Te Whatu Ora
Health New Zealand

Agenda

Regional Integration Team: Northern Region

Date:	Tuesday 20 December 2023		
Start Time:	13:00	**Finish Time:**	17.00
Location:	**Unisys House, Penrose** **Microsoft Teams Meeting:** Click here to join the meeting		

Members: Danny Wu, Regional Wayfinder – Northern Region (Co-Chair)
Tracee Te Huia, Regional Director (Co-Chair)
Hayden McRobbie, Regional Director – National Public Health Service
Mark Shepherd, Regional Director – Hospital and Specialist Services
Harriet Pauga, Regional Director – Pacific
Penny Andrew, Executive Director
Sanjoy Nand, Regional Clinic Lead
Quinton Grey, Executive Assistant to the Regional Wayfinder (Secretariat)

Guests: Martin Dawe, Tony Phemister, Mari Longhurst, Valerio Malez, Selina Moore, Ailsa Tuck

Apologies: Daniel Gotz, Senior Advisor

Time	Item	Method	Lead
1.00pm	**Xmas lunch**		Danny Wu / Tracee Te Huia
1.30pm	**Meeting commencement** • Karakia • Apologies • Minutes • Matters arising • Other business		Danny Wu
1.35pm	**Activity: Personality testing** • Match the person with the personality		Danny Wu
2:00pm	**IMPB priorities** • Understanding the drivers • Alignment with regional plans		Danny Wu
3:30pm	**Plan prioritisation** • Afternoon tea also served		Danny Wu
4:00pm	**Implementation and operational management**		Danny Wu
4:30pm	**Process for next version, engagement and submission timeframe**		Danny Wu
4:45pm	**Regional Child Health Network – PHN review**	2023-11-23 RIT Draft paper (003).do	Mark Shepherd
5.00pm	**Karakia whakamutunga**		All

Te Whatu Ora
Health New Zealand

Meeting Minutes

Meeting	Northern Regional Integration Team
Date & time	20 December 2023 – 1:30pm to 5.00pm
Present	Tracee Te Huia, Hayden McRobbie, Mark Shepherd, Harriet Pauga, Danny Wu, Penny Andrews, Sanjoy Nand, Quinton Grey
Guests	Martin Dawe, Tony Phemister, Mari Longhurst, Valerio Malez, Selina Moore, Ailsa Tuck
Apologies	Daniel Gotz

Item	Agenda Item

1	**Commencement**
	• Karakia (Tracee Te Huia, Harriet Pauga)
	• Welcome and Whakawhanaungatanga
	  ○ Lunch taken prior to meeting.
	• Previous meeting minutes:
	  ○ Approved by all
	• Matters Arising:
	  ○ Nil
	• Agenda Items to add:
	  ○ Nil

2	**Activity: Personality Testing** • RIT members undertook an online survey prior to the meeting to determine their personality profiles identified by the Myers-Briggs Type Indicator (MBTI). • The results were assessed and identified a broad range of personality types across the RIT membership with few overlaps. • The results of this activity can assist RIT in future by showing how members can work more collaboratively across their personality types.
3.	**IMPB priorities (Danny Wu)** • No notes.
4.	**Plan prioritisation (Danny Wu)** • No notes.
5.	**Implementation and operational management (Danny Wu, Martin Dawe)** • RIT was asked to nominate representatives for a Steering Group to support the purpose and functions of RIT. • Names have been supplied to Martin who will set up a first meeting in Mid-February 2024 and provide a draft terms of reference.
6.	**Process for next version, engagement and submission timeframe (Martin Dawe)** • RIT approved submission of the next version (0.6) of the draft regional plan. • Will be rewritten next year using a Life Course approach. • Work to be undertaken with content leads in February 2024 under the guidance of a Steering Group (to be established).
7.	**Regional Child Health Network – PHN review (Mark Shepherd)** • Paper presented to highlight the impact for the northern region of national decision-making around the Public Health Nursing review. • RIT took the paper as read.
8.	**General Business** • Nil.

6.	**Next meeting: Tuesday 30th of January 2023**

Actions
None.

Te Whatu Ora
Health New Zealand

To	Regional Integration Team (RIT)
From	Child Health Regional Network
Date	23.11.23
Subject	Paper to highlight impact for the northern region of national decision making around Public Health Nursing review.

Recommendations

It is recommended that the Regional Integration Team notes and discusses:

- The Northern Region Child Health Leadership concerns about the proposed National Public Health Nursing Project

Background:

- As a result of health reforms there is a NPHS (National Public Health Service) project underway to review Public Health Nursing Services. The project plan was discussed at the Northern Region Community and Population Child Health Leadership Group Meeting in November. Paula Snowdon, the Project Manager, NPHS attended the meeting at the request of the group.
- The General Managers and Clinical leads all raised concerns about the intention and process of the project. The stability of current services was perceived as being at risk, further the PHN workforce felt they have had little communication or consultation regarding the project purpose and scope*.

The Public Health Nurses Project under NPHSS focuses on 2 work streams. These are:

- *Work stream* 1 which is establishing a programme of work to look at the Public Health Nursing workforce within Te Whatu Ora across NPHS, Hospital and Specialist Services (H&SS), to determine the optimal future accountability for delivering public health nursing services and the positioning of this workforce within Te Whatu Ora to deliver on the aspiration of Te Pae Tata – '*supporting health service delivery that better serves all New Zealand's people and communities*.

- *Work stream 2* which is focused on supporting Public Health professional development by establishing a programme of work that looks at Public Health Nursing role definition and scope of practice, skills and competencies and the opportunity to participate in the national nursing pipeline work.

Key Concerns/ Risks:

The rationale for shifting the workforce including how it will ensure continuity and enhance outcomes is unclear. Currently the proposal is focused on shifting a workforce (PHN) before it has been clearly articulated what functions/services NPHS is looking to provide with this workforce.

