in relation to the Scope;

    b. monitor the number, categories and demographics of deaths relevant to the Scope, and to identify patterns and trends over time;

    c. support nationwide local review to:
        i. inform quality improvement initiatives, for system and practice improvements to reduce morbidity and mortality within local communities
        ii. provide data collection systems for national review; and

    d. ensure the security of Information.

16. The Committee will report its advice and recommendations to the Commission based on its independent review and analysis. The Commission will receive and consider such reports.

Working relationships and communications

17. The Committee will develop and maintain positive working relationships with:

    a. other MRCs and the Commission, to ensure coordination and integration of their respective functions, minimise duplication, and improve efficiency and sustainability;

    b. relevant government bodies;

    c. relevant stakeholder organisations; and

    d. the MRC Māori Caucus, Ngā Pou Arawhenua.

18. The Committee will share with other MRCs, information it obtains in the course of performing its functions, provided:

    a. the information to be shared is relevant to the functions of the receiving MRC(s); and

    b. sharing the information with the receiving MRC is in accordance with the provisions in Schedule 5 to the Act.

19. The Committee (and its members) will advise the Commission in writing before it makes any media statements, public comment or publication in accordance with the Commission's communications policies.

Composition of the Committee

20. The Committee will have a maximum of ten members.

21. Two of these members will be ex-officio (non-voting) members and supported by their respective organisations. One of these members will be from the Ministry of Social Development – Oranga Tamariki – Ministry for Children, and one will be from the Ministry of Health. The Chief Executives will nominate an appropriate member, who is then appointed by the Commission.

22. One member will have relevant, lived experience, whānau, consumer expertise and will provide a whānau, consumer, community perspective, and will be well networked to whānau, consumer, community groups.

23. The other members will together have knowledge and or expertise covering the following areas:

    a. mortality review systems

    b. issues affecting children and youth

    c. the impact mortalities within the Scope have on families and whānau

    d. epidemiology, research and health systems

    e. paediatrics

    f. Pacific health and wellbeing

    g. Māori health, Te Tiriti o Waitangi and wellbeing

    h. knowledge of the health of other ethnicities, and people with disabilities, and health inequity.

    i. knowledge of the impact of social and environmental determinants of health

    j. youth mental health and addictions programmes.

24. Members will be drawn from a range of disciplines and contexts including clinicians, health service providers, educators, consumer representatives such as child and youth advocacy groups, and people representing Māori and Pacific peoples' interests.

25. Members will be able to work strategically and have credibility in relevant communities.

Member's terms of appointment

26. Members of the Committee are appointed by the Commission for a term of up to three years. Members may be appointed for further terms, however, reappointment is not automatic, nor should it be expected.

27. The Commission may use a number of selection methods in order to bring specific knowledge and expertise to a Committee. This may include calling for nominations from expert groups to approaching appropriate people individually when required.

28. Any member of the Committee may at any time resign as a member by advising the Commission in writing.

29. The Commission may remove any member of the Committee at any time for inability to perform the functions of membership, conflict of interest, bankruptcy, neglect of duty, or misconduct, each proved to the Commission's satisfaction.

30. The Commission may from time to time alter or reconstitute the Committee, or discharge any member of the Committee or appoint new members to the Committee for the purpose of decreasing or increasing the membership, filling any vacancies or ensuring coverage of expertise as anticipated in sections 21 to 23.

31. Member's fees will be set with reference to the Cabinet Fees Framework[2] and specified in each member's letter of appointment.

32. Actual and reasonable expenses for activities required by the Committee of its members (e.g. travel, accommodation) will be met from the Committee's Budget provided the Secretariat has approved the expense prior to it being incurred.

Collaboration with other organisations

33. In order for the Committee to work collaboratively with other organisations, groups, or individuals that have an interest in, or will be affected by, its activities and advice, the Committee may invite representatives of stakeholder organisations (including from the Public Sector) to attend and speak at its meetings.

34. To avoid doubt, such representatives are not members of the Committee, have no voting rights and are not entitled to members' fees.

35. Attendance by such representatives at committee meetings, will be at the cost of their respective organisation.

Co-opting additional expertise

36. The Committee may co-opt additional people to the Committee or to working groups of the Committee, where it determines additional expertise is required.

37. The expense associated with additional co-opted resources must be met within the Committee's Budget.

38. Such co-opted persons are not members of the Committee, have no voting rights and are not entitled to members' fees.

Meetings and Procedures

39. The Committee will determine and regulate its own procedures in consultation with the Secretariat provided those procedures are within the Budget and not inconsistent with the Act. Such procedures will be recorded and maintained by the Secretariat, and cover matters including:

[2] Cabinet Fees Framework https://www.publicservice.govt.nz/our-work/fees/#:~:text=Guidance%20on%20fees%20paid%20to,Fees%20Framework%20(the%20Framework)

a. the timing and frequency of meetings;

b. attendance expectations of members;

c. the quorum of the Committee that must be present to conduct the Committee's business; and

d. how the Committee will make decisions and treatment of dissenting views.

40. The Chair is responsible for ensuring minutes are taken at each meeting and a record of decisions is maintained.

Chairs and Deputy Chair

41. The Commission will appoint up to two members of the Committee to be either Co-Chairs or Chair and Deputy Chair. A co-chair allowance is applicable where the Commission identifies the opportunity to reflect a suitable Māori/Crown partnership and there is Committee member interest in being appointed to the role.

42. One or both Chairs will:

a. preside at every meeting of the Committee

b. attend regular meetings of the MRC Chairs (Chairs' Meetings) to ensure cooperation and integration across MRCs wherever possible, and the best allocation of limited resources

c. meet with the Commission, on its request

d. attend other MRC meetings at the Commission's request.

43. The Deputy Chairperson (where one is appointed) may act as the Chair in situations where the Chairperson is not present or is otherwise unable to act.

Role and responsibilities of the Committee and its members

44. The Committee as a whole will:

a. ensure that the independent views of members are given due weight and consideration;

b. ensure fair and full participation of members;

c. regularly review its own performance; and

d. give effect to its responsibilities under Te Tiriti o Waitangi.

45. All Committee members (including the Chairs and Deputy Chair) will:

a. participate actively in Committee meetings and relevant events;

b. communicate and engage with other committee members constructively;

c. support the Committee's work;

d. prepare in advance for meetings and other duties;

e. demonstrate their commitment by attending all meetings (where relevant);

f. be informed about the Committee and its strategic environment;

g. commit to representing the interests of the Committee as a whole; and

h. be committed to the Committee's continual improvement by participating in self-assessment processes and professional development opportunities that support the Committee's work, including as made available or recommended by the Chair or the Commission.

46. Members must remain fully familiar with the duties and obligation of their position at all times and ensure they:

    a. comply with the Act;

    b. act with honesty and integrity;

    c. act in good faith and not at the expense of the Committee's interests;

    d. act with reasonable skill, diligence and care;

    e. not disclose information gained in their capacity as a member; and

    f. maintain their independence (see also 'Conflicts of Interest' below).

47. Members attend meetings and undertake Committee activities as independent persons responsible to the Committee as a whole. Members are not appointed as representatives of professional organisations and groups. The Committee should not, therefore, assume that a particular group's interests have been taken into account because a member is associated with a particular group.

Conflicts of Interest

48. Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. Proper observation of these principles will protect the Committee and its members and will ensure that it provides independent advice and retains the Commission's and public confidence.

49. Members are required to declare any relevant interests to the full Committee and the Commission. In accordance with *Conflicts of Interest Guide*, the Commission will, determine whether or not the interest represents a conflict, and if so, what action will be taken.

50. Members will declare any actual, potential or perceived conflicts of interest at the start of each meeting.

Confidentiality

51. In these terms of reference, 'Information' means any information

a. that is personal information within the meaning of section 2(1) of the Privacy Act 1993; and

b. that became known to any member or executive officer or agent of a mortality review committee only because of the committee's functions being carried out (for example, because it is contained in a document created, and made available to the member or executive officer or agent, only because of those functions being carried out), whether or not the carrying out of those functions is completed.

52. The maintenance of confidentiality of Information is crucial to the functioning of the Committee. Members must comply with the provisions of Schedule 5 to the Act regarding production, disclosure and recording of information.[3]

Secretariat

53. The Commission employs staff to assist the Committee and act as its secretariat (the Secretariat). The cost of the Secretariat to the Commission is funded by the Committee's Budget.

54. The Committee is expected to work constructively and cooperatively with the Secretariat, and vice-versa.

55. The Secretariat acts on the instruction of a Chair/ or both Chairs where relevant.

56. The Secretariat will support the Committee in the performance of its Functions, including by providing:

    a. expert subject matter knowledge and expertise, policy analysis and analytical support and guidance in relation to matters outside the scope of the Members collective expertise e.g. guidance on governmental and ministerial processes;

    b. budget management, contract management and service procurement to assist the Committee to achieve its Work Plan within the Committee's Budget;

    c. central communications systems support for correspondence and public relations purposes, including secure communication between Committee Members and 'agents'[4];

    d. liaison on behalf of the Committee within and across government and non-government organisations;

    e. administrative support to organise, minute and follow up on committee meetings and/ or working groups as set out in the Work Plan and within the Committee's Budget; and

    f. additional support for the Committee to carry out its Functions, as agreed with the Chair and within the Committee's Budget.

Performance measures

[3] Note, disclosure of information contrary to Schedule 5 of the Act is an offence.
[4] Appointed in accordance with Schedule 5 of the Act

57. The Committee will achieve the Commission's strategic priorities communicated to Chair/s, and effectively perform its Functions when it provides relevant and timely advice to the Commission based on data, analysis and consultation with appropriate groups and organisations.

58. The Committee must:

    a. agree in advance to a Work Plan with the Commission

    b. achieve its Work Plan

    c. stay within the Committee's Budget.

Review

59. The Commission may review these terms of reference at any time and at least three years from the date at which they are approved by it.

Family Violence Death Review Committee Terms of Reference

May 2021

Background

1. The objectives of Health Quality & Safety Commission (the Commission) are to lead and coordinate work across the health and disability sector for the purposes of:

    a. monitoring and improving the quality and safety of health and disability support services; and

    b. helping providers across the health and disability sector to improve the quality and safety of health and disability support services.

2. Under the New Zealand Public Health and Disability Act 2000 (the Act), the Commission may appoint mortality review committees (MRC) to carry out any of the functions specified in section 59E(1) of the Act, notified by the Commission to the MRC.

MRC Functions and Scope

3. These terms of reference constitute notice under Section 59E(1) of the Act, that the Commission appoints an MRC to be known as the Family Violence Death Review Committee (the Committee).

4. The functions of the Committee are to (the Functions):

    a. review and report to the Commission on specified classes of deaths of persons, or deaths of persons of specified classes, as set out in section 5 (the Scope);

    b. advise the Commission on ongoing quality assurance programmes to support continuous quality improvement in health and disability support services; and

    c. advise the Commission on any other matters related to mortality that the Commission specifies in a notice to the Committee.

5. The Committee's Scope is to consider family violence deaths and other mortality and morbidity as directed by the Commission in writing, or as specified within the Committee's agreed Work Plan.

6. For the purpose of these Terms of Reference, family violence is defined as: any behaviour that coerces, controls or harms, an (ex) intimate partner and/or family member(s) by the means of deprivation, negligent treatment, isolation, intimidation, threats, violence, and/or causes them to fear for their own, or another family member's safety or well-being. It can include physical, sexual, psychological, emotional, and economic abuse, as well as neglect and exploitation. It includes children's exposure to these forms of abuse and the effects of abusive behaviour. It is understood as a pattern of abusive behaviour and can also span multiple relationships and generations.

7. For the purposes of these Terms of Reference a family violence death is defined as: the unnatural death of a person (adult or child) where the suspected offender(s) is a family or extended family member, caregiver, intimate partner, previous partner of the victim, or previous partner of the victim's current partner, and where the death was an episode of family violence and/or there is an identifiable history of family violence.

8. The following categories of family violence-related deaths are excluded from this definition:
    a. non-family member bystanders or interveners
    b. suicides
    c. suicide-assisted deaths
    d. deaths from chronic illness associated with family violence.

9. The MRC is an independent advisor to the Commission. It will obtain information and undertake independent analysis, based on strategies and methodologies it designs, to inform and assist the Commission to reduce morbidity and mortality, within the Scope.

Approach to performing its Functions

10. In performing its Functions, the Committee will:

    a. provide independent advice to the Commission with a view to reducing the numbers of deaths within the Scope;

    b. give effect to the Commission's responsibilities under Te Tiriti o Waitangi and ensure its review methodology, reports and recommendations contribute to achieving equitable outcomes for Māori by:

        i. implementing *Te Pou, Māori responsive rubric and guidelines*[1]

        ii. considering advice from Ngā Pou Arawhenua and other Māori stakeholders.

    c. consult and engage with an appropriate range of stakeholders (including relevant Māori, and consumer representatives) in relation to informing and carrying out its Functions; and

    d. ensure its advice and recommendations comply with the laws of New Zealand.

Work Plan

11. In accordance with section 59E(2) of the Act, the Committee is required to develop a strategic plan and methodologies that:

    a. are designed to reduce morbidity and mortality; and

    b. are relevant to the Committee's Functions.

12. By March of each year, the Committee will submit to the Commission for its approval, a proposed programme of work for the following financial year that sets out the Committee's:

[1] https://www.hqsc.govt.nz/publications-and-resources/publication/3903/

a. strategic plan, methodologies and activities to undertake its activities in accordance with these terms of reference and achieve the Commission's expectations communicated to the Committee in Letters of Expectation;

b. approach to delivering the Commission's reporting requirements;

c. plan to disseminate (including publish) the Committee's recommendations; and

d. budget for undertaking the programme of work.

13. If the Commission approves the proposed programme of work (the Work Plan), it will allocate a budget to it. The Committee must achieve the Work Plan within the assigned budget (the Committee's Budget).

14. In any case where the Budget is insufficient to achieve the Work Plan (e.g. due to unexpected higher costs), the Committee will discuss and agree with the Commission a variation to the Work Plan.

Data collection, reports and other activities

15. The Commission will, in accordance with the Work Plan and from the Committee's Budget fund mortality data collection, analysis, and review activities relevant to the Scope, to inform the Committee and assist it to perform its Functions.

16. The Committee will oversee the activities described in section 15 to ensure its advice to the Commission is relevant, evidence-based and provided as quickly as practicable.

17. The Committee will provide advice to service providers in the health (including DHBs) and social sectors, on developing and enhancing systems to:

a. collect data in relation to the Scope;

b. monitor the number, categories and demographics of deaths relevant to the Scope, and to identify patterns and trends over time;

c. ensure the security of Information.

18. The Committee will report its advice and recommendations to the Commission based on its independent review and analysis. The Commission will receive and consider such reports.

Working relationships and communications

19. The Committee will develop and maintain positive working relationships with:

a. other MRCs and the Commission, to ensure coordination and integration of their respective functions, minimise duplication, and improve efficiency and sustainability;

b. relevant government bodies;

c. relevant stakeholder organisations; and

d. the MRC Māori Caucus, Ngā Pou Arawhenua.

20. The Committee will share with other MRCs, information it obtains in the course of performing its functions, provided:

    a. the information to be shared is relevant to the functions of the receiving MRC(s); and

    b. sharing the information with the receiving MRC is in accordance with the provisions in Schedule 5 to the Act.

21. The Committee (and its members) will advise the Commission in writing before it makes any media statements, public comment or publication in accordance with the Commission's communications policies.

Composition of the Committee

22. The Committee will have a maximum of eight members.

23. One member will have relevant, lived experience, whānau, consumer expertise and will provide a whānau, consumer, community perspective, and will be well networked to whānau, consumer, community groups.

24. The other eight members will demonstrate critical thinking skills, have knowledge of health and social inequities and have expertise that includes the following:

    a. mortality review systems

    b. legal (criminal and family), medical, indigenous, social science and/or health research and practice

    c. in the field of intimate partner violence

    d. in the field of child abuse and protection issues

    e. knowledge of, or experience in, service provision or operational policy in the social sector, including family violence services

    f. Māori members with knowledge of family violence issues, or experience in working with Māori whānau affected by family violence

    g. members of other ethnic groups, or people with disabilities, with knowledge of family violence issues, or experience in working with families affected by family violence.

25. Members will be able to work strategically and have credibility in relevant communities.

Member's terms of appointment

26. Members of the Committee are appointed by the Commission for a term of up to three years. Members may be appointed for further terms, however, reappointment is not automatic, nor should it be expected.

27. The Commission may use a number of selection methods in order to bring specific knowledge and expertise to a Committee. This may include calling for nominations from expert groups to approaching appropriate people individually when required.

28. Any member of the Committee may at any time resign as a member by advising the Commission in writing.

29. The Commission may remove any member of the Committee at any time for inability to perform the functions of membership, conflict of interest, bankruptcy, neglect of duty, or misconduct, each proved to the Commission's satisfaction.

30. The Commission may from time to time alter or reconstitute the Committee, or discharge any member of the Committee or appoint new members to the Committee for the purpose of decreasing or increasing the membership, filling any vacancies or ensuring coverage of expertise as anticipated in sections 23 and 24.

31. Member's fees will be set with reference to the Cabinet Fees Framework[2] and specified in each member's letter of appointment.

32. Actual and reasonable expenses for activities required by the Committee of its members (e.g. travel, accommodation) will be met from the Committee's Budget provided the Secretariat has approved the expense prior to it being incurred.

Collaboration with other organisations

33. In order for the Committee to work collaboratively with other organisations, groups, or individuals that have an interest in, or will be affected by, its activities and advice, the Committee may invite representatives of stakeholder organisations (including from the Public Sector) to attend and speak at its meetings.

34. To avoid doubt, such representatives are not members of the Committee, have no voting rights and are not entitled to members' fees.

35. Attendance by such representatives at committee meetings, will be at the cost of their respective organisation.

Co-opting additional expertise

36. The Committee may co-opt additional people to the Committee or to working groups of the Committee, where it determines additional expertise is required.

37. The expense associated with additional co-opted resources must be met within the Committee's Budget.

38. Such co-opted persons are not members of the Committee, have no voting rights and are not entitled to members' fees.

Meetings and Procedures

39. The Committee will determine and regulate its own procedures in consultation with the Secretariat provided those procedures are within the Budget and not inconsistent with the Act. Such procedures will be recorded and maintained by the Secretariat, and cover matters including:

---

[2] Cabinet Fees Framework https://www.publicservice.govt.nz/our-work/fees/#:~:text=Guidance%20on%20fees%20paid%20to,Fees%20Framework%20(the%20Framework)

a. the timing and frequency of meetings;

b. attendance expectations of members;

c. the quorum of the Committee that must be present to conduct the Committee's business; and

d. how the Committee will make decisions and treatment of dissenting views.

40. The Chair is responsible for ensuring minutes are taken at each meeting and a record of decisions is maintained.

Chairs and Deputy Chair

41. The Commission will appoint up to two members of the Committee to be either Co-Chairs or Chair and Deputy Chair. A co-chair allowance is applicable where the Commission identifies the opportunity to reflect a suitable Māori/Crown partnership and there is Committee member interest in being appointed to the role.

42. One or both Chairs will:

a. preside at every meeting of the Committee

b. attend regular meetings of the MRC Chairs (Chairs' Meetings) to ensure cooperation and integration across MRCs wherever possible, and the best allocation of limited resources

c. meet with the Commission, on its request

d. attend other MRC meetings at the Commission's request.

43. The Deputy Chairperson (where one is appointed) may act as the Chair in situations where the Chairperson is not present or is otherwise unable to act.

Role and responsibilities of the Committee and its members

44. The Committee as a whole will:

a. ensure that the independent views of members are given due weight and consideration;

b. ensure fair and full participation of members;

c. regularly review its own performance; and

d. give effect to its responsibilities under Te Tiriti o Waitangi.

45. All Committee members (including the Chairs and Deputy Chair) will:

a. participate actively in Committee meetings and relevant events;

b. communicate and engage with other committee members constructively;

c. support the Committee's work;

d. prepare in advance for meetings and other duties;

e. demonstrate their commitment by attending all meetings (where relevant);

f. be informed about the Committee and its strategic environment;

g. commit to representing the interests of the Committee as a whole; and

h. be committed to the Committee's continual improvement by participating in self-assessment processes and professional development opportunities that support the Committee's work, including as made available or recommended by the Chair or the Commission.

46. Members must remain fully familiar with the duties and obligation of their position at all times and ensure they:

a. comply with the Act;

b. act with honesty and integrity;

c. act in good faith and not at the expense of the Committee's interests;

d. act with reasonable skill, diligence and care;

e. not disclose information gained in their capacity as a member; and

f. maintain their independence (see also 'Conflicts of Interest' below).

47. Members attend meetings and undertake Committee activities as independent persons responsible to the Committee as a whole. Members are not appointed as representatives of professional organisations and groups. The Committee should not, therefore, assume that a particular group's interests have been taken into account because a member is associated with a particular group.

Conflicts of Interest

48. Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. Proper observation of these principles will protect the Committee and its members and will ensure that it provides independent advice and retains the Commission's and public confidence.

49. Members are required to declare any relevant interests to the full Committee and the Commission. In accordance with *Conflicts of Interest Guide*, the Commission will, determine whether or not the interest represents a conflict, and if so, what action will be taken.

50. Members will declare any actual, potential or perceived conflicts of interest at the start of each meeting.

Confidentiality

51. In these terms of reference, 'Information' means any information

a. that is personal information within the meaning of section 2(1) of the Privacy Act 1993; and

b. that became known to any member or executive officer or agent of a mortality review committee only because of the committee's functions being carried out (for example, because it is contained in a document created, and made available to the member or executive officer or agent, only because of those functions being carried out), whether or not the carrying out of those functions is completed.

52. The maintenance of confidentiality of Information is crucial to the functioning of the Committee. Members must comply with the provisions of Schedule 5 to the Act regarding production, disclosure and recording of information.[3]

Secretariat

53. The Commission employs staff to assist the Committee and act as its secretariat (the Secretariat). The cost of the Secretariat to the Commission is funded by the Committee's Budget.

54. The Committee is expected to work constructively and cooperatively with the Secretariat, and vice-versa.

55. The Secretariat acts on the instruction of a Chair/ or both Chairs where relevant.

56. The Secretariat will support the Committee in the performance of its Functions, including by providing:

a. expert subject matter knowledge and expertise, policy analysis and analytical support and guidance in relation to matters outside the scope of the Members collective expertise e.g. guidance on governmental and ministerial processes;

b. budget management, contract management and service procurement to assist the Committee to achieve its Work Plan within the Committee's Budget;

c. central communications systems support for correspondence and public relations purposes, including secure communication between Committee Members and 'agents'[4];

d. liaison on behalf of the Committee within and across government and non-government organisations;

e. administrative support to organise, minute and follow up on committee meetings and/ or working groups as set out in the Work Plan and within the Committee's Budget; and

f. additional support for the Committee to carry out its Functions, as agreed with the Chair and within the Committee's Budget.

Performance measures

[3] Note, disclosure of information contrary to Schedule 5 of the Act is an offence.
[4] Appointed in accordance with Schedule 5 of the Act

57. The Committee will achieve the Commission's strategic priorities communicated to Chair/s, and effectively perform its Functions when it provides relevant and timely advice to the Commission based on data, analysis and consultation with appropriate groups and organisations.

58. The Committee must:

    a. agree in advance to a Work Plan with the Commission

    b. achieve its Work Plan

    c. stay within the Committee's Budget.

Review

59. The Commission may review these terms of reference at any time and at least three years from the date at which they are approved by it.

Perinatal and Maternal Mortality Review Committee Terms of Reference

May 2021

Background

1. The objectives of Health Quality & Safety Commission (the Commission) are to lead and coordinate work across the health and disability sector for the purposes of:

    a. monitoring and improving the quality and safety of health and disability support services; and

    b. helping providers across the health and disability sector to improve the quality and safety of health and disability support services.

2. Under the New Zealand Public Health and Disability Act 2000 (the Act), the Commission may appoint mortality review committees (MRC) to carry out any of the functions specified in section 59E(1) of the Act, notified by the Commission to the MRC.

MRC Functions and Scope

3. These terms of reference constitute notice under Section 59E(1) of the Act, that the Commission appoints an MRC to be known as the Perinatal and Maternal Mortality Review Committee (the Committee).

4. The functions of the Committee are to (the Functions):

    a. review and report to the Commission on specified classes of deaths of persons, or deaths of persons of specified classes, as set out in section 5 (the Scope);

    b. advise the Commission on ongoing quality assurance programmes to support continuous quality improvement in health and disability support services; and

    c. advise the Commission on any other matters related to mortality that the Commission specifies in a notice to the Committee.

5. The Committee's Scope is to consider perinatal and maternal mortality, and other mortality and morbidity as directed by the Commission in writing, or as specified within the Committee's agreed Work Plan.

6. For the purposes of the Terms of Reference of the Perinatal and Maternal Mortality Review Committee:

    a. perinatal deaths are defined as the age range from 20 weeks gestation to 28 completed days after birth or weighing at least 400 grams (if gestation is unknown).

    b. maternal deaths are defined as deaths directly related to pregnancy or childbirth, up to within 42 days of termination of pregnancy, irrespective of the duration and

site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management.

7. The MRC is an independent advisor to the Commission. It will obtain information and undertake independent analysis, based on strategies and methodologies it designs, to inform and assist the Commission to reduce morbidity and mortality, within the Scope.

Approach to performing its Functions

8. In performing its Functions, the Committee will:

    a. provide independent advice to the Commission with a view to reducing the numbers of deaths within the Scope;

    b. give effect to the Commission's responsibilities under Te Tiriti o Waitangi and ensure its review methodology, reports and recommendations contribute to achieving equitable outcomes for Māori by:

        i. implementing *Te Pou, Māori responsive rubric and guidelines*[1]

        ii. considering advice from Ngā Pou Arawhenua and other Māori stakeholders.

    c. consult and engage with an appropriate range of stakeholders (including relevant Māori, and consumer representatives) in relation to informing and carrying out its Functions; and

    d. ensure its advice and recommendations comply with the laws of New Zealand.

Work Plan

9. In accordance with section 59E(2) of the Act, the Committee is required to develop a strategic plan and methodologies that:

    a. are designed to reduce morbidity and mortality; and

    b. are relevant to the Committee's Functions.

10. By March of each year, the Committee will submit to the Commission for its approval, a proposed programme of work for the following financial year that sets out the Committee's:

    a. strategic plan, methodologies and activities to undertake its activities in accordance with these terms of reference and achieve the Commission's expectations communicated to the Committee in Letters of Expectation;

    b. approach to delivering the Commission's reporting requirements;

    c. plan to disseminate (including publish) the Committee's recommendations; and

    d. budget for undertaking the programme of work.

[1] https://www.hqsc.govt.nz/publications-and-resources/publication/3903/

11. If the Commission approves the proposed programme of work (the Work Plan), it will allocate a budget to it. The Committee must achieve the Work Plan within the assigned budget (the Committee's Budget).

12. In any case where the Budget is insufficient to achieve the Work Plan (e.g. due to unexpected higher costs), the Committee will discuss and agree with the Commission a variation to the Work Plan.

Data collection, reports and other activities

13. The Commission will, in accordance with the Work Plan and from the Committee's Budget fund mortality data collection, analysis, and review activities relevant to the Scope, to inform the Committee and assist it to perform its Functions.

14. The Committee will oversee the activities described in section 13 to ensure its advice to the Commission is relevant, evidence-based and provided as quickly as practicable.

15. The Committee will provide advice to service providers in the health (including DHBs) and social sectors, on developing and enhancing systems to:

    a. collect data in relation to the Scope;

    b. monitor the number, categories and demographics of deaths relevant to the Scope, and to identify patterns and trends over time;

    c. support nationwide local review to:
        i. inform quality improvement initiatives, for system and practice improvements to reduce morbidity and mortality within local communities
        ii. provide data collection systems for national review; and

    d. ensure the security of Information.

16. The Committee will report its advice and recommendations to the Commission based on its independent review and analysis. The Commission will receive and consider such reports.

Working relationships and communications

17. The Committee will develop and maintain positive working relationships with:

    a. other MRCs and the Commission, to ensure coordination and integration of their respective functions, minimise duplication, and improve efficiency and sustainability;

    b. relevant government bodies;

    c. relevant stakeholder organisations; and

    d. the MRC Māori Caucus, Ngā Pou Arawhenua.

18. The Committee will share with other MRCs, information it obtains in the course of performing its functions, provided:

a. the information to be shared is relevant to the functions of the receiving MRC(s); and

b. sharing the information with the receiving MRC is in accordance with the provisions in Schedule 5 to the Act.

19. The Committee (and its members) will advise the Commission in writing before it makes any media statements, public comment or publication in accordance with the Commission's communications policies.

Composition of the Committee

20. The Committee will have a maximum of eight members.

21. One member will have relevant, lived experience, whānau, consumer expertise and will provide a whānau, consumer, community perspective, and will be well networked to whānau, consumer, community groups.

22. The other members will together have knowledge and or expertise covering the following areas:

a. knowledge of quality improvement and risk management, in particular quality assurance in the health sector and including Māori quality frameworks

b. knowledge of quantitative and qualitative data and information gathering systems and analysis, including Maori research frameworks and methodologies

c. knowledge and experience of clinical epidemiology

d. knowledge of maternity service provision and management in DHBs and/or in the community

e. clinical experience in neonatal paediatrics, obstetrics, midwifery and other clinical expertise relevant to the Committee's function

f. knowledge of and experience in Māori health, Te Tiriti o Waitangi and health equity for Māori

g. knowledge of the health of other ethnicities and people with disabilities, and health inequity.

23. Members will be able to work strategically and have credibility in relevant communities.

Member's terms of appointment

24. Members of the Committee are appointed by the Commission for a term of up to three years. Members may be appointed for further terms, however, reappointment is not automatic, nor should it be expected.

25. The Commission may use a number of selection methods in order to bring specific knowledge and expertise to a Committee. This may include calling for nominations from expert groups to approaching appropriate people individually when required.

26. Any member of the Committee may at any time resign as a member by advising the Commission in writing.

27. The Commission may remove any member of the Committee at any time for inability to perform the functions of membership, conflict of interest, bankruptcy, neglect of duty, or misconduct, each proved to the Commission's satisfaction.

28. The Commission may from time to time alter or reconstitute the Committee, or discharge any member of the Committee or appoint new members to the Committee for the purpose of decreasing or increasing the membership, filling any vacancies or ensuring coverage of expertise as anticipated in sections 21 and 212.

29. Member's fees will be set with reference to the Cabinet Fees Framework[2] and specified in each member's letter of appointment.

30. Actual and reasonable expenses for activities required by the Committee of its members (e.g. travel, accommodation) will be met from the Committee's Budget provided the Secretariat has approved the expense prior to it being incurred.

Collaboration with other organisations

31. In order for the Committee to work collaboratively with other organisations, groups, or individuals that have an interest in, or will be affected by, its activities and advice, the Committee may invite representatives of stakeholder organisations (including from the Public Sector) to attend and speak at its meetings.

32. To avoid doubt, such representatives are not members of the Committee, have no voting rights and are not entitled to members' fees.

33. Attendance by such representatives at committee meetings, will be at the cost of their respective organisation.

Co-opting additional expertise

34. The Committee may co-opt additional people to the Committee or to working groups of the Committee, where it determines additional expertise is required.

35. The expense associated with additional co-opted resources must be met within the Committee's Budget.

36. Such co-opted persons are not members of the Committee, have no voting rights and are not entitled to members' fees.

Meetings and Procedures

37. The Committee will determine and regulate its own procedures in consultation with the Secretariat provided those procedures are within the Budget and not inconsistent with the Act. Such procedures will be recorded and maintained by the Secretariat, and cover matters including:

[2] Cabinet Fees Framework https://www.publicservice.govt.nz/our-work/fees/#:~:text=Guidance%20on%20fees%20paid%20to,Fees%20Framework%20(the%20Framework)

a. the timing and frequency of meetings;

b. attendance expectations of members;

c. the quorum of the Committee that must be present to conduct the Committee's business; and

d. how the Committee will make decisions and treatment of dissenting views.