There is a need to understand existing functions, intended new functions and understand and mitigate potential unintended consequences of moving the workforce;

The risk of fragmentation- without clear direction of scope, breadth of change and desired outcomes the potential for further fragmentation of the system is high.
With the establishment of the NPHS there appears to be a strategic desire to move into the individual health space. This is a significant shift from the previous focus of PHUs on public health. With a complex interface of primary care, HSS and NPHS all working within the same communities there needs to be clarity around roles and responsibilities.

A key priority of the regional child health network is school-based health services, and it is unclear where decision regarding the provision of such services sit across the different parts of the system. Currently Te Aka Whai Ora and HSS are responsible for contracting/delivering these services in the metro Auckland region.

The scope of the proposal is unclear. There are many associated roles that provide essential functions including Kaia tawhai/community health roles, VHT, other allied support, senior nursing roles including Nurse Practitioners and community paediatricians.

Opportunities and Recommendations

Te Pae Tata and the subsequent health reforms gives us a unique opportunity to jointly understand and respond to local community and whānau need. A partnership approach across the system is required to ensure services are joined up and working together. An agreed understanding of required **functions** enables a holistic and transdisciplinary team to be developed into which specific roles can be adapted.

The child health clinical leadership across the region would like to be able to engage in genuine consultation about what moving these roles is trying to achieve. We believe the decision to move PHNs to NPHS should be deferred until there has been further work done to articulate the services/functions that the NPHS is looking to develop before there is a decision made about moving roles.

We ask that RIT support a process of collective planning of regional services impacting child health. This will require a particular emphasis on early intervention for priority populations, and how integration will be supported.

APPENDIX 1

Current State Summary of PHN Roles in the Northern Region

Currently, in the Northern Region, public health nurse roles carry out a diverse range of functions, covering a spectrum from clinical case work with individual Tamariki in the home through to the delivery of population-based immunisation, screening, and school-based programmes. Relationships within and outside the health sector are foundational to their work. PHNs in the Northern Region do critical work among priority populations. There is concern that the heterogeneity of these functions and diversity of relationships may be overlooked.

PHNs and complementary workforce in various parts of the region are providing a range of services. These include:

Northland

HSS-school based services, ear health, vision and hearing testing, ear nursing services

NPHS- PHN- communicable disease

Auckland Regional Public Health-

NPHS- Communicable diseases across Waitemata, Te Toka Tumai and Counties

Waitemata

HSS- school-based immunisation programme, school-based health services, vision and hearing testing, ear heath nursing. Medical officer

Te Toka Tumai

Starship Community Nurse (no longer called PHN) - integrated model of Tamariki ora, school-based health services, immunisation in schools, ENT specialist nursing outreach, homecare services for Tamariki with acute and complex health needs. Also integrated with child disability services in locality model. Vision and hearing testing, regional refugee health promotion, community health workers. Nurse Practitioners and Community Paediatrician.

Counties Manukau

HSS- outreach immunisation, school-based immunisation program
In Counties Manukau School Based health services (Mana Kidz) are not delivered by PHNs. The contract for Mana Kidz is held by Te Aka Whai Ora with NHC which coordinates a network of providers who employ registered nurses.

Te Whatu Ora
Health New Zealand

To	Regional Integration Team (RIT)
From	Child Health Regional Network
Date	23.11.23
Subject	Paper to highlight impact for the northern region of national decision making around Public Health Nursing review.

Recommendations

It is recommended that the Regional Integration Team notes and discusses:

- The Northern Region Child Health Leadership concerns about the proposed National Public Health Nursing Project

Background:

- As a result of health reforms there is a NPHS (National Public Health Service) project underway to review Public Health Nursing Services. The project plan was discussed at the Northern Region Community and Population Child Health Leadership Group Meeting in November. Paula Snowdon, the Project Manager, NPHS attended the meeting at the request of the group.
- The General Managers and Clinical leads all raised concerns about the intention and process of the project. The stability of current services was perceived as being at risk, further the PHN workforce felt they have had little communication or consultation regarding the project purpose and scope*.

The Public Health Nurses Project under NPHSS focuses on 2 work streams. These are:

- *Work stream* 1 which is establishing a programme of work to look at the Public Health Nursing workforce within Te Whatu Ora across NPHS, Hospital and Specialist Services (H&SS), to determine the optimal future accountability for delivering public health nursing services and the positioning of this workforce within Te Whatu Ora to deliver on the aspiration of Te Pae Tata – '*supporting health service delivery that better serves all New Zealand's people and communities*.

- *Work stream 2* which is focused on supporting Public Health professional development by establishing a programme of work that looks at Public Health Nursing role definition and scope of practice, skills and competencies and the opportunity to participate in the national nursing pipeline work.

Key Concerns/ Risks:

The rationale for shifting the workforce including how it will ensure continuity and enhance outcomes is unclear. Currently the proposal is focused on shifting a workforce (PHN) before it has been clearly articulated what functions/services NPHS is looking to provide with this workforce.

There is a need to understand existing functions, intended new functions and understand and mitigate potential unintended consequences of moving the workforce;

The risk of fragmentation- without clear direction of scope, breadth of change and desired outcomes the potential for further fragmentation of the system is high.
With the establishment of the NPHS there appears to be a strategic desire to move into the individual health space. This is a significant shift from the previous focus of PHUs on public health. With a complex interface of primary care, HSS and NPHS all working within the same communities there needs to be clarity around roles and responsibilities.

A key priority of the regional child health network is school-based health services, and it is unclear where decision regarding the provision of such services sit across the different parts of the system. Currently Te Aka Whai Ora and HSS are responsible for contracting/delivering these services in the metro Auckland region.

The scope of the proposal is unclear. There are many associated roles that provide essential functions including Kaia tawhai/community health roles, VHT, other allied support, senior nursing roles including Nurse Practitioners and community paediatricians.