38. The Chair is responsible for ensuring minutes are taken at each meeting and a record of decisions is maintained.

Chairs and Deputy Chair

39. The Commission will appoint up to two members of the Committee to be either Co-Chairs or Chair and Deputy Chair. A co-chair allowance is applicable where the Commission identifies the opportunity to reflect a suitable Māori/Crown partnership and there is Committee member interest in being appointed to the role.

40. One or both Chairs will:

a. preside at every meeting of the Committee

b. attend regular meetings of the MRC Chairs (Chairs' Meetings) to ensure cooperation and integration across MRCs wherever possible, and the best allocation of limited resources

c. meet with the Commission, on its request

d. attend other MRC meetings at the Commission's request.

41. The Deputy Chairperson (where one is appointed) may act as the Chair in situations where the Chairperson is not present or is otherwise unable to act.

Role and responsibilities of the Committee and its members

42. The Committee as a whole will:

a. ensure that the independent views of members are given due weight and consideration;

b. ensure fair and full participation of members;

c. regularly review its own performance; and

d. give effect to its responsibilities under Te Tiriti o Waitangi.

43. All Committee members (including the Chairs and Deputy Chair) will:

a. participate actively in Committee meetings and relevant events;

b. communicate and engage with other committee members constructively;

c. support the Committee's work;

d. prepare in advance for meetings and other duties;

e. demonstrate their commitment by attending all meetings (where relevant);

f. be informed about the Committee and its strategic environment;

g. commit to representing the interests of the Committee as a whole; and

h. be committed to the Committee's continual improvement by participating in self-assessment processes and professional development opportunities that support the Committee's work, including as made available or recommended by the Chair or the Commission.

44. Members must remain fully familiar with the duties and obligation of their position at all times and ensure they:

a. comply with the Act;

b. act with honesty and integrity;

c. act in good faith and not at the expense of the Committee's interests;

d. act with reasonable skill, diligence and care;

e. not disclose information gained in their capacity as a member; and

f. maintain their independence (see also 'Conflicts of Interest' below).

45. Members attend meetings and undertake Committee activities as independent persons responsible to the Committee as a whole. Members are not appointed as representatives of professional organisations and groups. The Committee should not, therefore, assume that a particular group's interests have been taken into account because a member is associated with a particular group.

Conflicts of Interest

46. Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. Proper observation of these principles will protect the Committee and its members and will ensure that it provides independent advice and retains the Commission's and public confidence.

47. Members are required to declare any relevant interests to the full Committee and the Commission. In accordance with *Conflicts of Interest Guide*, the Commission will, determine whether or not the interest represents a conflict, and if so, what action will be taken.

48. Members will declare any actual, potential or perceived conflicts of interest at the start of each meeting.

Confidentiality

49. In these terms of reference, 'Information' means any information

a. that is personal information within the meaning of section 2(1) of the Privacy Act 1993; and

b. that became known to any member or executive officer or agent of a mortality review committee only because of the committee's functions being carried out (for example, because it is contained in a document created, and made available to the member or executive officer or agent, only because of those functions being carried out), whether or not the carrying out of those functions is completed.

50. The maintenance of confidentiality of Information is crucial to the functioning of the Committee. Members must comply with the provisions of Schedule 5 to the Act regarding production, disclosure and recording of information.[3]

Secretariat

51. The Commission employs staff to assist the Committee and act as its secretariat (the Secretariat). The cost of the Secretariat to the Commission is funded by the Committee's Budget.

52. The Committee is expected to work constructively and cooperatively with the Secretariat, and vice-versa.

53. The Secretariat acts on the instruction of a Chair/ or both Chairs where relevant.

54. The Secretariat will support the Committee in the performance of its Functions, including by providing:

    a. expert subject matter knowledge and expertise, policy analysis and analytical support and guidance in relation to matters outside the scope of the Members collective expertise e.g. guidance on governmental and ministerial processes;

    b. budget management, contract management and service procurement to assist the Committee to achieve its Work Plan within the Committee's Budget;

    c. central communications systems support for correspondence and public relations purposes, including secure communication between Committee Members and 'agents'[4];

    d. liaison on behalf of the Committee within and across government and non-government organisations;

    e. administrative support to organise, minute and follow up on committee meetings and/ or working groups as set out in the Work Plan and within the Committee's Budget; and

    f. additional support for the Committee to carry out its Functions, as agreed with the Chair and within the Committee's Budget.

Performance measures

[3] Note, disclosure of information contrary to Schedule 5 of the Act is an offence.
[4] Appointed in accordance with Schedule 5 of the Act

55. The Committee will achieve the Commission's strategic priorities communicated to Chair/s, and effectively perform its Functions when it provides relevant and timely advice to the Commission based on data, analysis and consultation with appropriate groups and organisations.

56. The Committee must:

    a. agree in advance to a Work Plan with the Commission

    b. achieve its Work Plan

    c. stay within the Committee's Budget.

Review

57. The Commission may review these terms of reference at any time and at least three years from the date at which they are approved by it.

Perioperative Mortality Review Committee Terms of Reference

May 2021

Background

1. The objectives of Health Quality & Safety Commission (the Commission) are to lead and coordinate work across the health and disability sector for the purposes of:

    a. monitoring and improving the quality and safety of health and disability support services; and

    b. helping providers across the health and disability sector to improve the quality and safety of health and disability support services.

2. Under the New Zealand Public Health and Disability Act 2000 (the Act), the Commission may appoint mortality review committees (MRC) to carry out any of the functions specified in section 59E(1) of the Act, notified by the Commission to the MRC.

MRC Functions and Scope

3. These terms of reference constitute notice under Section 59E(1) of the Act, that the Commission appoints an MRC to be known as the Perioperative Mortality Review Committee (the Committee).

4. The functions of the Committee are to (the Functions):

    a. review and report to the Commission on specified classes of deaths of persons, or deaths of persons of specified classes, as set out in section 5 (the Scope);

    b. advise the Commission on ongoing quality assurance programmes to support continuous quality improvement in health and disability support services; and

    c. advise the Commission on any other matters related to mortality that the Commission specifies in a notice to the Committee.

5. The Committee's Scope is to consider perioperative mortality and other mortality and morbidity as directed by the Commission Board in writing, or as specified within the Committee's agreed Work Plan.

6. For the purposes of the Terms of Reference of the Perioperative Mortality Review Committee, *perioperative mortality deaths* include:

    a. a death that occurred during or after an operative procedure

        i. within 90 days

        ii. after both 90 days but before discharge from hospital to home or a rehabilitation facility

b. The POMRC will continue to review deaths during or after an operative procedure that occur within 30 days in the categories set out above

c. c. a death that occurred whilst under the care of a surgeon in hospital even though an operation was NOT undertaken.

d. d. A death that occurred during or after an anaesthetic (local, regional or general) or sedation.

7. For the purposes of this definition:

   a. An operative procedure is defined as any procedure requiring anaesthesia (local, regional or general) or sedation.

   b. A surgeon is defined as a doctor who has achieved vocational registration with the Medical Council of New Zealand in a speciality of surgery (including oral surgery).

   c. For the removal of doubt, gastroscopies, colonoscopies, and cardiac or vascular angiographic procedures (diagnostic or therapeutic) carried out in designated endoscopy or radiological rooms would be included in this definition.

8. The MRC is an independent advisor to the Commission. It will obtain information and undertake independent analysis, based on strategies and methodologies it designs, to inform and assist the Commission to reduce morbidity and mortality, within the Scope.

Approach to performing its Functions

9. In performing its Functions, the Committee will:

   a. provide independent advice to the Commission with a view to reducing the numbers of deaths within the Scope;

   b. give effect to the Commission's responsibilities under Te Tiriti o Waitangi and ensure its review methodology, reports and recommendations contribute to achieving equitable outcomes for Māori by:

      i. implementing *Te Pou, Māori responsive rubric and guidelines*[1]

      ii. considering advice from Ngā Pou Arawhenua and other Māori stakeholders.

   c. consult and engage with an appropriate range of stakeholders (including relevant Māori, and consumer representatives) in relation to informing and carrying out its Functions; and

   d. ensure its advice and recommendations comply with the laws of New Zealand.

Work Plan

10. In accordance with section 59E(2) of the Act, the Committee is required to develop a strategic plan and methodologies that:

[1] https://www.hqsc.govt.nz/publications-and-resources/publication/3903/

a. are designed to reduce morbidity and mortality; and

b. are relevant to the Committee's Functions.

11. By March of each year, the Committee will submit to the Commission for its approval, a proposed programme of work for the following financial year that sets out the Committee's:

    a. strategic plan, methodologies and activities to undertake its activities in accordance with these terms of reference and achieve the Commission's expectations communicated to the Committee in Letters of Expectation;

    b. approach to delivering the Commission's reporting requirements;

    c. plan to disseminate (including publish) the Committee's recommendations; and

    d. budget for undertaking the programme of work.

12. If the Commission approves the proposed programme of work (the Work Plan), it will allocate a budget to it. The Committee must achieve the Work Plan within the assigned budget (the Committee's Budget).

13. In any case where the Budget is insufficient to achieve the Work Plan (e.g. due to unexpected higher costs), the Committee will discuss and agree with the Commission a variation to the Work Plan.

Data collection, reports and other activities

14. The Commission will, in accordance with the Work Plan and from the Committee's Budget fund mortality data collection, analysis, and review activities relevant to the Scope, to inform the Committee and assist it to perform its Functions.

15. The Committee will oversee the activities described in section 14 to ensure its advice to the Commission is relevant, evidence-based and provided as quickly as practicable.

16. The Committee will provide advice to service providers in the health (including DHBs) and social sectors, on developing and enhancing systems to:

    a. collect data in relation to the Scope;

    b. monitor the number, categories and demographics of deaths relevant to the Scope, and to identify patterns and trends over time;

    c. ensure the security of Information.

17. The Committee will report its advice and recommendations to the Commission based on its independent review and analysis. The Commission will receive and consider such reports.

Working relationships and communications

18. The Committee will develop and maintain positive working relationships with:

a. other MRCs and the Commission, to ensure coordination and integration of their respective functions, minimise duplication, and improve efficiency and sustainability;

b. relevant government bodies;

c. relevant stakeholder organisations; and

d. the MRC Māori Caucus, Ngā Pou Arawhenua.

19. The Committee will share with other MRCs, information it obtains in the course of performing its functions, provided:

    a. the information to be shared is relevant to the functions of the receiving MRC(s); and

    b. sharing the information with the receiving MRC is in accordance with the provisions in Schedule 5 to the Act.

20. The Committee (and its members) will advise the Commission in writing before it makes any media statements, public comment or publication in accordance with the Commission's communications policies.

Composition of the Committee

21. The Committee will have a maximum of eight members.

22. One member will have relevant, lived experience, whānau, consumer expertise and will provide a whānau, consumer, community perspective, and will be well networked to whānau, consumer, community groups.

23. The other members will together have knowledge and or expertise covering the following areas:

    a. substantial clinical experience and national credibility in one or more of the following: anaesthesia; surgery; obstetrics and gynaecology; intensive care; surgical nursing; and procedural internal medicine (e.g. cardiology)

    b. knowledge of and experience in clinical epidemiology

    c. knowledge of quality and risk management, in particular quality improvement in the health sector, and including Māori quality frameworks

    d. knowledge of quantitative and qualitative data and information gathering systems and analysis, including Maori research frameworks and methodologies

    e. senior level health service provision and management, both public and private

    f. knowledge of and experience in Māori health, Te Tiriti o Waitangi and health equity for Māori

    g. knowledge of the health of other ethnicities and people with disabilities, and health inequity.

24. Members will be able to work strategically and have credibility in relevant communities.

Member's terms of appointment

25. Members of the Committee are appointed by the Commission for a term of up to three years. Members may be appointed for further terms, however, reappointment is not automatic, nor should it be expected.

26. The Commission may use a number of selection methods in order to bring specific knowledge and expertise to a Committee. This may include calling for nominations from expert groups to approaching appropriate people individually when required.

27. Any member of the Committee may at any time resign as a member by advising the Commission in writing.

28. The Commission may remove any member of the Committee at any time for inability to perform the functions of membership, conflict of interest, bankruptcy, neglect of duty, or misconduct, each proved to the Commission's satisfaction.

29. The Commission may from time to time alter or reconstitute the Committee, or discharge any member of the Committee or appoint new members to the Committee for the purpose of decreasing or increasing the membership, filling any vacancies or ensuring coverage of expertise as anticipated in sections 22 and 23.

30. Member's fees will be set with reference to the Cabinet Fees Framework[2] and specified in each member's letter of appointment.

31. Actual and reasonable expenses for activities required by the Committee of its members (e.g. travel, accommodation) will be met from the Committee's Budget provided the Secretariat has approved the expense prior to it being incurred.

Collaboration with other organisations

32. In order for the Committee to work collaboratively with other organisations, groups, or individuals that have an interest in, or will be affected by, its activities and advice, the Committee may invite representatives of stakeholder organisations (including from the Public Sector) to attend and speak at its meetings.

33. To avoid doubt, such representatives are not members of the Committee, have no voting rights and are not entitled to members' fees.

34. Attendance by such representatives at committee meetings, will be at the cost of their respective organisation.

Co-opting additional expertise

35. The Committee may co-opt additional people to the Committee or to working groups of the Committee, where it determines additional expertise is required.

36. The expense associated with additional co-opted resources must be met within the Committee's Budget.

---

[2] Cabinet Fees Framework https://www.publicservice.govt.nz/our-work/fees/#:~:text=Guidance%20on%20fees%20paid%20to,Fees%20Framework%20(the%20Framework)

37. Such co-opted persons are not members of the Committee, have no voting rights and are not entitled to members' fees.

Meetings and Procedures

38. The Committee will determine and regulate its own procedures in consultation with the Secretariat provided those procedures are within the Budget and not inconsistent with the Act. Such procedures will be recorded and maintained by the Secretariat, and cover matters including:

    a. the timing and frequency of meetings;

    b. attendance expectations of members;

    c. the quorum of the Committee that must be present to conduct the Committee's business; and

    d. how the Committee will make decisions and treatment of dissenting views.

39. The Chair is responsible for ensuring minutes are taken at each meeting and a record of decisions is maintained.

Chairs and Deputy Chair

40. The Commission will appoint up to two members of the Committee to be either Co-Chairs or Chair and Deputy Chair. A co-chair allowance is applicable where the Commission identifies the opportunity to reflect a suitable Māori/Crown partnership and there is Committee member interest in being appointed to the role.

41. One or both Chairs will:

    a. preside at every meeting of the Committee

    b. attend regular meetings of the MRC Chairs (Chairs' Meetings) to ensure cooperation and integration across MRCs wherever possible, and the best allocation of limited resources

    c. meet with the Commission, on its request

    d. attend other MRC meetings at the Commission's request.

42. The Deputy Chairperson (where one is appointed) may act as the Chair in situations where the Chairperson is not present or is otherwise unable to act.

Role and responsibilities of the Committee and its members

43. The Committee as a whole will:

    a. ensure that the independent views of members are given due weight and consideration;

    b. ensure fair and full participation of members;

    c. regularly review its own performance; and

d. give effect to its responsibilities under Te Tiriti o Waitangi.

44. All Committee members (including the Chairs and Deputy Chair) will:

    a. participate actively in Committee meetings and relevant events;

    b. communicate and engage with other committee members constructively;

    c. support the Committee's work;

    d. prepare in advance for meetings and other duties;

    e. demonstrate their commitment by attending all meetings (where relevant);

    f. be informed about the Committee and its strategic environment;

    g. commit to representing the interests of the Committee as a whole; and

    h. be committed to the Committee's continual improvement by participating in self-assessment processes and professional development opportunities that support the Committee's work, including as made available or recommended by the Chair or the Commission.

45. Members must remain fully familiar with the duties and obligation of their position at all times and ensure they:

    a. comply with the Act;

    b. act with honesty and integrity;

    c. act in good faith and not at the expense of the Committee's interests;

    d. act with reasonable skill, diligence and care;

    e. not disclose information gained in their capacity as a member; and

    f. maintain their independence (see also 'Conflicts of Interest' below).

46. Members attend meetings and undertake Committee activities as independent persons responsible to the Committee as a whole. Members are not appointed as representatives of professional organisations and groups. The Committee should not, therefore, assume that a particular group's interests have been taken into account because a member is associated with a particular group.

Conflicts of Interest

47. Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. Proper observation of these principles will protect the Committee and its members and will ensure that it provides independent advice and retains the Commission's and public confidence.

48. Members are required to declare any relevant interests to the full Committee and the Commission. In accordance with *Conflicts of Interest Guide*, the Commission will,

determine whether or not the interest represents a conflict, and if so, what action will be taken.

49. Members will declare any actual, potential or perceived conflicts of interest at the start of each meeting.

Confidentiality

50. In these terms of reference, 'Information' means any information

    a. that is personal information within the meaning of section 2(1) of the Privacy Act 1993; and

    b. that became known to any member or executive officer or agent of a mortality review committee only because of the committee's functions being carried out (for example, because it is contained in a document created, and made available to the member or executive officer or agent, only because of those functions being carried out), whether or not the carrying out of those functions is completed.

51. The maintenance of confidentiality of Information is crucial to the functioning of the Committee. Members must comply with the provisions of Schedule 5 to the Act regarding production, disclosure and recording of information.[3]

Secretariat

52. The Commission employs staff to assist the Committee and act as its secretariat (the Secretariat). The cost of the Secretariat to the Commission is funded by the Committee's Budget.

53. The Committee is expected to work constructively and cooperatively with the Secretariat, and vice-versa.

54. The Secretariat acts on the instruction of a Chair/ or both Chairs where relevant.

55. The Secretariat will support the Committee in the performance of its Functions, including by providing:

    a. expert subject matter knowledge and expertise, policy analysis and analytical support and guidance in relation to matters outside the scope of the Members collective expertise e.g. guidance on governmental and ministerial processes;

    b. budget management, contract management and service procurement to assist the Committee to achieve its Work Plan within the Committee's Budget;

    c. central communications systems support for correspondence and public relations purposes, including secure communication between Committee Members and 'agents'[4];

    d. liaison on behalf of the Committee within and across government and non-government organisations;

[3] Note, disclosure of information contrary to Schedule 5 of the Act is an offence.
[4] Appointed in accordance with Schedule 5 of the Act

e. administrative support to organise, minute and follow up on committee meetings and/ or working groups as set out in the Work Plan and within the Committee's Budget; and

f. additional support for the Committee to carry out its Functions, as agreed with the Chair and within the Committee's Budget.

Performance measures

56. The Committee will achieve the Commission's strategic priorities communicated to Chair/s, and effectively perform its Functions when it provides relevant and timely advice to the Commission based on data, analysis and consultation with appropriate groups and organisations.

57. The Committee must:

    a. agree in advance to a Work Plan with the Commission

    b. achieve its Work Plan

    c. stay within the Committee's Budget.

Review

58. The Commission may review these terms of reference at any time and at least three years from the date at which they are approved by it.

Suicide Mortality Review Committee Terms of Reference

May 2021

Background

1. The objectives of Health Quality & Safety Commission (the Commission) are to lead and coordinate work across the health and disability sector for the purposes of:

    a. monitoring and improving the quality and safety of health and disability support services; and

    b. helping providers across the health and disability sector to improve the quality and safety of health and disability support services.

2. Under the New Zealand Public Health and Disability Act 2000 (the Act), the Commission may appoint mortality review committees (MRC) to carry out any of the functions specified in section 59E(1) of the Act, notified by the Commission to the MRC.

MRC Functions and Scope

3. These terms of reference constitute notice under Section 59E(1) of the Act, that the Commission appoints an MRC to be known as the Suicide Mortality Review Committee (the Committee).

4. The functions of the Committee are to (the Functions):

    a. review and report to the Commission on specified classes of deaths of persons, or deaths of persons of specified classes, as set out in section 5 (the Scope);

    b. advise the Commission on ongoing quality assurance programmes to support continuous quality improvement in health and disability support services; and

    c. advise the Commission on any other matters related to mortality that the Commission specifies in a notice to the Committee.

5. The Committee's Scope is to consider suicide and other mortality and morbidity as directed by the Commission in writing, or as specified within the Committee's agreed work programme.

6. For the purposes of these terms of reference suicide mortality is considered to be all deaths resulting from intentionally killing oneself.

7. The MRC is an independent advisor to the Commission. It will obtain information and undertake independent analysis, based on strategies and methodologies it designs, to inform and assist the Commission to reduce morbidity and mortality, within the Scope.

8. The Committee will also undertake all activities to ensure that the requirements of the agreement with the Ministry of Health are met.

Approach to performing its Functions

9. In performing its Functions, the Committee will:

    a. provide independent advice to the Commission with a view to reducing the numbers of deaths within the Scope;

    b. give effect to the Commission's responsibilities under Te Tiriti o Waitangi and ensure its review methodology, reports and recommendations contribute to achieving equitable outcomes for Māori by:

        i. implementing *Te Pou, Māori responsive rubric and guidelines*[1]

        ii. considering advice from Ngā Pou Arawhenua and other Māori stakeholders.

    c. consult and engage with an appropriate range of stakeholders (including relevant Māori, and consumer representatives) in relation to informing and carrying out its Functions; and

    d. ensure its advice and recommendations comply with the laws of New Zealand.

Work Plan

10. In accordance with section 59E(2) of the Act, the Committee is required to develop a strategic plan and methodologies that:

    a. are designed to reduce morbidity and mortality; and

    b. are relevant to the Committee's Functions.

11. By March of each year, the Committee will submit to the Commission for its approval, a proposed programme of work for the following financial year that sets out the Committee's:

    a. strategic plan, methodologies and activities to undertake its activities in accordance with these terms of reference and achieve the Commission's expectations communicated to the Committee in Letters of Expectation;

    b. approach to delivering the Commission's reporting requirements;

    c. plan to disseminate (including publish) the Committee's recommendations; and

    d. budget for undertaking the programme of work.

12. If the Commission approves the proposed programme of work (the Work Plan), it will allocate a budget to it. The Committee must achieve the Work Plan within the assigned budget (the Committee's Budget).

13. In any case where the Budget is insufficient to achieve the Work Plan (e.g. due to unexpected higher costs), the Committee will discuss and agree with the Commission a variation to the Work Plan.

[1] https://www.hqsc.govt.nz/publications-and-resources/publication/3903/

Data collection, reports and other activities

14. The Commission will, in accordance with the Work Plan and from the Committee's Budget fund mortality data collection, analysis, and review activities relevant to the Scope, to inform the Committee and assist it to perform its Functions.

15. The Committee will oversee the activities described in section 14 to ensure its advice to the Commission is relevant, evidence-based and provided as quickly as practicable.

16. The Committee will provide advice to service providers in the health (including DHBs) and social sectors, on developing and enhancing systems to:

    a. collect data in relation to the Scope;

    b. monitor the number, categories and demographics of deaths relevant to the Scope, and to identify patterns and trends over time;

    c. ensure the security of Information.

17. The Committee will report its advice and recommendations to the Commission based on its independent review and analysis. The Commission will receive and consider such reports.

Working relationships and communications

18. The Committee will develop and maintain positive working relationships with:

    a. other MRCs and the Commission, to ensure coordination and integration of their respective functions, minimise duplication, and improve efficiency and sustainability;

    b. relevant government bodies;

    c. relevant stakeholder organisations; and

    d. the MRC Māori Caucus, Ngā Pou Arawhenua.

19. The Committee will share with other MRCs, information it obtains in the course of performing its functions, provided:

    a. the information to be shared is relevant to the functions of the receiving MRC(s); and

    b. sharing the information with the receiving MRC is in accordance with the provisions in Schedule 5 to the Act.

20. The Committee (and its members) will advise the Commission in writing before it makes any media statements, public comment or publication in accordance with the Commission's communications policies.

Composition of the Committee

21. The Committee will have a maximum of eight members.

22. One member will have relevant, lived experience, whānau, consumer expertise and will provide a whānau, consumer, community perspective, and will be well networked to whānau, consumer, community groups.

23. The other members will together have knowledge and or expertise covering the following areas:

    a. mortality review systems

    b. suicide and suicide prevention

    c. Māori suicide issues, including knowledge of and experience in Māori health, Te Tiriti o Waitangi and health equity for Māori

    d. suicide from a service user, family and whānau perspective

    e. research methods and process, particularly in relation to health and social systems

    f. knowledge of quantitative and qualitative data and information gathering systems and analysis, including Māori research frameworks and methodologies

    g. clinical experience in mental health and addiction services

    h. an understanding of topics surrounding inequity and inequitable outcomes

    i. knowledge of the health of other ethnicities and people with disabilities, and health inequity.

24. Members will be able to work strategically and have credibility in relevant communities.

Member's terms of appointment

25. Members of the Committee are appointed by the Commission for a term of up to three years. Members may be appointed for further terms, however, reappointment is not automatic, nor should it be expected.

26. The Commission may use a number of selection methods in order to bring specific knowledge and expertise to a Committee. This may include calling for nominations from expert groups to approaching appropriate people individually when required.

27. Any member of the Committee may at any time resign as a member by advising the Commission in writing.

28. The Commission may remove any member of the Committee at any time for inability to perform the functions of membership, conflict of interest, bankruptcy, neglect of duty, or misconduct, each proved to the Commission's satisfaction.

29. The Commission may from time to time alter or reconstitute the Committee, or discharge any member of the Committee or appoint new members to the Committee for the purpose of decreasing or increasing the membership, filling any vacancies or ensuring coverage of expertise as anticipated in sections 22 and 23.

30. Member's fees will be set with reference to the Cabinet Fees Framework[2] and specified in each member's letter of appointment.

31. Actual and reasonable expenses for activities required by the Committee of its members (e.g. travel, accommodation) will be met from the Committee's Budget provided the Secretariat has approved the expense prior to it being incurred.

Collaboration with other organisations

32. In order for the Committee to work collaboratively with other organisations, groups, or individuals that have an interest in, or will be affected by, its activities and advice, the Committee may invite representatives of stakeholder organisations (including from the Public Sector) to attend and speak at its meetings.

33. To avoid doubt, such representatives are not members of the Committee, have no voting rights and are not entitled to members' fees.

34. Attendance by such representatives at committee meetings, will be at the cost of their respective organisation.

Co-opting additional expertise

35. The Committee may co-opt additional people to the Committee or to working groups of the Committee, where it determines additional expertise is required.

36. The expense associated with additional co-opted resources must be met within the Committee's Budget.

37. Such co-opted persons are not members of the Committee, have no voting rights and are not entitled to members' fees.

Meetings and Procedures

38. The Committee will determine and regulate its own procedures in consultation with the Secretariat provided those procedures are within the Budget and not inconsistent with the Act. Such procedures will be recorded and maintained by the Secretariat, and cover matters including:

    a. the timing and frequency of meetings;

    b. attendance expectations of members;

    c. the quorum of the Committee that must be present to conduct the Committee's business; and

    d. how the Committee will make decisions and treatment of dissenting views.

39. The Chair is responsible for ensuring minutes are taken at each meeting and a record of decisions is maintained.

[2] Cabinet Fees Framework https://www.publicservice.govt.nz/our-work/fees/#:~:text=Guidance%20on%20fees%20paid%20to,Fees%20Framework%20(the%20Framework)

Chairs and Deputy Chair

40. The Commission will appoint up to two members of the Committee to be either Co-Chairs or Chair and Deputy Chair. A co-chair allowance is applicable where the Commission identifies the opportunity to reflect a suitable Māori/Crown partnership and there is Committee member interest in being appointed to the role.

41. One or both Chairs will:

    a. preside at every meeting of the Committee

    b. attend regular meetings of the MRC Chairs (Chairs' Meetings) to ensure cooperation and integration across MRCs wherever possible, and the best allocation of limited resources

    c. meet with the Commission, on its request

    d. attend other MRC meetings at the Commission's request.

42. The Deputy Chairperson (where one is appointed) may act as the Chair in situations where the Chairperson is not present or is otherwise unable to act.

Role and responsibilities of the Committee and its members

43. The Committee as a whole will:

    a. ensure that the independent views of members are given due weight and consideration;

    b. ensure fair and full participation of members;

    c. regularly review its own performance; and

    d. give effect to its responsibilities under Te Tiriti o Waitangi.

44. All Committee members (including the Chairs and Deputy Chair) will:

    a. participate actively in Committee meetings and relevant events;

    b. communicate and engage with other committee members constructively;

    c. support the Committee's work;

    d. prepare in advance for meetings and other duties;

    e. demonstrate their commitment by attending all meetings (where relevant);

    f. be informed about the Committee and its strategic environment;

    g. commit to representing the interests of the Committee as a whole; and

    h. be committed to the Committee's continual improvement by participating in self-assessment processes and professional development opportunities that support the Committee's work, including as made available or recommended by the Chair or the Commission.

45. Members must remain fully familiar with the duties and obligation of their position at all times and ensure they:

    a. comply with the Act;

    b. act with honesty and integrity;

    c. act in good faith and not at the expense of the Committee's interests;

    d. act with reasonable skill, diligence and care;

    e. not disclose information gained in their capacity as a member; and

    f. maintain their independence (see also 'Conflicts of Interest' below).

46. Members attend meetings and undertake Committee activities as independent persons responsible to the Committee as a whole. Members are not appointed as representatives of professional organisations and groups. The Committee should not, therefore, assume that a particular group's interests have been taken into account because a member is associated with a particular group.

Conflicts of Interest

47. Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. Proper observation of these principles will protect the Committee and its members and will ensure that it provides independent advice and retains the Commission's and public confidence.

48. Members are required to declare any relevant interests to the full Committee and the Commission. In accordance with *Conflicts of Interest Guide*, the Commission will, determine whether or not the interest represents a conflict, and if so, what action will be taken.

49. Members will declare any actual, potential or perceived conflicts of interest at the start of each meeting.

Confidentiality

50. In these terms of reference, 'Information' means any information

    a. that is personal information within the meaning of section 2(1) of the Privacy Act 1993; and

    b. that became known to any member or executive officer or agent of a mortality review committee only because of the committee's functions being carried out (for example, because it is contained in a document created, and made available to the member or executive officer or agent, only because of those functions being carried out), whether or not the carrying out of those functions is completed.

51. The maintenance of confidentiality of Information is crucial to the functioning of the Committee. Members must comply with the provisions of Schedule 5 to the Act regarding production, disclosure and recording of information.[3]

[3] Note, disclosure of information contrary to Schedule 5 of the Act is an offence.

Secretariat

52. The Commission employs staff to assist the Committee and act as its secretariat (the Secretariat). The cost of the Secretariat to the Commission is funded by the Committee's Budget.

53. The Committee is expected to work constructively and cooperatively with the Secretariat, and vice-versa.

54. The Secretariat acts on the instruction of a Chair/ or both Chairs where relevant.

55. The Secretariat will support the Committee in the performance of its Functions, including by providing:

    a. expert subject matter knowledge and expertise, policy analysis and analytical support and guidance in relation to matters outside the scope of the Members collective expertise e.g. guidance on governmental and ministerial processes;

    b. budget management, contract management and service procurement to assist the Committee to achieve its Work Plan within the Committee's Budget;

    c. central communications systems support for correspondence and public relations purposes, including secure communication between Committee Members and 'agents'[4];

    d. liaison on behalf of the Committee within and across government and non-government organisations;

    e. administrative support to organise, minute and follow up on committee meetings and/ or working groups as set out in the Work Plan and within the Committee's Budget; and

    f. additional support for the Committee to carry out its Functions, as agreed with the Chair and within the Committee's Budget.

Performance measures

56. The Committee will achieve the Commission's strategic priorities communicated to Chair/s, and effectively perform its Functions when it provides relevant and timely advice to the Commission based on data, analysis and consultation with appropriate groups and organisations.

57. The Committee must:

    a. agree in advance to a Work Plan with the Commission

    b. achieve its Work Plan

    c. stay within the Committee's Budget.

Review

[4] Appointed in accordance with Schedule 5 of the Act

58. The Commission may review these terms of reference at any time and at least three years from the date at which they are approved by it.

PATIENT EXPERIENCE OF CARE GOVERNANCE GROUP

Governance Group Terms of Reference

Background

Research[1] shows links between patient experience and clinical safety and health outcomes including:

- adherence to medication and treatment,
- engagement in preventative care such as screening services and immunisations, and
- ability to use available health resources effectively.

Understanding patients' experience is vital to improving patient safety and the quality of care.