Opportunities and Recommendations

Te Pae Tata and the subsequent health reforms gives us a unique opportunity to jointly understand and respond to local community and whānau need. A partnership approach across the system is required to ensure services are joined up and working together. An agreed understanding of required **functions** enables a holistic and transdisciplinary team to be developed into which specific roles can be adapted.

The child health clinical leadership across the region would like to be able to engage in genuine consultation about what moving these roles is trying to achieve. We believe the decision to move PHNs to NPHS should be deferred until there has been further work done to articulate the services/functions that the NPHS is looking to develop before there is a decision made about moving roles.

We ask that RIT support a process of collective planning of regional services impacting child health. This will require a particular emphasis on early intervention for priority populations, and how integration will be supported.

APPENDIX 1

Current State Summary of PHN Roles in the Northern Region

Currently, in the Northern Region, public health nurse roles carry out a diverse range of functions, covering a spectrum from clinical case work with individual Tamariki in the home through to the delivery of population-based immunisation, screening, and school-based programmes. Relationships within and outside the health sector are foundational to their work. PHNs in the Northern Region do critical work among priority populations. There is concern that the heterogeneity of these functions and diversity of relationships may be overlooked.

PHNs and complementary workforce in various parts of the region are providing a range of services. These include:

Northland

HSS-school based services, ear health, vision and hearing testing, ear nursing services

NPHS- PHN- communicable disease

Auckland Regional Public Health-

NPHS- Communicable diseases across Waitemata, Te Toka Tumai and Counties

Waitemata

HSS- school-based immunisation programme, school-based health services, vision and hearing testing, ear heath nursing. Medical officer

Te Toka Tumai

Starship Community Nurse (no longer called PHN) - integrated model of Tamariki ora, school-based health services, immunisation in schools, ENT specialist nursing outreach, homecare services for Tamariki with acute and complex health needs. Also integrated with child disability services in locality model. Vision and hearing testing, regional refugee health promotion, community health workers. Nurse Practitioners and Community Paediatrician.

Counties Manukau

HSS- outreach immunisation, school-based immunisation program
In Counties Manukau School Based health services (Mana Kidz) are not delivered by PHNs. The contract for Mana Kidz is held by Te Aka Whai Ora with NHC which coordinates a network of providers who employ registered nurses.

Te Whatu Ora
Health New Zealand

Agenda

Regional Integration Team: Northern Region

Date:	20th February 2024		
Start Time:	16:00	**Finish Time:**	17.00
Location:	**Microsoft Teams Meeting:** Click here to join the meeting		

Members: Danny Wu, Regional Wayfinder – Northern Region (Co-Chair)
Tracee Te Huia, Regional Director (Co-Chair)
Hayden McRobbie, Regional Director – National Public Health Service
Harriet Pauga, Regional Director - Pacific
Mark Shepherd, Regional Director – Hospital and Specialist Services
Sanjoy Nand, Regional Clinic Lead
Daniel Gotz, Senior Advisor
Janine Pratt – Group Manager, Office of the Regional Wayfinder
Rochelle Bastion – Regional Integration Team Lead
Quinton Grey, Executive Assistant to the Regional Wayfinder (Secretariat)

Guests: Martin Dawe

Apologies: Penny Andrew

Time	Item	Method	Lead
4.00pm	**Commencement** • Karakia • Apologies • Introductions • Matters arising • Other business		Danny Wu
4.05	Review of Previous Meeting minutes and Action Points	MIN 20240213 - Minutes - RIT Norther	Danny Wu
4.10	**Planning and Reporting** • RHWP – Update including Steering Group feedback	Verbal	Martin Dawe
4.20	**Quality Governance and Clinical Leadership** • Regional Clinical Quality Assurance • HSQC Clinical Governance Framework		Richard Sullivan
4.35	**Service Development** • Regional Immunisation Leadership Group	2024-02-16_Northern Region Immunisat	Hayden McRobbie

4.45	**National and Regional Activities** • National and Regional Innovation Awards • Nominations for CPCT Governance Group	V3 Draft CPCT Enablement Govern…	Penny Andrew Sanjoy Nand
4.50	**Management and Administration** • Conflict of Interest Register • Risk and Issue Register		Janine or Rochelle?
4.55pm	**General Business** • Northern Region Quality Improvement Scientific Symposium (Penny) • National quality and safety measures framework and digital reporting system (Penny)	Essential background inform… Proposed Framework Measure… 20230108 Proposal for partnering on Qua… Draft QIIS programme structur… Northern RIT - QISS Programme 1902202…	All
5.00pm	**Karakia whakamutunga**		All

Te Whatu Ora
Health New Zealand

Meeting Minutes

Meeting	Regional Integration Team, Northern Region
Date & time	20 February 2024 – 4:00pm to 5.00pm
Present	Penny Andrew, Rochelle Bastion, Daniel Gotz, Hayden McRobbie, Sanjoy Nand, Harriet Pauga, Janine Pratt, Mark Shepherd, Danny Wu
Guests	Martin Dawe
Apologies	Tracee Te Huia

Item	Agenda Item	Lead

1.	**Commencement**
	• Karakia (Danny)
	• Welcome and whakawhanaungatanga.
	  ○ Introductions.
	• Previous meeting minutes:
	  ○ Approved by all present.
	• Matters Arising:
	  ○ Nil.
	• Additional agenda items:
	  ○ Nil.
		Chair

2.	**Health and Wellbeing Plan** 1. Update from first Steering Group meeting 14 February 2024 • Good attendance and discussion, concerns raised around the timeframe, stretched resources and the need to re-work in the absence of a GPS and updated New Zealand Health Plan. • Particular concern raised about stretched teams being able to lead/contribute to content development particularly the integration points for areas like chronic conditions for HSS and Commissioning. • Concern raised about the request to remove the 3Ws by the national team as these are still priorities for the new minister but have slightly different phraseology. • Some proposed changes to the draft TOR were made regarding relationships with network groups, engagement with IMPBs, and clarifying decision making – Martin and Janine to make changes for agreement at the next meeting. • Agreed that some further work by Valerio, Rochelle and Janine on an engagement plan was required. • Noted that regional plan development will transition to the Steering Group and Office of the Regional Wayfinder by the end of March. • Next meeting scheduled for 13 March with the aim that a partial re-write of the regional plan will be tabled and discussed. 2. Update from Regional Planner Forum/national team. • Some general agreement that the timeframe will be adjusted to aim to have a final draft (content only, not designed) regional plan to RIT for approval/sign-off by mid-May 2024.	**Martin Dawe**

- Sandra indicated that the signed-off draft would then go through Abbe's office to be presented to the respective ELTs and she is following up on what type of covering paper the regional plans will have, and what time frames would apply.
- Draft GPS is still expected by the end of February and broader engagement is planned for March. The Health Plan is focusing on the 5+5=90 approach and that this had prompted a re-structuring of the New Zealand Health Plan, although she noted this would NOT impact on the structure of the regional plan using a Life Course approach.

ACTION POINT: Quinton to forward steering group minutes to RIT.
ACTION POINT: Chairs to discuss with RIT co-chairs about the process on aligning our plans and board priorities before submitting to ELT.

3. Immunisation **Hayden McRobbie**

- Take paper as read.
- Proposal to establish permanent whole of system leadership group to provide oversight and decision making.
- Would have responsibility to RIT.
- Core functions to link with national groups, translate national strategy and investment signals into regional context, respond to funding requests, and provide accountability for activity.
- Operational group would be focused on the delivery across the board and include wide membership including Māori and Pacific providers.
- Hayden McRobbie would co-chair as accountable director with a co-chair to support the work.
- Requesting RIT endorsement of proposed structures.
- Requesting RIT endorsement to draft terms of reference, which will include membership.
- RIT endorsed the proposed structures.
- RIT endorsed drafting the terms of reference.

4. CPCT Governance Group **Sanjoy Nand**

Continuation from discussion last week.
Need to ensure we have the right representation from HNZ
Debbie Holdsworth nominated for HNZ, one from Te Aka Whai Ora and one from Pacific
Conversations to take place outside of RIT.

5. Northern Region Quality Improvement Scientific Symposium **Penny Andrews**

- ELT decision to run four regional quality improvement scientific symposia and one national symposium, with RIT to facilitate delivery of the Northern region symposium.
- RIT is asked to:
  - note the proposed structure of the National QISS programme
  - RIT is asked to nominate members from teams to form a regional working group
  - RIT is asked to discuss/agree key milestones, dates and venue location
  - Note the symposium themes will be determined by HNZ ELT
  - Discuss themes specific to the northern region that could feature in the sympoium
  - Note that SI&I will lead a programme to stimulate improvement and innovation initiatives at care delivery level
  - Note that SI&I and Te Tāhū Hauora will develop a toolkit to support the RITs and regional working group to facilitate symposium delivery.

-

6. National quality and safety measures framework and digital reporting system — **Penny Andrews**

- Feedback is being sought on a draft national Quality and Safety Measures Framework.

ACTION POINT: Penny to forward links to Quinton for dissemination to RIT.

7. Administration — **Rochelle Bastion**

Will be sending out a conflict of interest register.
Will be talking about risk and conflict management in future meetings.

8. General Business — **Danny Wu**

- Draft evaluation of winter plan.
- SLT of each delivery team will need to see it prior to it going to ELT
- Once finalised, there will be lots of OIAs

The meeting was closed by the Chair with a karakia.

Next meeting: Tuesday 27 February 2024

Actions	Assigned to	Due date
Forward minutes from Steering Group meeting 14 February 2024 to RIT	Quinton Grey	27/02/2024
Discuss with RIT co-chairs the process on aligning our plans and board priorities before submitting to ELT	Danny Wu / Tracee Te Huia	27/02/2024
Penny Andrews to provide links to Quinton Grey to disseminate	Penny Andrew / Quinton Grey	27/02/2024

Te Whatu Ora
Health New Zealand

National Quality and Safety Measures Framework for Clinical Quality Assurance Committee (CQAC)

January 2024

Contents

Purpose

1. We are seeking feedback on a draft national Quality and Safety Measures Framework. We would like feedback to better understand and refine measures needed in a reporting system that aims to reveal meaningful information about the quality and safety of patient care across the motu and identify areas for improvement.

Background

How did this start?