Purpose

The Patient Experience of Care Governance Group (the Governance Group) has been established to provide independent advice to the Ministry of Health (the Ministry) and the Health Quality & Safety Commission (the Commission) on the ongoing management of the Adult Inpatient Experience and the Primary Care patient experience surveys. This includes ensuring the results of the surveys are best used to improve the patient experience at local and national levels. The Governance Group will also provide governance on the collection, storage, access and use of the survey data until a broader information governance group is established.

Role

The role of the Governance Group is to:

1. Advise on the ongoing management of the two surveys.
2. Advise on improving the survey tool and uptake of the surveys, in particular for Māori and high priority populations.
3. Champion the two surveys within the broader health sector and other stakeholders.
4. Provide guidance that will enable the shift of focus from implementation of the survey to the use the survey results to improve the health care experience of patients and communities.
5. Support and advise on national publication of the survey results.
6. Support and advise on increasing the profile of the surveys in the health sector and in the communities.
7. Ensure there is Māori participation and partnership in the ongoing management of the two surveys through appropriate clinical and consumer representation.
8. Ensure that Māori data governance provisions are considered in collection, storage, use and sharing of survey data collected to align with the Te Mana Raraunga principles.
9. We must be fair, impartial, responsible & trustworthy.

---

[1] Doyle C, Lennox L, Bell D. 2013. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*, 3:e001570.doi:10.1136/bmjopen-2012-001570.

Membership and Term

The Ministry and the Commission will appoint the members and the Chair of the Governance Group. Members are appointed for two years but with the expectation the appointments will be enduring to maintain continuity.

1. The Governance Group will comprise up to 12 official members including the Chair. The Governance Group may co-opt ex-officio members for specific subject matter professional and/or technical advice as required eg the software provider for the surveys.
2. Governance Group members are not permitted to delegate their positions to others.
3. All meetings will be convened by the Chair.

Composition

The Governance Group will include the following perspectives:

1. Māori equity perspective
2. equity perspective for Pacific and other high priority populations
3. PHO and general practice perspective
4. DHB and hospital perspective
5. community and allied health perspective
6. consumer perspective
7. Ministry of Health perspective
8. Commission perspective

Skill mix required

Essential

- Māori health expertise
- understanding of health inequities and experience in working with communities and the health and social sector system to address inequities
- understanding of quality improvement, health system integration, and data and analytics
- ability to demonstrate that the views they express are expertise based and not representative based, and
- ability to work collaboratively towards the Governance Group's recommendations.

Desirable

- performance monitoring and management experience, and
- ability to balance future thinking and innovation with practicalities of operations.

Attendees – titles and names could change over time

1. National Programme Manager, System Level Measures, Ministry of Health
2. Senior Evaluation Manager, HQSC
3. Secretariat support

Ex officio member

1. Representative from the software provider of the surveys (currently this is Ipsos)

Any member of the Governance Group may tender their resignation at any time by way of letter addressed to the Chair of the Governance Group.

Duties and responsibilities of members

The Governance Group has an obligation to conduct its activities in an open and ethical manner. Members are expected to:

1. Advocate and promote increased use of survey results, guide and support implementation of equity focused quality improvement initiatives across the DHBs, PHOs, general practice teams and other health partners such as pharmacies.
2. Have a commitment to work for the greater good of the health and disability sector with a strategic national focus.
3. Attend meetings and undertake activities as independent persons responsible to the group as a whole.
4. Make every effort to attend all meetings, undertake agreed actions and be familiar with current research and evidence under discussion.
5. The Chair will delegate their role to another Governance Group member if they are unable to attend a meeting.

Meetings

Meetings will be held quarterly following the survey round. Members can either attend the meeting in person or use the video or teleconference facilities available. Decisions may be made outside of the meeting schedule should circumstances require.

Quorum

A quorum will be 50% of members.

Decision making

The Governance Group's decision making will be by consensus. Where consensus cannot be reached, a majority vote will apply.

Fees and allowances

Members who are employed by a New Zealand Public Sector Organisation including public service departments, state-owned enterprises, or crown entities are not entitled to claim fees for meeting attendance.

Attendance fees may be claimed by members not included in the above clause

The level of attendance fees will be set in accordance with the State Services Commission guidelines ("Fees and allowances for statutory and other bodies") and the Cabinet Office circular CO (12) 6. In addition to the daily rate for meetings, there will be a half day's

preparation fee. The Chair will be entitled to an allowance of two extra days per month to cover additional work undertaken.

The attendance fee for meetings and teleconferences is calculated on a pro rata basis (the hourly rate will be calculated at one seventh of the daily rate)

Actual and reasonable travel and accommodation expenses of those members entitled to attendance fees will be met by the Commission. Travel arrangements will be coordinated by the secretariat. All accommodation and air travel must be booked through the Commission's preferred provider. All members are expected to follow the Travel Policy and Guidelines, which are available on request from the secretariat. It is policy to book the least expensive airfares available. Fully-flexible fares may only be purchased with prior consent from the Commission and the reasons behind the purchase must be fully documented.

If members are unable to travel on their scheduled flights due to illness or other unavoidable reasons, they must advise the secretariat as soon as possible, to enable time to cancel or reschedule flights.

Overnight accommodation will be provided for members if there are no early morning flights available to enable the member to arrive on time to a meeting, or if the member lives at such a distance from the airport that it is unreasonable to travel on the morning of the meeting. The Commission must approve all accommodation bookings.

For those members self-driving to and from the airport and meeting venues they will be reimbursed at the rate of 77 cents per kilometre. Mileage reimbursements are not subject to withholding tax.

Management of Conflicts of Interest

Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. Proper observation of these principles will protect the Governance Group and its members and will ensure that it retains stakeholder confidence.

When members believe they have a potential conflict of interest on a subject that will prevent them from reaching an impartial decision or undertaking an activity consistent with the group's functions, they must declare that conflict of interest and withdraw themselves from the discussion and/or activity.

Members may question other members if they consider that there is a potential conflict of interest.

Communications/Confidentiality

Public statements and media comments on behalf of the group should be made through the Chairperson and in agreement with the Commission and the Ministry.

There is an understanding that within the group there may be a need for others to talk with their colleagues, however, any decisions made within the group should be identified as group decisions and particular comments not attributed to a particular person.

Each document is to be considered to be able to be shared unless marked confidential, and document distribution to be determined within each meeting. All draft documents are to be clearly marked draft.

Secretariat services

The Commission will provide secretariat services.

Financial delegation

The Governance Group does not have any financial delegation.

Te Hononga Whētuki ā-Motu
National Trauma Network

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Trauma programme – major trauma rehabilitation project
Expert Advisory Group
Terms of Reference

30 September 2020

1. Background

In March 2019 the Accident Compensation Corporation (ACC) contracted the Health Quality & Safety Commission (the Commission) to provide support to the National Trauma Network (the Network).

The Network is led by a clinical lead and programme manager, in collaboration with a wide range of stakeholders including district health boards (DHBs), ambulance services, the transport sector, and researchers. Further information can be found on the Network website: www.majortrauma.nz.

The Commission has established a trauma programme with three workstreams:

1. Quality improvement
2. Intelligence
3. Research.

The quality improvement workstream of the programme is focusing on projects in three discrete areas where expert advice and local and international examples tell us improvements in process and/ or outcome can be achieved: 1) critical haemorrhage; 2) major trauma rehabilitation; and 3) severe traumatic brain injury. The projects will be phased over the coming three financial years.

This terms of reference (TOR) document applies to the expert advisory group (EAG) for the major trauma rehabilitation project (the project).

2. Project Purpose

The purpose of this project is to reduce unwarranted variation in rehabilitation services across the country, that there is equitable access to services and that these services meet the needs of the complex cohort of major trauma patients. This project is not about developing new services. Rather it's about improving existing services and ensuring better access to services so that it is easy and timely for patients and their whānau to access the right rehabilitation services and achieve the best recovery possible.

This project aims to;

1. Understand existing trauma rehabilitation provision, access and outcomes
2. Identify potential new initiatives that will remove barriers to achieving optimal outcomes for major trauma patients

3. Work with local quality improvement project teams to implement these (via a national collaborative[1], using a consumer co-design approach[2] and supporting kaupapa Māori rehabilitation processes where possible)
4. Increase the quality improvement skills and knowledge of those who provide rehabilitation.

This will be achieved by working with the sector and experts, including patients, their whanau and stakeholders including DHBs, rehabilitation providers, community health providers such as GPs, etc.

There are three phases to the project; scoping, delivery and evaluation.

Scoping started in early 2020 and, at the time of the EAG forming is ongoing. The scoping phase involves building a picture of the current state of rehabilitation provided to people following major trauma injury. This includes understanding ACC processes, engagement with key stakeholders, discussions with consumers to understand issues from their perspective and literature review.

The scoping and implementation phases will overlap, with the implementation phase expected to start in late 2020.

Because the problems and potential solutions for major trauma rehabilitation are unknown, a national collaborative approach has been chosen to deliver the project. The national collaborative will work at two discrete but overlapping levels.

The first level has a local quality improvement (QI) and co-design focus. As part of the collaborative the national programme team will support local teams to fully understand and solve major trauma rehabilitation issues in their region using quality improvement methodologies. The second level is the national level and will, based on the outcome of the collaborative, look at issues which impact all trauma patients and ensure that solutions to these problems (identified by the local QI work) are shared nationally.

A separate project plan has been developed and should be referred to for more information about the project.

3. EAG purpose

A clinical lead, Kat Quick, has recently been appointed to the project team on a 0.4 FTE basis. She will chair the EAG.

The EAG is a 'safe' group that the project team can consult and debate with, in confidence. It will also be an 'expert' group and members have been appointed because their knowledge and

[1] A collaborative involves bringing regional project teams together for three in-person learning sessions over the course of a year. The focus of these sessions is learning from each other and recognised experts in the topic area and learning quality improvement methodologies (tools and techniques). The teams take the learning 'home' and work on their projects between each learning session – known as the action period. Support during the action periods is provided by the national project team and peers through Zoom meetings, online forums and on-site mentoring visits. The end products/ outputs are written summaries of the projects that others can learn from and replicate to resolve similar issues. (2003, *The Breakthrough Series – IHI's Collaborative Model for Achieving Breakthrough Improvement*)

[2] https://www.hqsc.govt.nz/our-programmes/partners-in-care/work-programmes/co-design/

skills are recognised in the sector. Members will be from varying parts of the major trauma rehabilitation sector/ patient pathway and in addition to representing these services, they will be expected to utilise their expertise to promote optimising consumer outcome and experience.

During the scoping phase the group will be expected to support the scoping and planning for the collaborative; it is possible that expanded or different membership will be required to support the implementation phase. The appropriateness or otherwise of the membership will be discussed at key points during the project.

The Commission and the Network leadership will support the EAG to carry out its tasks.

4. Key Tasks

The key tasks for the EAG are to:

a. **Lead** the development of the major trauma rehabilitation quality improvement implementation plan (i.e.: the plan is the major output from the scoping phase)
b. **Ensure Te Tiriti o Waitangi is prioritised** throughout and across the project to make sure services meet the needs of Māori, including considering the following:
    - Te Tiriti is central and Māori are equal or lead parties across the project(s).
    - Mechanisms are in place to ensure equitable Māori participation and/or leadership in setting priorities, resourcing, implementing and evaluating the project.
    - There is evidence of Māori values influencing and holding authority across the project. Including acknowledgement of the importance of Wairua, rongoā, healing and wellness across the project.
    - There is evidence of Māori exercising their citizenship as Māori across the project(s).
c. **Provide expert advice** on national and international best practice recommendations and identify the opportunities for improvement in major trauma rehabilitation
d. **Use** practical knowledge, expertise and consultation with key stakeholders to guide the project team to ensure that the implementation plan is both robust and implementable and will lead to improved outcomes for consumers
e. **Advise and support** the project team to undertake the national collaborative and facilitate the local collaborative teams through their projects
f. **Assist with sector engagement** by proactively supporting effective relationships across the rehabilitation sector and champion implementation at a local, regional and national level
g. **Ensure the development of the collaborative projects gives effect to the Commissions priorities**: consumer partnerships, equity, building leadership and improvement capability, and measurement (data for improvement).

5. Project governance

The EAG is responsible for providing advice to the Commission via the trauma programme team. The Commission does not need to accept this advice; where the EAG's advice is not followed the Commission will provide the group with the rationale for this.

The trauma programme team will manage the project's governance (i.e.: via the Commission's internal steering group and via the external ACC-Commission contract governance group and Network governance group).

6. Membership

The EAG comprises approximately 15-18 members, who are experts in their respective fields and/ or representatives of key stakeholders. Members should be actively engaged in the community or group/s they seek to represent. In order to ensure the group stays small enough to be efficient, members can represent multiple stakeholders or groups.

Membership will include, (but not necessarily all of or limited to) representatives of:

a. Consumers/ family/ whānau who can demonstrate their links and ability to engage widely with other consumers and or/groups
b. Māori consumers
c. Rehab providers
d. Māori rehab providers
e. DHB Allied Health
f. Trauma Nurse
g. ACC
h. Ministry of Health
i. Research
j. College of Physicians
k. National Trauma Network.

The group may also co-opt other representatives to attend meetings on an 'as required' basis, if there is a need for specialist advice that cannot be met from the existing membership, by prior approval of the Chair.

7. Responsibilities

The EAG has an obligation to conduct its activities in an open and ethical manner. Members are expected to:

a. Work co-operatively, respecting the views of others with a focus on improving health outcomes and overall system performance as well as improving the experience for health care for consumers, whānau and family
b. Work strategically contributing to a sustainable system of improvement
c. Act, as a collective group, in the best interests of quality and safety initiatives locally, regionally and nationally
d. Be a point of liaison with the relevant stakeholders, groups and colleges
e. Make every effort to attend all meetings and devote sufficient time to become familiar with the priorities of the group and the wider environment within which it operates
f. Identify and declare any conflicts of interests (via the conflict of interest register) and proactively manage any conflicts
g. Refer requests for media comments to the Chair.

8. Meetings and decision-making

a. The EAG will meet a minimum of four times per year, by Zoom or in person
b. A quorum will be a minimum of seven members
c. Where substantive decisions or recommendations are required, all members will be encouraged to contribute by email
d. Decisions will be made by consensus.

9. Secretariat

The Commission will provide the secretariat for the group. The responsibilities of the secretariat include:

a. Preparing and distributing the agenda and associated papers at least five days prior to meetings
b. Recording and circulating the minutes no later than a fortnight following the meeting date
c. Managing the organisational arrangements for meetings, including flight bookings, the provision of rooms and audio-visual equipment
d. Managing the membership appointment process.

10. Reporting and Communication

Minutes will be taken at each meeting to record the matters discussed, decisions made, agreed action points and recommendations made.

Key messages from the EAG will be communicated via the Commission and Network's communication channels and mechanisms, such as websites, newsletters and emails to key stakeholders.

Approved versions of the minutes will be published on the Commission's website.

11. Terms and conditions of appointment

The term of the membership is until end of 2021. Members will be expected to continue their participation in the EAG until the end of 2021, at which time the EAG role and make up will be reviewed.

Any member may resign at any time by advising the Chair in writing.

12. Fees

Members who are staff of a New Zealand public sector organisation including public service departments, state-owned enterprises or crown entities are not permitted to claim a fee to attend the EAG meetings.

The Commission has a fees framework that applies to members who are not included in the above groupings, where any reasonable costs incurred in attending face-to-face meetings will

be met by the Commission, including a nominal fee to cover attendance and time spent in preparation.

13. Travel

The Commission will arrange any travel required for meetings or activities associated with the group. Travel must be booked through the Commission and/ or with the Commission's approval.

14. Review

The terms of reference for the group will be reviewed as the project moves between phases and as required (i.e.: if requested by a member of the group or if the project timeframe gets extended).

Te Hononga Whētuki ā-Motu
National Trauma Network

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Terms of Reference

Serious Traumatic Brain Injury (sTBI) Expert Advisory Group

August 2021

Readers note – these terms of reference are in draft pending approval from the EAG once it is established

1. Background

In March 2019 the Accident Compensation Corporation (ACC) contracted the Commission to provide support to the National Trauma Network's (the 'Network) programme of work. The Network is led by clinical and programme directors in collaboration with a wide range of stakeholders including district health boards (DHBs), ambulance services, transport sector, and researchers. Further information can be found on the NTN website www.majortrauma.nz.