Clinical Quality Assurance Committee request

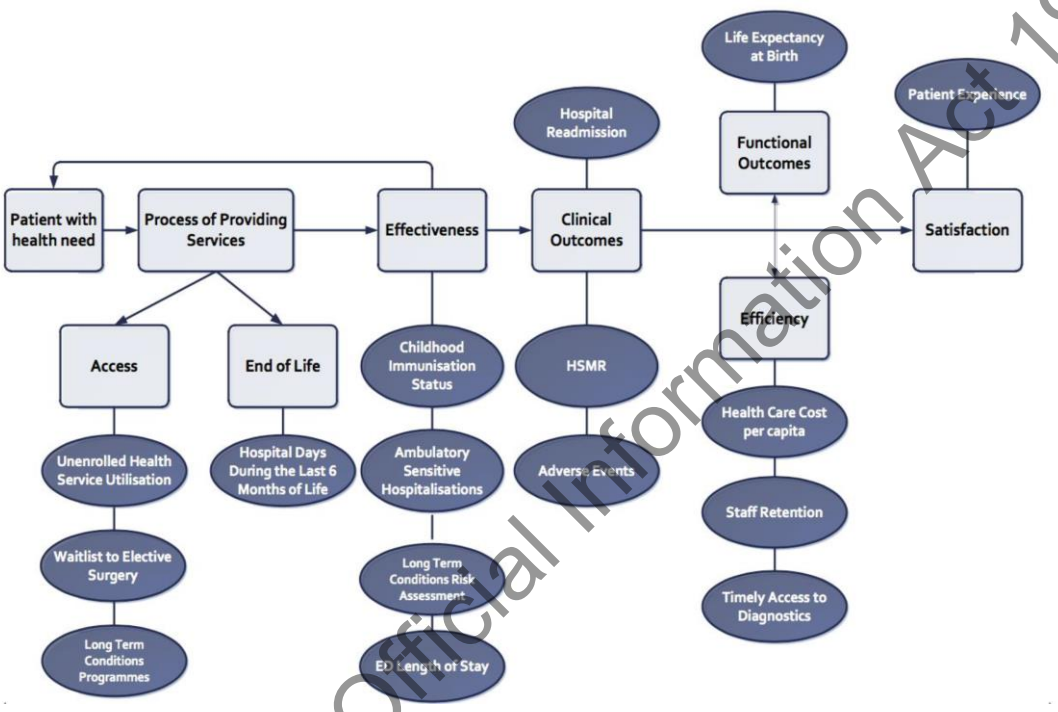
2. The Clinical Quality Assurance Committee of the Board of Te Whatu Ora (CQAC) requested the Service Improvement and Innovation Directorate (SI&I) lead the development of quality and safety measures reporting to the Committee.
3. In December 2022, the SI&I Directorate recommended to CQAC a preliminary set of quality and safety summary measures be reported to CQAC while a national whole system Quality and Safety Measures Framework and digital reporting system is developed.
4. The proposal to CQAC included a digital reporting system that displays measures over time and across regions and facilities; will cascade measures down to individual districts/units; and will display data by quality domain, health condition and ethnicity, in order to uncover inequities and unwarranted variation in performance. The recommendation was approved by CQAC.
5. A working group was formed to develop a draft national whole system Quality and Safety Measures Framework. The group included expertise from Te Tāhū Hauora (Health Quality and Safety Commission), Te Aka Whai Ora, Hospital and Specialist Services and Commissioning and Community (Primary Care). Input from the Clinical Senates of Te Aka Whai Ora and Pacific Services has also been sought.

Background to recommendation to CQAC

6. Prior to the Pae Ora legislation and the dissolution of the District Health Boards (DHB), each DHB reported to their Board information about quality and safety. This usually entailed reporting local performance across the dimensions of quality (for example 'Metrics that

Matter at Counties Manukau DHB (CMDHB), and also the quality improvements being undertaken. There was often some form of benchmarking with Te Tāhū Hauora and/or the Australasian Health Round Table (HRT data).

Figure 1. Counties Manukau District Health Board (CMDHB) Whole Systems Measures (2016)



7. Reporting at a national level as a unified system requires a different approach, with a limited number of summary measures reported at a national level and the ability to 'drill down' to uncover inequities and unwarranted variation in performance.
8. The development of system-level healthcare quality and safety measures, and reporting these to Boards, is well described in the literature. In most cases reporting systems are based on a strategic framework and a set of principles for selecting measures. An environmental scan undertaken for the Victorian Agency for Health Information (VAHI),[1] provides a helpful overview of strategies for the development and selection of measures and reporting systems. The VAHI report found that while most frameworks and implementation approaches share

[1] Jane Li, Yang Xie, Sankalp Khanna, Rajiv Jayasena (2019) Safety and Quality Reporting at a Board Level: Environmental Scan. CSIRO, Australia. Available at: BSQR EnvironmentalScanReportNov2019.pdf (safercare.vic.gov.au).

core elements such as efficiency, timely access, effectiveness, safety and patient-centredness, reaching consensus on the specific measures that will be reported is the most difficult part.

9. A whole system measures approach, proposed here, is based on the Institute for Healthcare Improvement's (IHI's) Whole System Measures framework[2]. The IHI first proposed whole system measures for Boards in 2001, to report against the six dimensions of healthcare quality: safe, effective, timely, equitable and efficient care that is patient centred.[3] This approach has been widely adopted internationally, with notable examples in the NHS and the US, and it was used by the then CMDHB to develop system measures across the patient journey (see figure 1). [4]
10. In the US the Kaiser Permanente organisation is somewhat analogous to Te Whatu Ora with their system covering a network of 39 hospitals across several states, although they cover a larger population (>12 million people). Kaiser developed a data dashboard known as "Big Q", which distilled hundreds of performance measures into a vital few high level measures, to allow leaders to answer the question "as a system, are we improving?"(see Table 1). Displayed over time and across regions and facilities, the measures were purposefully benchmarked to external best-in-class performers.[5] This is the type of approach that the SI&I Directorate recommended to CQAC and that we aim to replicate for Aotearoa New Zealand.

[2] Martin LA, Nelson EC, Lloyd RC, Nolan TW. *Whole System Measures*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2007. (Available on www.IHI.org).

[3] With acknowledgement of Te Ao Maori we would change this to whānau-centred. Also the original equity domain was actually about equality of access and was silent on the equity of outcomes.

[4] Jane Li, Yang Xie, Sankalp Khanna, Rajiv Jayasena (2019) Safety and Quality Reporting at a Board Level: Environmental Scan. CSIRO, Australia. Available at: BSQR EnvironmentalScanReportNov2019.pdf (safercare.vic.gov.au).