The Commission has established a trauma programme with three workstreams:
1. Quality improvement
2. Intelligence
3. Research.

This sTBI project is the third of three discrete areas of focus within the quality improvement workstream which have included critical haemorrhage and major trauma rehabilitation. The work will be undertaken until the conclusion of the contract in June 2023.

In April 2021, the Perioperative Mortality Review Committee (POMRC) made a number of system recommendations that may be relevant to the scope of this project including:
- The development of a national consensus guideline on prioritising CT scans for trauma cases.
- DHBs complete an audit of the application of the national consensus guidelines for each [Māori trauma] patient who did not get a CT scan to see if the guidelines were followed correctly.
- DHBs review all cases of sTBI who were treated at non-neurosurgical centres, focusing on the appropriateness and effectiveness of decisions made about whether to transfer the patient, and on patient outcomes. DHBs should then change their destination and interhospital transfer policies so that, where safe and feasible, all patients with a significant TBI are transferred to a neuroscience centre.
- DHBs review their protocols on transferring patients with sTBI to neurosurgical centres, with a specific focus on whether these sufficiently address inequity to achieve equitable care and case management. Trauma leads within each DHB should identify training opportunities that will support health care professionals to follow local protocols.

Given the future direction of health system reforms, this project presents an opportunity to define some national consistency in the processes that support improved and consistent acute care management for sTBI cases.

This terms of reference (TOR) document applies to the expert advisory group (EAG) for the *sTBI* project (referred to from now on as 'the project').

2. Project Purpose

The purpose of the project is to develop national consistency in the acute management of sTBI (isolated or complex) patients that ensures a reduction in mortality and secondary injury morbidity regardless of location of injury.

In alignment with the POMRC report recommendations, we believe there are three areas of focus to achieve this consistency in care which include, but may not be limited to the:

- pre-hospital management of cases and transport to requisite directive care facility,
- first receiving hospital acute management, including time to CT and factors affecting transfer to directive care facility, and reduction of secondary injury.
- neuroscience facility capacity and the benefits a multidisciplinary team with expertise in neuroscience may offer to ensure best possible outcomes for sTBI patients, including initiation of recovery and rehabilitation.

Detailed scoping and planning work for the sTBI project is about to commence. To ensure successful improvement in this area, we see a crucial role in the EAG defining the scope, providing guidance, oversight and local influence where required to this project.

3. EAG purpose

A clinical lead, Dr David Knight, has been appointed to the project team on a 0.2 FTE basis and will chair the EAG.

The EAG's purpose is to support Dr Knight to be successful in ensuring the project be appropriately scoped, implemented and, most importantly, that its findings are used to support systemic improvement in the outcomes and experiences of care for individuals and whanau of people experiencing an sTBI.

The EAG is a 'safe' group that the project team can consult and debate with, in confidence. It will also be an 'expert' group and members have been appointed because their knowledge and skills are recognised in the sector. Members will be from varying clinical professions influential in the delivery of care for sTBI patients and whanau.

In addition, membership will be extended to no less than three consumer representatives, including two Māori consumers. This partnership with consumers will enable their perspective to be presented including the identification of problems and appropriate solutions and/or considerations from their perspective.

All EAG members will be expected to recognise the unique contributions of members representing these services. They will be expected to utilise their expertise to promote optimising consumer and whānau outcome and experience.

The Commission and the Network leadership will support the EAG to carry out its tasks.

4. Key Tasks

The key tasks for the EAG are to:

a. **Provide expert advice** on the interpretation and use of findings from this project and identified opportunities for quality improvement to support patients with an sTBI and their whanau to experience the best possible outcomes of care.
b. **Ensure Te Tiriti o Waitangi is prioritised** throughout and across the project to make sure services meet the needs of Māori

c. **Use** practical knowledge and expertise to guide the project team to ensure that the project approach is both robust and implementable and will lead to improved outcomes for whānau
d. **Assist with sector engagement** by proactively supporting effective relationships across the DHBs at a local, regional, and national level

5. Project governance

The EAG is responsible for providing advice to the Commission via the project lead and trauma programme team. The Commission does not need to accept this advice; where the EAG's advice is not followed the Commission will provide the group with the rationale for this.

The trauma programme team will manage the project's governance (i.e.: via the Commission's internal steering group and via the external ACC-Commission contract governance group and Network governance group).

6. Membership

The EAG comprises approximately 10 clinical members, who are experts in their respective fields and/ or representatives of key stakeholders. There will also be approximately 8 non-clinical members comprised of consumer and whanau who will share experiences of sTBI to inform improvement opportunities. The remaining non-clinical members will provide administrative support to ensure programme and project delivery. Members should be actively connected to/ engaged with the community or group/s they seek to represent. In order to ensure the group stays small enough to be efficient, members can represent multiple stakeholders or groups.

Membership will include, (but not necessarily all or be limited to) representatives of:

a. Intensive Care - Small/medium urban hospital
b. Neurosurgical facility
c. Emergency Department Physician
d. DHB Chief Operating Officer
e. Trauma Nurse Specialist
f. Allied Health member
g. Intensive Care Paramedic
h. ACC clinical partner
i. Consumer representative (3)

This group will be joined by programme staff from the Commission's trauma programme and the National Trauma Network.

The group may also co-opt other representatives to attend meetings on an 'as required' basis, if there is a need for specialist advice that cannot be met from the existing membership, by prior approval of the Chair.

7. Responsibilities

The EAG has an obligation to conduct its activities in an open and ethical manner. Members are expected to:

a. Work co-operatively, respecting the views of others with a focus on improving health outcomes and overall system performance as well as improving the experience for health care for consumers and whānau
b. Work strategically contributing to a sustainable system of improvement
c. Act, as a collective group, in the best interests of quality and safety initiatives locally, regionally and nationally
d. Be a point of liaison with the relevant stakeholders, groups and colleges
e. Make every effort to attend all meetings and devote sufficient time to become familiar with the priorities of the group and the wider environment within which it operates
f. Identify and declare any conflicts of interests (via the conflict of interest register) and proactively manage any conflicts
g. Refer requests for media comments to the Chair

8. Meetings and decision-making

a. The EAG will meet a minimum of four times, by Zoom or in person
b. A quorum will be a minimum of five members (not from the Network or the Commission)
c. Where substantive decisions or recommendations are required, all members will be encouraged to contribute by email
d. Decisions will be made by consensus.

9. Secretariat

The Commission will provide the secretariat for the group. The responsibilities of the secretariat include:

a. Preparing and distributing the agenda and associated papers at least five days prior to meetings
b. Recording and circulating the minutes no later than a fortnight following the meeting date
c. Managing the organisational arrangements for meetings, including flight bookings, the provision of rooms and audio-visual equipment
d. Managing the membership appointment process

10. Reporting and Communication

Minutes will be taken at each meeting to record the matters discussed, decisions made, agreed action points and recommendations made.

Key messages from the EAG will be communicated via the Commission and Network's communication channels and mechanisms, such as websites, newsletters and emails to key stakeholders.

Approved versions of the minutes will be published on the Commission's website.

11. Terms and conditions of appointment

The term of the membership is until end of December 2022. Members will be expected to continue their participation in the EAG until the end of December 2022, at which time the EAG role and make up will be reviewed.

Any member may resign at any time by advising the Chair in writing.

12. Fees

Members who are staff of a New Zealand public sector organisation including public service departments, state-owned enterprises or crown entities are not permitted to claim a fee to attend the EAG meetings.

The Commission has a fees framework that applies to members who are not included in the above groupings, where any reasonable costs incurred in attending face-to-face meetings will be met by the Commission, including a nominal fee to cover attendance and time spent in preparation.

13. Travel

The Commission will arrange any travel required for meetings or activities associated with the group. Travel must be booked through the Commission and/ or with the Commission's approval.

14. Review

The terms of reference for the group will be reviewed as the project moves between phases and as required (i.e.: if requested by a member of the group or if the project timeframe gets extended).

Te Hononga Whētuki ā-Motu
National Trauma Network

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Terms of Reference

Serious Traumatic Brain Injury (sTBI) Expert Advisory Group

August 2021

Readers note – these terms of reference are in draft pending approval from the EAG once it is established

1. Background

In March 2019 the Accident Compensation Corporation (ACC) contracted the Commission to provide support to the National Trauma Network's (the 'Network) programme of work. The Network is led by clinical and programme directors in collaboration with a wide range of stakeholders including district health boards (DHBs), ambulance services, transport sector, and researchers. Further information can be found on the NTN website www.majortrauma.nz.

The Commission has established a trauma programme with three workstreams:

1. Quality improvement
2. Intelligence
3. Research.

This sTBI project is the third of three discrete areas of focus within the quality improvement workstream which have included critical haemorrhage and major trauma rehabilitation. The work will be undertaken until the conclusion of the contract in June 2023.

In April 2021, the Perioperative Mortality Review Committee (POMRC) made a number of system recommendations that may be relevant to the scope of this project including:

- The development of a national consensus guideline on prioritising CT scans for trauma cases.
- DHBs complete an audit of the application of the national consensus guidelines for each [Māori trauma] patient who did not get a CT scan to see if the guidelines were followed correctly.
- DHBs review all cases of sTBI who were treated at non-neurosurgical centres, focusing on the appropriateness and effectiveness of decisions made about whether to transfer the patient, and on patient outcomes. DHBs should then change their destination and interhospital transfer policies so that, where safe and feasible, all patients with a significant TBI are transferred to a neuroscience centre.
- DHBs review their protocols on transferring patients with sTBI to neurosurgical centres, with a specific focus on whether these sufficiently address inequity to achieve equitable care and case management. Trauma leads within each DHB should identify training opportunities that will support health care professionals to follow local protocols.

Given the future direction of health system reforms, this project presents an opportunity to define some national consistency in the processes that support improved and consistent acute care management for sTBI cases.

This terms of reference (TOR) document applies to the expert advisory group (EAG) for the *sTBI* project (referred to from now on as 'the project').

2. Project Purpose

The purpose of the project is to develop national consistency in the acute management of sTBI (isolated or complex) patients that ensures a reduction in mortality and secondary injury morbidity regardless of location of injury.

In alignment with the POMRC report recommendations, we believe there are three areas of focus to achieve this consistency in care which include, but may not be limited to the:

- pre-hospital management of cases and transport to requisite directive care facility,
- first receiving hospital acute management, including time to CT and factors affecting transfer to directive care facility, and reduction of secondary injury.
- neuroscience facility capacity and the benefits a multidisciplinary team with expertise in neuroscience may offer to ensure best possible outcomes for sTBI patients, including initiation of recovery and rehabilitation.

Detailed scoping and planning work for the sTBI project is about to commence. To ensure successful improvement in this area, we see a crucial role in the EAG defining the scope, providing guidance, oversight and local influence where required to this project.

3. EAG purpose

A clinical lead, Dr David Knight, has been appointed to the project team on a 0.2 FTE basis and will chair the EAG.

The EAG's purpose is to support Dr Knight to be successful in ensuring the project be appropriately scoped, implemented and, most importantly, that its findings are used to support systemic improvement in the outcomes and experiences of care for individuals and whanau of people experiencing an sTBI.

The EAG is a 'safe' group that the project team can consult and debate with, in confidence. It will also be an 'expert' group and members have been appointed because their knowledge and skills are recognised in the sector. Members will be from varying clinical professions influential in the delivery of care for sTBI patients and whanau.

In addition, membership will be extended to no less than three consumer representatives, including two Māori consumers. This partnership with consumers will enable their perspective to be presented including the identification of problems and appropriate solutions and/or considerations from their perspective.

All EAG members will be expected to recognise the unique contributions of members representing these services. They will be expected to utilise their expertise to promote optimising consumer and whānau outcome and experience.

The Commission and the Network leadership will support the EAG to carry out its tasks.

4. Key Tasks

The key tasks for the EAG are to:

a. **Provide expert advice** on the interpretation and use of findings from this project and identified opportunities for quality improvement to support patients with an sTBI and their whanau to experience the best possible outcomes of care.
b. **Ensure Te Tiriti o Waitangi is prioritised** throughout and across the project to make sure services meet the needs of Māori

c. **Use** practical knowledge and expertise to guide the project team to ensure that the project approach is both robust and implementable and will lead to improved outcomes for whānau
d. **Assist with sector engagement** by proactively supporting effective relationships across the DHBs at a local, regional, and national level

5. Project governance

The EAG is responsible for providing advice to the Commission via the project lead and trauma programme team. The Commission does not need to accept this advice; where the EAG's advice is not followed the Commission will provide the group with the rationale for this.

The trauma programme team will manage the project's governance (i.e.: via the Commission's internal steering group and via the external ACC-Commission contract governance group and Network governance group).

6. Membership

The EAG comprises approximately 10 clinical members, who are experts in their respective fields and/ or representatives of key stakeholders. There will also be approximately 8 non-clinical members comprised of consumer and whanau who will share experiences of sTBI to inform improvement opportunities. The remaining non-clinical members will provide administrative support to ensure programme and project delivery. Members should be actively connected to/ engaged with the community or group/s they seek to represent. In order to ensure the group stays small enough to be efficient, members can represent multiple stakeholders or groups.

Membership will include, (but not necessarily all or be limited to) representatives of:

a. Intensive Care - Small/medium urban hospital
b. Neurosurgical facility
c. Emergency Department Physician
d. DHB Chief Operating Officer
e. Trauma Nurse Specialist
f. Allied Health member
g. Intensive Care Paramedic
h. ACC clinical partner
i. Consumer representative (3)

This group will be joined by programme staff from the Commission's trauma programme and the National Trauma Network.

The group may also co-opt other representatives to attend meetings on an 'as required' basis, if there is a need for specialist advice that cannot be met from the existing membership, by prior approval of the Chair.

7. Responsibilities

The EAG has an obligation to conduct its activities in an open and ethical manner. Members are expected to:

a. Work co-operatively, respecting the views of others with a focus on improving health outcomes and overall system performance as well as improving the experience for health care for consumers and whānau
b. Work strategically contributing to a sustainable system of improvement
c. Act, as a collective group, in the best interests of quality and safety initiatives locally, regionally and nationally
d. Be a point of liaison with the relevant stakeholders, groups and colleges
e. Make every effort to attend all meetings and devote sufficient time to become familiar with the priorities of the group and the wider environment within which it operates
f. Identify and declare any conflicts of interests (via the conflict of interest register) and proactively manage any conflicts
g. Refer requests for media comments to the Chair

8. Meetings and decision-making

a. The EAG will meet a minimum of four times, by Zoom or in person
b. A quorum will be a minimum of five members (not from the Network or the Commission)
c. Where substantive decisions or recommendations are required, all members will be encouraged to contribute by email
d. Decisions will be made by consensus.

9. Secretariat

The Commission will provide the secretariat for the group. The responsibilities of the secretariat include:

a. Preparing and distributing the agenda and associated papers at least five days prior to meetings
b. Recording and circulating the minutes no later than a fortnight following the meeting date
c. Managing the organisational arrangements for meetings, including flight bookings, the provision of rooms and audio-visual equipment
d. Managing the membership appointment process

10. Reporting and Communication

Minutes will be taken at each meeting to record the matters discussed, decisions made, agreed action points and recommendations made.

Key messages from the EAG will be communicated via the Commission and Network's communication channels and mechanisms, such as websites, newsletters and emails to key stakeholders.

Approved versions of the minutes will be published on the Commission's website.

11. Terms and conditions of appointment

The term of the membership is until end of December 2022. Members will be expected to continue their participation in the EAG until the end of December 2022, at which time the EAG role and make up will be reviewed.

Any member may resign at any time by advising the Chair in writing.

12. Fees

Members who are staff of a New Zealand public sector organisation including public service departments, state-owned enterprises or crown entities are not permitted to claim a fee to attend the EAG meetings.

The Commission has a fees framework that applies to members who are not included in the above groupings, where any reasonable costs incurred in attending face-to-face meetings will be met by the Commission, including a nominal fee to cover attendance and time spent in preparation.

13. Travel

The Commission will arrange any travel required for meetings or activities associated with the group. Travel must be booked through the Commission and/ or with the Commission's approval.

14. Review

The terms of reference for the group will be reviewed as the project moves between phases and as required (i.e.: if requested by a member of the group or if the project timeframe gets extended).

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

Terms of Reference
Te Kāhui Mahi Ngātahi /Consumer Advisory Group (CAG) of the Health Quality & Safety Commission

1. Establishment

1.1. The Te Kāhui Mahi Ngātahi / Consumer Advisory Group (CAG) is established by the Health Quality & Safety Commission Board (the Board).

2. Te Tiriti o Waitangi

2.1. Throughout their work, the Te Kāhui Mahi Ngātahi / Consumer Advisory Group recognises its obligations to iwi and Māori in line with the Articles of Te Tiriti o Waitangi including:

- **Kawanatanga** - partnering and shared decision making
- **Tino Rangatiratanga** - self-determination
- **Oritetanga** - equity for Tangata whenua
- **Wairuatanga** - upholding values, belief systems

2.2. The Te Kāhui Mahi Ngātahi / CAG recognise that iwi and Māori have their own health aspirations, priorities, goals, and ways of working

2.3. The Te Kāhui Mahi Ngātahi / CAG will engage in co-design with iwi and Māori, Te Rōpū Advisory Group, and other key groups to support the achievement of Māori health equity

2.4. The Te Kāhui Mahi Ngātahi / CAG is committed to improving health systems and practice through the appropriate use of mātauranga Māori.

3. Functions

3.1. The functions of Te Kāhui Mahi Ngātahi /CAG are to:

3.1.1 advise the Board and Chief Executive on strategic issues, priorities and frameworks (this includes advice from a consumer, whanau, hapu and iwi perspective, including a consumer view on health quality and safety)

3.1.2 identify key issues for consumers, whanau, hapu and iwi and organisations such as:

- responsiveness of existing providers to patients, consumers, families
- the provision of culturally safe services to whānau, hapu and iwi
- strategic direction of the Commission's programmes for consumers, whānau, hapu and iwi
- Culturally appropriate process for examining quality and safety.

3.1.3 engage and work with iwi and Māori, clinical advisory groups and international groups as requested by the Board, Chief Executive or Director, Consumer Engagement

3.1.4 engage in the co-design with the Commission's Consumer Network/s and wider health and disability sector on the Commission's activities and

interests as requested by the Board, Chief Executive or Director, Consumer Engagement.

4. Accountability

4.1. The Te Kāhui Mahi Ngātahi / CAG is accountable to the Board

4.2. The Board may specifically delegate to the Te Kāhui Mahi Ngātahi / CAG the authority to make decisions and take actions on its behalf in relation to certain matters

4.3. The Te Kāhui Mahi Ngātahi / CAG may only give advice or release information to other parties under authority of the Board, Chief Executive or Director, Consumer Engagement

4.4. Meetings should comply with the same statutory and best practice requirements that apply to Board meetings.

5. Te Kāhui Mahi Ngātahi / Consumer Advisory Group membership

5.1 The Te Kāhui Mahi Ngātahi / CAG will consist of eight members who are networked, known, respected and knowledgeable. They will have a recognised range of skills and knowledge in health from a consumer perspective. They will be people who are acknowledged by their peers as having the ability to represent patients, consumers, families, and whānau to the Commission and to assist the Commission in its deliberations and commitment to consumer engagement. They will come from a range of Tangata whenua experiences, occupational, other ethnicities, and professional backgrounds

5.2 One member of the Te Kāhui Mahi Ngātahi / CAG will also be a member of the Consumer Network Group

5.3 The Board of the Commission will appoint the Chairperson and members of the Te Kāhui Mahi Ngātahi / CAG

5.4 Terms of appointment will be for an initial period of three years with the possibility of extension up to a maximum of six years. In order to maintain continuity, any re-appointment for a subsequent term may be staggered.

6. Fees and allowances

6.1 Members of the Te Kāhui Mahi Ngātahi / CAG who are employed by a New Zealand Public Sector Organisation including public service departments, state-owned enterprises, or crown entities are not entitled to claim fees for meeting attendance

6.2 The level of attendance fees will be set in accordance with the State Services Commission's framework for fees for statutory bodies (2006) and the Cabinet Office circular CO (09) 5. In addition to the daily rate for meetings, there will be a half day's preparation fee. The Chair will be entitled to an allowance of two extra days per month to cover additional work undertaken

6.3 The attendance fee for meetings and teleconferences is calculated on a pro rata basis (the hourly rate will be calculated at one eighth of the daily rate)

6.4 Actual and reasonable travel and accommodation expenses of all members will be met by the Commission.

7. Quorum

7.1 Five out of eight members must be present to reach quorum.

8. Frequency of meetings

8.1 the Te Kāhui Mahi Ngātahi / CAG will meet four to five times a year and as required on specific issues. These will be a mix of in-person and via Zoom.

9. Reporting

9.1 All members of the Te Kāhui Mahi Ngātahi / CAG will attend a Board meeting in person at least once a year at an arranged time to discuss key issues

9.2 The Te Kāhui Mahi Ngātahi / CAG may, at any time, report to the Board, Chief Executive and Director, Consumer Engagement any other matter it deems of sufficient importance

9.3 Reporting may be written and/or in person.

10. Consumer Advisory Group Support

10.1 The Partners in Care team will be the primary contact and support for the Te Kāhui Mahi Ngātahi / CAG. This may include ensuring that the agenda and supporting papers are circulated and taking minutes. If additional support is required to carry out its functions, this will be agreed with the Chief Executive.

11. Conflicts of interest

11.1 Members must declare any conflicts of interest at the start of each meeting or before discussion of the relevant agenda item or topic. Details of any conflicts of interest should be appropriately recorded in the minutes

11.2 Where any member is deemed to have a real, or perceived, conflict of interest at a meeting, it may be appropriate that they are excused from deliberations on the issue where the conflict of interest exists.

12. Standards of Integrity & Conduct

12.1 All members are expected to adhere to the Standards of Integrity and Conduct set by the State Services Commissioner as per the State Sector Act 1988, section 57. This outlines the four main pillars of being fair, impartial, responsible and trustworthy. Any major breach of these, after investigation, may result in the termination of the appointment.

13. Review of Te Kāhui Mahi Ngātahi / Consumer Advisory Group Terms of Reference

13.1 This Terms of Reference and the functions of the Te Kāhui Mahi Ngātahi / CAG will be reviewed every two years from the date of approval (i.e. next update September 2023), unless required beforehand.

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

Terms of Reference

Revised August 2019

Consumer Network: Whakapere – Whakamarama – Whakamana (Engagement, Enlightenment, Empowerment)

Professor Sir Mason Durie

1. Background/Introduction

1.1 The Health Quality Safety Commission (the Commission) is a Crown entity established under the New Zealand Public Health & Disability Act 2000 to ensure all New Zealanders receive the best health and disability care within our available resources.

1.2 The Commission recognises the different levels of involvement that consumers have with the health, disability and aged care sectors. These levels include the partnerships forged with providers about their own individual and family needs, the delivery of services, setting priorities, policy development, planning and governance.

1.3 The Commission established the partners in care programme to foster strategic partnerships and improve consumer engagement across health and disability services and relevant agencies in New Zealand. The Commission's Statement of Intent 2017-2020 focuses on four strategic themes, with the partners in care programme underpinning all work programmes and projects.

1.4 To support the implementation of the work programme, a consumer network was established in 2012, so consumers can easily communicate with the Commission and vice versa. Spreading these networks will involve collaborations within existing consumer groups, health providers, government and non-government agencies. Members of the Consumer Network are required to have well established networks and the ability to consult widely within their constituent groups.

2. Purpose

2.1 The purpose of the Consumer Network is to support the Commission to promote strategic partnerships and effective consumer engagement across the health and disability sector, leading to improved experiences of consumers and their family/whānau who use these services.

3. Functions of the Consumer Network

3.1 Provide direction and support for the partners in care work programme, from a consumer's perspective, or that which represents consumer's interests.

3.2 Act as a conduit between the Commission and consumer groups, to seek and provide information and feedback as relevant.

3.3 Build and maintain networks in consumer/provider/government health and disability sectors, and proactively promote consumer engagement within these networks.

3.4 Attend meetings, seminars, conferences and other events paid for by the Commission, provide written and/or verbal reports about attendance, and give presentations at such events as required.

3.5 Review material from the Commission's work programmes and provide feedback and/or advice as required.

3.6 Provide guidance about strategies to enhance collaborative relationships between consumer groups, service providers and government agencies.

3.7 Discuss and provide independent advice to the Commission about building and promoting leadership capability for service providers and consumers in health and disability services.

3.8 Provide training to new consumer representatives on their role, as required.

3.9 Provide advice from time to time on other areas as agreed by the Consumer Network and the Commission.

4. Consumer Network membership

4.1 The Consumer Network will comprise members who collectively have wide knowledge and experience in a variety of health and disability consumer networks. This may be through their own experience as a health consumer, as a family/whānau member of a health consumer, or as an appointed representative of a specific consumer group.

4.2 Where possible the group will include male/female balance, and represent and reflect cultural, age and geographic diversity, and address equity for other groups such as rainbow representation (gender and sexual orientation diversity) and people with disabilities.

4.3 The group will include at least two Māori representatives.

4.4 Membership will consist of up to 14 members (excluding the Chair). Their skills and experience will include:

4.4.1 Well established networks in consumer/provider/government health and disability sectors and the proactive regular use of these networks.

4.4.2 Experience in the health and disability sector as a consumer, or as a family/whānau member of a consumer, or as an appointed representative of a specific consumer group.

4.4.3 The ability to network with consumer, provider, non-government and government groups.

4.4.4 A good understanding of the health quality and safety context in the New Zealand health and disability sector.

4.4.5 Proven leadership skills.

4.4.6 The ability to act as a champion for the partners in care programme and influence its impact across the sector.

4.4.7 Being a team player with good communication skills.

4.5 The Commission will chair meetings of the Network. Other team members from the Commission will also attend meetings as required.

4.6 The Commission will provide administrative and analytical support to the network.

5. Consumer Advisory Group to the Board (CAG)

5.1 One member of the Consumer Network will also be an active member of the Commission's Consumer Advisory Group to the Board (CAG), as required by the Board.

5.2 Consumer Network members will engage with the CAG, including meeting annually (or more frequently as needed) to discuss important national issues, and how the Consumer Network will liaise and work in partnership with the CAG.

6. Term of appointment

6.1 The Term of Appointment will be for two or three years (to allow for continuity) with an option for renewal for one further term. To ensure continuity, it is desirable that half of the group will be appointed for two years, the other half for three years. The demographics and skill mix of the group will guide this process.

6.2 If a vacancy occurs, the Commission will seek input from the Consumer Network on specific skills and knowledge required, prior to making an appointment.

6.3 Any member may resign at any time by advising the Chair in writing.

6.4 Membership may be terminated by the Commission for the following reasons:

6.4.1 Non-attendance at three consecutive meetings without reasonable cause.

6.4.2 Non-participation in external activities related to Commission consumer engagement priorities without reasonable cause.

6.4.3 Failure to optimise the members' networks for the benefit of Commission consumer engagement priorities, where it is within the member's sphere of influence to do so.

6.4.4 All members are expected to adhere to the Standards of Integrity and conduct set by the State Services Commissioner as per the State Sector Act 1988, section 57. This outlines the four main pillars of being fair, impartial, responsible and trustworthy. Any major breach of these, after investigation, may result in the termination of the appointment.

7. Expectations of members of the Consumer Network

7.1 The Consumer Network has an obligation to conduct its activities in an open and ethical manner.

7.2 The Consumer Network is a forum to provide information to and from the Commission's partners in care programme. Members do not represent the views of the Commission and will not promote themselves as members of the Commission.

7.3 Members are expected to:

7.3.1 Have a commitment to improving quality and safety of health care for consumers and their families/whānau.

7.3.2 Represent their regional, sector and consumer interests and groups, where possible.

7.3.3 Make every effort to attend all meetings, devote sufficient time to preparing for meetings (including reading relevant materials) and become familiar with affairs of the group and the wider environment in which it operates.

7.3.4 Become familiar with and use Loomio as a method of regular engagement and communication with consumer representatives (including Consumer Network and CAG members). This will include distributing information to their communities and providing feedback.

7.3.5 Refer requests for media comment to the Chair.

8. Guiding values and principles

8.1 **Respect**: Consumers and providers respect and value each other's expertise and experience. This value encompasses the following rights (and provider duties and obligations) which are set out in the *Code of Health and Disability Services Consumers' Rights 1996*:

- **Right 1** – the right to be treated with respect.
- **Right 2** – the right to freedom from discrimination, coercion, harassment and exploitation.
- **Right 3** – the right to dignity and independence.
- **Right 8** – the right to support.
- **Right 10** – the right to complain.

8.2 **Honesty**: Consumers and providers are open and truthful with each other. This encompasses the following consumer rights (and provider duties and obligations) which are set out in the *Code of Health and Disability Services Consumers' Rights*:

- **Right 5** – the right to effective communication.
- **Right 6** – the right to be fully informed.
- **Right 7** – the right to make an informed choice and give informed consent.

8.3 **Collaboration**: Recognition that there is an inter-dependent partnership. When consumers and providers work together, then service quality, consumer safety and systems can be improved. This applies to policy and programme development, implementation and evaluation; health/disability and aged care facility design; professional education; as well as in the delivery of care:

- **Right 4** – the right to services of an appropriate standard.
- **Right 8** – the right to support.
- **Right 9** – the rights in respect of teaching and research.

8.4 **Treaty of Waitangi**: The group will operate in accordance with the Te Tiriti o Waitangi (The Treaty of Waitangi) principles of partnership, participation and protection. The group will keep Te Rōpū Māori (the Commission's Māori Advisory Group) updated and informed of consumer network activities.

9. Fees and allowances

9.1 Members who are staff of a New Zealand public sector organisation including public service departments, state-owned enterprises or Crown entities, are not permitted to claim fees to attend Consumer Network meetings. However, reasonable expenses for all Consumer Network members will be met by the Commission (eg travel, parking, child-care, accommodation).

9.2 Group members who are not from the public sector will be paid a standard fee of $330.00 (GST excl) per one-day meeting, and an additional 0.5 day for pre-reading of agenda documents and preparation as necessary.

10. Quorum

10.1 The quorum will be 50 percent of the total number of current members.

11. Meeting venue and time

11.1 Meetings will be held three to four times a year, with teleconferences in between, depending on requirements.

11.2 All meetings will be held in Wellington or Auckland at the Commission's premises. The usual time for meetings to be held is from 9.30am to 3.30pm.

12. Reporting

12.1 The Chair will provide the Commission's Chief Executive with regular updates on the operation and activities of the Consumer Network during the year. Reporting may be in writing and/or in person.

12.2 Consumer Network members will provide a report of their contributions to the group's activities between each meeting. This report will be tabled at each meeting.

13. Conflicts of interest and confidentiality

13.1 Members will sign a conflict of interest register when joining the Consumer Network and identify where they believe they may have a potential or existing conflict of interest. This obligation is ongoing and will be re-visited at each meeting.

13.2 Members will identify any potential or existing conflict of interest before discussion of a particular issue. The Consumer Network will then decide what part the member may take in any ensuing discussion.

13.3 Members will treat information held by or about the Commission as confidential and proprietary to the Commission. Information should only be disclosed beyond the Consumer Network that is necessary for the Consumer Network to fulfil its role.

13.4 The Consumer Network and its members will comply with protocols of the Commission on the use, storage, return and destruction of any information of any nature whatsoever obtained, as a consequence of undertaking advisory functions.

13.5 The Commission holds copyright/intellectual property rights on any written outputs of the Consumer Network.

14. Review of Consumer Network Terms of Reference

14.1 This Terms of Reference and the functions of the Consumer Network will be reviewed two years from the date of the last document's approval and updated as necessary.

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

The mental health and addiction quality improvement programme
Terms of reference for the Consumer Advisory Group-March 2020

1. Purpose

The purpose of the mental health and addiction (MHA) quality improvement programme *Consumer Advisory Group (CAG)* is to provide *quality advice from the consumer/ tāngata whai ora, family and whānau perspective* and to support the Health Quality & Safety Commission (the Commission) to contribute to the national MHA quality improvement programme. *The group* will inform all aspects of the MHA quality improvement programme (the programme) for consumers/ tāngata whai ora, family and whānau, contributing to achieving the MHA sector's aim, to improve the quality and safety of MHA services and the Commission's overarching vision, namely:

New Zealand will have a sustainable, world-class, patient-centered health care and disability support system, which will attract and retain its workforce through its commitment to continually improve health quality and deliver equitable and sustainable care.