[5] L Schilling, A Chase, A Liu, M Stiefel, R Brentari. Kaiser Permanente's Performance Improvement System, Part 1: From Benchmarking to Executing on Strategic Priorities. The Joint Commission on Quality and Patient Safety, 2010; 36 (11): 484-498

Table 1. Kaiser Permanente's Measures in Big Q dashboard

Table 1. Measures in "Big Q" Data Dashboard*

Domain	Measure	Definition
Clinical Effectiveness	Hospital Standardized Mortality Ratio[26]	Ratio of observed to expected mortality, after adjustment for selected patient-mix and community variables, among Medicare patients with diagnoses accounting for 80% of inpatient mortality
	Healthcare Effectiveness Data and Information Set (HEDIS) composite[27]	An averaged aggregation of 33 HEDIS outpatient measures into a single measure that spans conditions and types of care
	The Joint Commission composite[28]	An averaged aggregation of 21 Joint Commission indicator measures into a single measure that spans conditions and populations.
Safety	Serious Reportable Event (SRE)[29] composite	Mean number of days elapsed between SREs, charted quarterly, programwide for Kaiser Permanente. It is comprised of 12 serious reportable event incident types.
Resource Stewardship	Total care delivery costs	Year-to-date percentage change in total costs of care delivery per member per month, programwide
Service	Health plan rating	Programwide assessment of health plan by commercial HMO members using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 4.0 H questionnaire.[30] The numerator reflects overall ratings of 9 or 10 on a scale of 0–10.
	Health care rating	Programwide assessment of health care by commercial HMO members using the CAHPS 4.0 H questionnaire.[30] The numerator reflects overall ratings of 9 or 10 on a scale of 0–10.
	Hospital rating	Programwide assessment of hospitals by patients on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.[31] The numerator reflects overall ratings of 9 or 10 on a scale of 0–10.

11. Based on insights from the VAHI environmental scan and literature review, the proposal to CQAC included a set of principles for selecting quality and safety measures to the Board; the development of a draft Quality and Safety Measures Framework; seeking feedback on the framework from key stakeholders; and the development of a digital reporting system based on an approved framework.

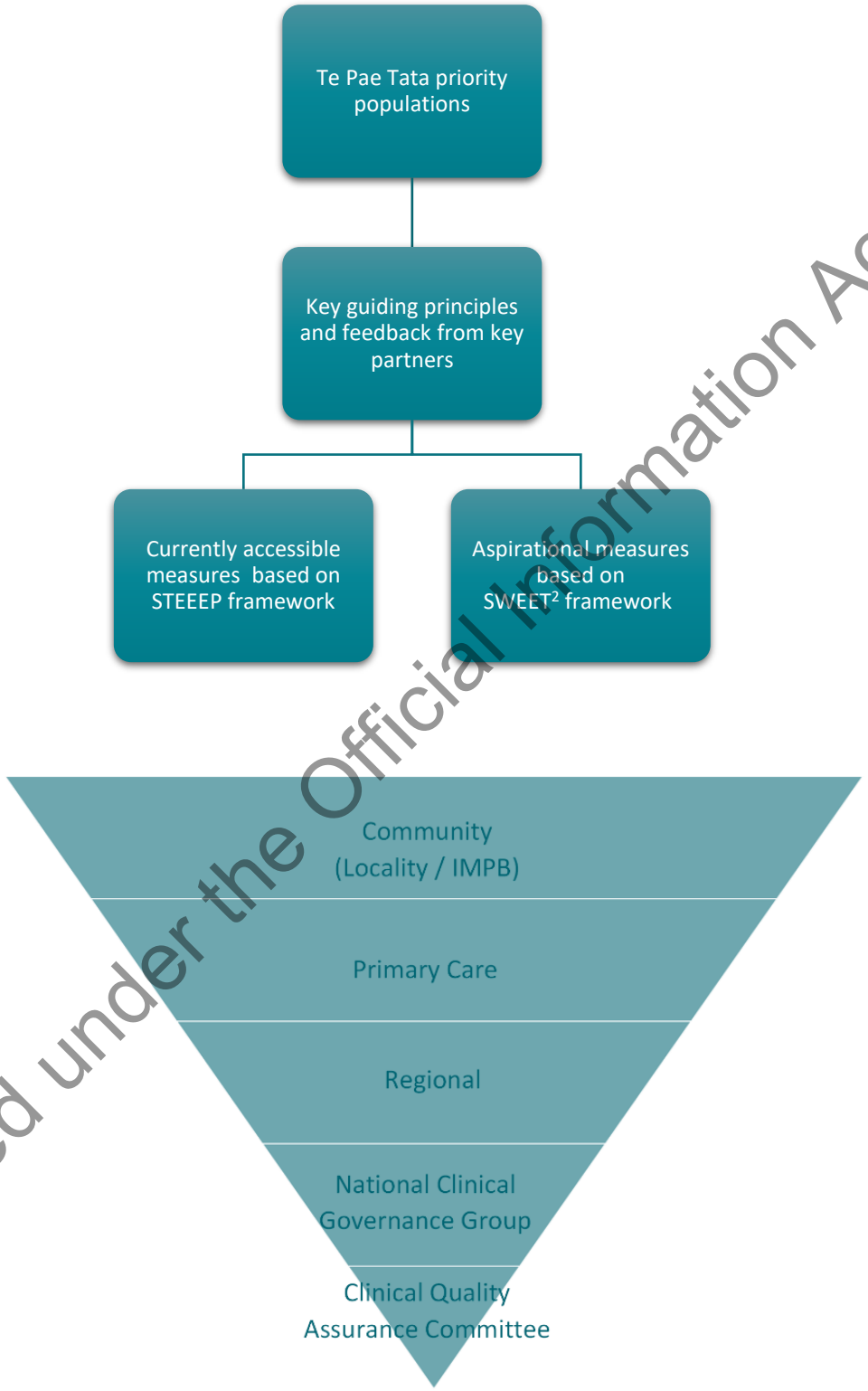
Table 2. Key guiding principles used to select measures

Principle	Explanation
Strategic alignment	Strategic alignment: measures must be aligned with Te Whatu Ora's obligations and strategic priorities in particular Te Tiriti o Waitangi and the commitment to equity. Measures must also align with Te Whatu Ora's clinical governance framework and Te Aka Whai Ora's Strategic Framework.
Interdependencies	Te Aka Whai Ora will be a key partner, and within Te Whatu Ora the Division of Data and Digital will be important to build the electronic dashboard and to adapt the Atlas of Variation template. The Hospital and Specialist Services division and the Clinical chiefs will also have vital roles in assessing the validity of the measures.
Three major roles of summary measures	Summary measures must satisfy three major roles: a. Provide visibility to monitor the performance of the system, so that the Board can have confidence in the quality of care being provided b. Suggest areas for performance improvement c. Provide the basis for accountability for equity of outcomes
External benchmarking	Where possible, measures will be reported with external benchmarking (best practice).
Parsimony	A small set of measures is required – too many and they cease to have value in providing strategic guidance.
Immediate usefulness	Measures need to be useful for health system leaders and Boards to drive improved performance.
Availability	Measures will have data available monthly or quarterly where possible, and electronically collected.
Regular review	Measures will be regularly reviewed and new measures will not be introduced before assessing whether current measures are adding value.