A key task within the work programme of *the group* will be to advise the programme's emerging quality improvement project plans *from the consumer/ tāngata whai ora, family and whānau perspective.*

The key purpose of this CAG is to:

a. provide the sector with *quality consumer/ tāngata whai ora, family and whānau health* ***advice*** in the development and implementation of the MHA quality improvement programme and achieving improved outcomes and quality of support and care.
b. proactively support effective **relationships** between the *consumer/ tāngata whai ora, family* and whānau groups and the Commission
c. provide *appropriate consumer/ tāngata whai ora, family* and whānau advice and make **recommendations** to the Commission that are informed by evidence and international, national and local knowledge, and focused on strategies to improve mental health and addiction services for consumers/ tāngata whai ora, families and their whānau
d. **share** information that supports a national approach to MHA quality and safety improvements for *consumers/ tāngata whai ora, families and their whānau*
e. **foster** an integrated approach to improving the quality and safety of health and disability services with other Commission programmes.

The group will provide guidance on the mental health and addiction work programme consistent with evidence.

The group's priorities are to:

a. support *consumer/tāngata whai ora, family and whānau, wider* sector engagement and raise awareness of the programme
b. advise on the development of effective *interventions for consumers/ tāngata whai ora, family and whānau* within the programme
c. ensure the programme gives effect to the Commission's priorities: Increasing *consumer/ tāngata whai ora, family and whānau* experience, improving health equity, reducing harm and mortality, and reducing unwarranted variation.

2. Membership

The Chair will be the Commission's National Consumer, Family and Whānau Engagement Advisor, MHA Quality Improvement Programme.
The minute taker will be the contracted consumer, or family and whānau secretariat, and/or an HQSC staff member.

The membership will comprise experts *skilled* in their respective fields, and/or who are actively engaged in the community or group/s they seek to represent. Membership will include, but is not limited to, representatives of:

a. Consumers, family and whānau who may be employed as clinicians from primary and secondary care settings including DHBs/ NGOs and PHOs
b. People with expertise and *experience in bringing consumer/ tāngata whai ora, family and whānau* perspectives to Mental Health and Addiction, co-design and service quality improvement, including those consumers family and whānau with academic backgrounds
c. *Consumers/ tāngata whai ora* who can demonstrate their links to consumer groups and who will engage widely with other consumers of secondary care services
d. Consumers/tāngata whai ora, family and whānau employed in positions with professional bodies such as Te Pou
e. Consumers/tāngata whai ora, family and whānau who may be employed in advisory positions by DHBs/ NGOs/ PHOs
f. *Family and whānau members* who can demonstrate their links to MHA family and whānau groups and will engage widely with other family and whānau groups

There is no set number of members, although it is expected that the group will not exceed 6, excluding the Chair. Additional members may be co-opted to provide specialist advice as and when required.

3. Responsibilities

The group has an obligation to conduct its activities in an open and ethical manner. Members are expected to work in partnership with the Commission, and to:

a. work strategically contributing to a sustainable system of improvement
b. work co-operatively, respecting the views of others with a focus on improving health outcomes and overall system performance as well as improving the experience of health care for *consumers/ tāngata whai ora, family and whānau*
c. act, as a collective group, in the best interests of quality and safety initiatives locally, regionally and nationally
d. be a point of liaison with the relevant local, regional and national groups
e. make every effort to attend all meetings and devote sufficient time to become familiar with the priorities of the programme and the wider environment within which the CAG operates
f. make every effort to support and attend the events related to the programme and its projects
g. identify and declare any conflicts of interests and proactively manage any conflicts
h. refer requests for media comments to the Chair or the Commission's Chief Executive.

4. Meetings and Decision-making

Recommendations to the Commission will be made at *the group* meetings and ratified through the Chair. Decisions will be made by consensus.

a. *The group* will meet a minimum of quarterly, by tele/videoconference or face to face
b. A quorum will be a minimum of four members
c. Where substantive decisions or recommendations are required, all members will be encouraged to contribute by email.

5. Secretariat

The group will have a secretariat provided by the Commission, this may be a staff member or a contractor (or a combination of the two). The responsibilities of the secretariat include:

a. preparing and distributing the agenda and associated papers at least five days prior to meetings
b. receive and circulating the minutes no later than a fortnight following the meeting date.
c. managing the organisational arrangements for meetings, including flight bookings, the provision of rooms, set up and pack down, catering and audio-visual equipment.

6. Reporting and Communication

Key messages from the *group* will be communicated via the Chair, the Commission's communication networks and mechanisms such as the website, and e-digest newsletter.

A Communication plan for the programme is being developed and implemented and this will include how communications will recognise the consumer, family and whānau voice

7. Standards of Integrity & Conduct

All members are expected to adhere to the Standards of Integrity and Conduct set by the State Services Commissioner as per the State Sector Act 1988, section 57.

This outlines the four main pillars of being fair, impartial, responsible and trustworthy.
Any major breach of these, after investigation, may result in the termination of the appointment.

8. Terms and Conditions of Appointment

Members will be invited to join *the group* following a nomination. Terms of appointment are for a maximum of three years with the ability to re-appoint for a further term.

Any member may at any time resign by advising the Chair in writing.

9. Fees

Members who are staff of a New Zealand public sector organisation including public service departments, state-owned enterprises or crown entities are not permitted to claim a fee to attend the CAG meetings. The Commission has a fees framework that applies to members who are not included in the above groupings. Remuneration is in line with the State Services Commission policy for payment of advisory group members. The Commission will pay for the cost of travel to and from the meeting, provide a taxi card, provide one-night accommodation if required, meals, and a daily rate of $330, plus preparation time where appropriate. Preparation time will generally be half a day for every full meeting day, but only if there are several papers to be read in preparation for a meeting, outwith the Agenda and Minutes.

The terms of reference for the group will be reviewed and updated as required; after two years.

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

The mental health and addiction quality improvement programme

Terms of reference for the Māori Advisory Group

1. Purpose

The purpose of the mental health and addiction (MHA) quality improvement programme *Māori Advisory Group (MAG)* is to provide *quality advice from the Māori perspective* and support the Health Quality & Safety Commission (the Commission) *develop and implement* the national MHA quality improvement programme. *The group will work with identified aspects of the MHA* quality improvement programme (the programme) and contribute to achieving the MHA sector's aim to improve the quality and safety of MHA services and the Commission's overarching vision, namely:

New Zealand will have a sustainable, world-class, patient-centered health care and disability support system, which will attract and retain its workforce through its commitment to continually improve health quality, and deliver equitable and sustainable care.

A key task within the work programme of *the group* will be to advise the programme's emerging quality improvement project plans *from the Māori perspective.*

The key purpose of this MAG is to:

a. demonstrate the **principles of Te Tiriti o Waitangi/ the Treaty of Waitangi** through the prioritisation of a Māori world view in the mental health and addiction quality improvement programme
b. provide the sector with *quality kaupapa Māori* ***health advice*** in the selection, development and implementation and evaluation of the MHA quality improvement programme and achieving improved equitable outcomes and beyond.
c. proactively support effective **relationships** between the *Māori MHA* sector and the Commission
d. **provide *a mechanism for the MHA Programme to ensure it is informed about and able to incorporate*** evidence and international, national and local knowledge, and focused on strategies to improve mental health and addiction services for Māori whaiora and their whānau
e. **share** information that supports a national approach to MHA quality and safety improvements for *Maori whaiora and their whānau*
f. **foster** an integrated approach to improving the quality and safety of health and disability services with other Commission programmes.

The group will provide guidance on the mental health and addiction work programme consistent with evidence from Maori bodies of knowledge 9experience, tikanga, purakau, karakia, waiata and literature), and other bodies of knowledge.

The group's priorities are to:

a. support *Māori and wider* sector engagement and raise awareness of the programme
b. advise the development of effective *interventions for Māori* within the programme
c. ensure the programme gives effect to the Commission's priorities: Increasing *whaiora and whānau* experience, improving health equity, reducing harm and mortality, and reducing unwarranted variation.

2. Membership

The Chair will be appointed by the Commission. (*Kaumatua led decision)*

The membership will comprise those who identify as Māori and are experts *skilled* in their respective fields, and/or who are actively engaged in the community or group/s they seek to represent. Membership will include, but is not limited to, representatives of:

a. Clinicians from primary and secondary care settings,
b. People with expertise and *experience in Māori* mental health and addiction and quality improvement including those with academic backgrounds
c. *Whaiora* who can demonstrate their links to consumer groups and will engage widely with other consumers of secondary care services
d. Professional colleges and professional bodies
e. District Health Boards
f. Non-government organisations
g. Iwi providers
h. Whānau members who can demonstrate their links to whānau groups and will engage widely with other whānau groups

There is no set number of members. Additional members may be co-opted to provide specialist advice as and when required. Members may serve a two-year term.

3. Responsibilities

The MAG has an obligation to conduct its activities in an open and ethical manner. Members are expected to work in partnership with the Commission, and to:

a. work strategically contributing to a sustainable system of improvement
b. work co-operatively, respecting the views of others with a focus on improving health outcomes and overall system performance as well as improving the experience of health care for *whaiora and their whānau*
c. act, as a collective group, in the best interests of quality and safety initiatives locally, regionally and nationally
d. be a point of liaison with the relevant Maori personnel on regional groups and colleges
e. make every effort to attend all meetings and devote sufficient time to become familiar with the priorities of the group and the wider environment within which it operates
f. identify and declare any conflicts of interests and proactively manage any conflicts
g. refer requests for media comments to the Chair or the Commission's Chief Executive.

4. Meetings and Decision-making

Recommendations to the Commission will be made at *the MAG* meetings and ratified through the Chair. Decisions will be made by consensus.

a. *The MAG* will meet a minimum of quarterly, by tele/videoconference or face to face
b. A quorum will be a minimum of five members
c. Where substantive decisions or recommendations are required, all members will be encouraged to contribute by email.

5. Secretariat

The MAG will have a secretariat provided by the Commission. The responsibilities of the secretariat include:

a. preparing and distributing the agenda and associated papers at least five days prior to meetings
b. recording and circulating the minutes no later than a fortnight following the meeting date
c. managing the organisational arrangements for meetings, including flight bookings, the provision of rooms and audio-visual equipment

6. Reporting and Communication

Key messages from the *MAG* will be communicated via the Commission's communication networks and mechanisms such as the website, and e-digest newsletter.

A Communication plan for the programme will be developed and implemented.

7. Terms and Conditions of Appointment

Members will be invited to join *the group* following a nomination. Terms of appointment are for a maximum of two years with the ability to re-appoint for a further term.

Any member may at any time resign by advising the Chair in writing.

8. Fees

Members who are staff of a New Zealand public sector organisation including public service departments, state-owned enterprises or crown entities are not permitted to claim a fee to attend the MAG meetings. The Commission has a fees framework that applies to members who are not included in the above groupings.

The terms of reference for the group will be reviewed and updated in six months and as required.

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

Ngā poutama oranga hinengaro-mahitahi

The mental health and addiction quality improvement programme

Terms of reference for the Leadership Group

1. Purpose

The purpose of the mental health and addiction (MHA) quality improvement programme Leadership Group (LG) is to provide sector leadership, advice and support to the Health Quality & Safety Commission (the Commission) to lead the national MHA quality improvement programme (the programme). This sector leadership will inform all aspects of the programme and contribute to achieving the MHA sector's aim to improve the quality and safety of MHA services.

The key purpose of this LG is to:

a. provide **sector leadership** in the development and implementation of the MHA quality improvement programme and achieving improved outcomes
b. proactively support effective **relationships** between the MHA sector and the Commission
c. **provide advice** and make recommendations to the Commission's Chief Executive that are informed by evidence and international, national and local knowledge, and focused on strategies to improve MHA services
d. **share** information that supports a national approach to MHA quality and safety improvements
e. **foster** an integrated approach to improving the quality and safety of health and disability services with other Commission programmes.

The LG will provide guidance on the MHA work programme consistent with evidence.

The LG priorities are to:

a. support sector engagement and raise awareness of the programme
b. inform the development of the interventions within the programme
c. ensure the programme gives effect to the Commission's priorities.

2. Advice

The LG provides sector leadership and advice to the Commission's MHA quality improvement programme team. The Commission's Board has overall governance of the programme and seeks advice from experts who are leaders in their field.

3. Membership

The Co-Chairs (district health board (DHB) Chief Executive Officer MH Lead and Māori Clinical Director) will be appointed by the Commission.

The membership will comprise respected leaders, who are experts in their respective fields and/or who are actively engaged in the community or group/s they seek to represent. Membership will include, but is not limited to:

a. consumers and whānau who can demonstrate their links to consumer and whānau groups and will engage widely with other consumers and whānau of MHA services
b. specific Māori leaders with expertise in advancing Māori health (one at DHB Board or Executive level and one well connected to Māori stakeholders and networks
c. MHA services general managers with an interest and expertise in quality improvement
d. MHA services clinical directors with an interest and expertise in quality improvement
e. MHA services directors of nursing with an interest and expertise in quality improvement
f. Ministry of health, with a MHA focus, at Chief Advisor level

g. non-government organisations with an interest and expertise in quality improvement (one to two at a national level)

There is no set number of members. Where possible and appropriate the membership will include representation from both the North and South Islands. Additional members with expertise and experience in MHA and quality improvement including those with academic backgrounds may be co-opted to provide specialist advice as and when required.

4. Responsibilities

The LG has an obligation to conduct its activities in an open and ethical manner. Members are expected to work in partnership with the Commission, and to:

a. work strategically contributing to a sustainable system of improvement
b. work co-operatively, respecting the views of others with a focus on improving health outcomes and overall system performance as well as improving the experience for health care consumers, whānau and family
c. act, as a collective group, in the best interests of quality and safety initiatives locally, regionally and nationally
d. be a point of liaison with the relevant regional groups and colleges
e. make every effort to attend all meetings and devote sufficient time to become familiar with the priorities of the group and the wider environment within which it operates
f. identify and declare any conflicts of interests and proactively manage any conflicts
g. refer requests for media comments to the Co-Chairs or the Commission's Chief Executive.

5. Meetings and Decision-making

Recommendations to the Commission will be made at the LG meetings and ratified through the Co-Chairs. Decisions will be made by consensus.

a. The LG will meet a minimum of quarterly, online or face to face.
b. A quorum will be a minimum of five members.
c. Where substantive decisions or recommendations are required, all members will be encouraged to contribute by email.

6. Secretariat

The LG will have a secretariat provided by the Commission. The responsibilities of the secretariat include:

a. preparing and distributing the agenda and associated papers at least five days prior to meetings
b. recording and circulating the minutes no later than a fortnight following the meeting date
c. managing the organisational arrangements for meetings, including flight bookings, the provision of rooms and audio-visual equipment

7. Reporting and Communication

Key messages from the LG will be communicated via the Commission's communication networks and mechanisms such as the website and e-digest newsletter.

A communication plan for the programme will be developed and implemented.

8. Standards of Integrity & Conduct

All members are expected to adhere to the Standards of Integrity and Conduct set by the State Services Commissioner as per the State Sector Act 1988, section 57.This outlines the four main pillars of being fair, impartial, responsible and trustworthy.

Any major breach of these, after investigation, may result in the termination of the appointment.

9. Terms and Conditions of Appointment

Members will be invited to join the LG following a nomination. Terms of appointment are for the current contract with DHBs (until 30 June 2024). As the contract and the MHA quality improvement programme has been extended, members are considered reappointed for the extended contract term (1 July 2022 – 30 June 2024).

Members may resign at any time by advising the Co-Chairs in writing.

10. Fees

Members who are staff of a New Zealand public sector organisation including public service departments, state-owned enterprises or crown entities are not permitted to claim a fee to attend the LG meetings. The Commission has a fees framework that applies to members who are not included in the above groupings.

The terms of reference for the group will be reviewed and updated as required; after six months, and again after two years.

A new model - Advice and direction for MHA quality improvement programme