Where are we up to?

12. A Framework has been drafted with the intention of creating a construct that facilitates feedback. In addition, what is identified now may not reflect what is important in the future: the Framework can and will be regularly reviewed so that the domains and the measures selected for reporting are relevant and reflect current context.
13. The draft Framework is based on the Institute of Medicine (IOM) measures – STEEEP (Safe, Timely, Effective, Efficient, Equitable, and Patient centered) and Te Pae Tata priority populations.
14. We have held workshops to develop a Quality and Safety Measures Framework and we have engaged with key partners, Te Aka Whai Ora and the Te Whatu Ora Pacific Health team. In response to feedback from our key partners we have revised the measure domains for the national quality and safety measures. We have transitioned from the STEEEP framework (based on Institute of Medicine) to SWEET[2], which encompasses six key areas: Safe, Whānau centred experiences of care, Effective, Equitable, Timely (accessible), and Te Tiriti and Tikanga based.
15. The proposed Framework aims to embrace Te Ao Māori, with currently accessible measures reflecting the health and wellbeing of current generations. Additionally, it includes aspirational measures that we cannot access and report now but would like to do so, and these measures are intended to reflect the health and wellbeing of future generations in 50 to 100 years.

Figure 2. High level Framework



Why are we seeking feedback?

16. We are seeking your feedback to better understand and refine the draft Framework and the measures identified. The aim of the reporting system is to reveal meaningful information about the quality and safety of patient care across the health sector and identify areas for improvement.

What feedback are we seeking?

Part 1: Quality and Patient Safety Measures Framework

- *Do you agree on adopting the STEEEP framework and Te Pae Tata priority populations?*

  If you think there are important domains missing, please specify what these domains are, and explain why they are important.

Part 2: Proposed currently accessible quality and patient safety measures

- *Considering our limitations, do you agree that the currently accessible metrics serve as a reasonable starting point for measuring and monitoring the quality and safety of patient care?*

  Please support your view with an explanation.

Part 3: Future and aspirational Quality and Patient Safety Measures Framework

- *Do you agree with the proposed aspirational domains based on SWEET2 framework for measuring and monitoring of quality and safety of patient care?*

  If you think there are important domains missing, please specify what these domains are, and explain why they are important.

Part 4: Aspirational and potential quality and patient safety measures

- *Are there any gaps or deficiencies in the proposed measures list?*

Please explain gaps/deficiencies, for example on how these measures can be effectively measured and reported, measurement methods, numerators, and denominators.

- *Are there any measures you believe should be replaced or eliminated?*

  Please specify the measure(s) and provide reasons for replacement or elimination.

- *What criteria do you believe should be used to prioritise aspirational measures within the Quality and Safety reporting system?*

Please describe briefly

- *Considering the aspirational measures, what are your top five priorities for implementation to improve monitoring of quality and safety of patient care?*

  Please list them in order of importance, with 1 being the highest priority.

- *Do you suggest any other quality measures for Te Whatu Ora ?*

  Please specify measures along with their measurement methods, numerator and denominator

How to provide feedback

Online feedback tool (Microsoft Forms)

- We are using Microsoft Forms to gather your feedback.
- Please refer to this document, and the Proposed Framework Measures (see excel sheet for more detail).
- The link to the Microsoft Form is available on the website where you accessed this background document, or in your email.

Appendix: Proposed Framework Measures

Te Whatu Ora Quality and Safety Measures Framework - Proposed currently accessible measures				
Measure domain	**Measure category**	**Measure title**	**Measure definition**	**Definition source**
Safe	Complications	Rate of hospital-acquired complications	Hospital acquired complications per 10,000 episodes	HRT
		Rate of major hospital-acquired complications	Hospital acquired complications per 10,000 episodes	HRT
	Mortality	Hospital Standard Mortality Rate	Observed over expected hospital deaths	HRT
		Hospital Standard Mortality Rate	Observed over expected deaths within 30 days of admission to hospital regardless of where death took place	HRT
	Infections	Surgical site infection per 10,000 episodes	Surgical complications per 10,000 episodes	HRT
		Surgical site infections Hips and Knees (%)	Percentage of hip and knee cases with a recorded infection within 90 days	HQSC
		Surgical site infections Cardiac surgery (%)	Percentage of cardiac cases with a recorded infection within 90 days	HQSC
		Post-operative sepsis observed/expected ratio	Observed over expected post operative sepsis	HQSC

		Urinary incontinence per 10,000 episodes	Incontinence per 10,000 episodes	HRT
		Staph Aureus per 10,000 episodes	Number of Hospital Associated Staph Aureus Blood Stream (SAB) infections per 1,000 occupied bed days	HQSC
	Medications	People aged 65 and over dispensed 5+, 8+, 11+ unique long term medications	All available from https://reports.hqsc.govt.nz/measures-library/_w_bb3eb932/#!/measures	HQSC
		People aged 65+ dispensed the triple whammy [concurrent use of ACE inhibitor or ARB blocker/ Diuretic/ NSAID]		
		People who received both a benzo/zopi and a strong opioid		
		Medication complications per 10,000 episodes		HRT
	Falls	Falls with fractured neck of femur per 100,000 admissions	Falls with fractured neck of femur per 100,000 admissions	HQSC
		Falls resulting in fracture or intracranial injury per 10,000 episodes		HRT
	Pressure injuries	% patients with a documented and current pressure injury assessment	% patients with a documented and current pressure injury assessment	HQSC
		% at-risk patients with a documented and current individualised care plan with specific pressure injury actions	% at-risk patients with a documented and current individualised care plan with specific pressure injury actions	HQSC

		% patients with a hospital-acquired pressure injury	% patients with a hospital-acquired pressure injury	HQSC
		% patients with a non-hospital-acquired pressure injury	% patients with a non-hospital-acquired pressure injury	HQSC
	DVT/PE	Post operative DVT/PE observed expected ratio	Ratio of observed expected post operative DVTs	HQSC
		Complications (from HRT): incident of VPE/VTE in Ortho operations	Venous thromboembolism per 10,000 episodes	HRT
	Other	In hospital cardiopulmonary arrest	Inpatients cardiopulmonary arrests per 1,000 admissions	HQSC
		Rapid response escalations	Rapid response escalations per 1,000 admissions	HQSC
Timely (Access)	Access in planned care	ESPI 2, >120 days and >365 days (Broken down by ethnicity)	% of people waiting longer than reference time	MoH
		ESPI 5 , >120 days and >365 days (Broken down by ethnicity)	% of people waiting longer than reference time	MoH
	Access in community	Percentage of children enrolled with a general practice (or a kaupapa Māori provider delivering general practice care) by age 3-months		SPE
	Faster cancer treatment	Break down by cancer type 31day/62day pathway		TATK

		Outcome e.g., mortality	This is undefined AND PROBABLY NOT OUTCOME	TATK
	Shorter stays in ED	Performance against SSED target	% achieving target	
	Shorter stays in ED	50th and 95th percentile of stays	% achieving target	
Effective		Screening programme measures including bowel, breast cancer etc		MoH
		Fractured Neck Of Femur (NOF) to theatre within 48 hours	HRT?	
	Potential Atlas measures which cover a range of measures of effective patient management	% of people with gout regularly dispensed a urate lowering therapy	All available from https://reports.hqsc.govt.nz/measures-library/_w_bb3eb932/#!/measures	HQSC
		% of people with gout dispensed a NSAID without urate lowering therapy		
		Serum urate test within six months of urate lowering therapy		
		Hospital admissions for people with gout		
		People with identified diabetes regularly receiving metformin		
		People with identified diabetes regularly receiving CEI or ARB		
		People with identified diabetes receiving regular HbA1c monitoring		

		People with identified diabetes receiving regular screening for renal disease		
		Admissions to hospital for diabetic ketoacidosis, hypoglycaemia and lower limb amputation		
		People aged 1-49 with at least two asthma admissions within 90 and 91-365 days		
		People aged 0-49 not given a funded influenza vaccine tin the year after and asthma/ wheeze admission		
		People regularly dispenses SABA and no dispensed (or regularly dispensed) preventer in the year		
		% operations completed as day cases		
		% cancelled operations		
		readmission within 7 days (condition and/or service)		TBD?
Equitable (potential Atlas measures)	Pae ora: Better health and wellbeing in our communities	HPV vaccinations (in both girls and boys) - to discuss with Te Aka Whai ora on other measures		MoH
		Life expectancies		
	Kahu Taurima: Maternity and	Immunisation rate at 2 years		MoH

	early years (first 2000days)			
	Mate pukupuku: People with cancer	See Faster cancer treatment under Timely		TATK
	Māuiuitanga taumaha: People living with chronic health conditions	Refer to diabetes and COPD from Effective domain above		
	Oranga hinengaro: People living with mental distress, illness and addictions	Integrated Primary Mental Health initiative (Access & Choice) either percentage of practices or percentage of target population covered.		
Whanau-centred experiences of care		Quarterly HQSC patient survey (waiting time and being informed, and being included in their care - MULTIPLE OTHERS AVAILABLE) - inpatient and primary/community	Percentage of respondents giving the most positive response to the question	HQSC
		Whanau involvement - patient experience discharge questions		?MoH

Te Whatu Ora Quality and Safety Measures Framework - Proposed Aspirational Measures

Measure domain	Measure category	Aspirational measures
Safe	Complications	Rate of patients admitted acutely for the same condition for which they are currently on the waitlist
		Other mortality measures as per discussion with Mortality Review Committee e.g., peri-operative mortality, neonatal, maternal, comparison with HSMR in Australia
	Infections	Surgical site infection per 10,000 episodes for Abdominal site
		Surgical site infection per 10,000 episodes for Caesarean site
		Surgical site infection per 10,000 episodes for Hysterectomy site
		Aged Residential Care (ARC) avoidance
		Avoidable ED presentation from Aged Residential Care (ARC) due to infections
	Medications	Inappropriate prescribing / Proxy measure of medication reconciliation / Of the top 10 high-risk medications, rate of presentation from known complications i.e., anticoagulants, NSAID, insulin, colchicine, AF, heart valve disease, triple whammy
	Pressure injuries	
	Cultural safety (application of feedback from Te Aka Whai Ora and Pacific Health) - referencing Te Pare o Toi, Hauora a Toi and Tipu Mahi	Workforce
		Quality improvement work focused on equity
		Procurement, Commissioning and Access to services
		Primary care is accessible and focused on the needs of Māori and their rights as it pertains to Te Tiriti
		Ethnicity Data Integrity and Governance
		Authentic partnerships mechanisms
		Achieving health equity and giving effect to Te Tiriti

		Antiracism - Ao Mai Te Rā / institutionalised racism	
Whānau-centred experiences of care	Whanau wellness (application of feedback from Te Aka Whai Ora and Pacific Health)	Referencing He Pou Oranga - Tangata Whenua Determinants of Toi Ora	
		Tāngata whaikaha	
		PREMs/PROMs - These reflected developments in HQSC program - O/P and PROMs emerging - not available for 18 months	
Efficient		Cost of harm associated with delay in care (wait list)	
Effective		Chronic Kidney Disease	
		Prescribing for VPE/VTE (balanced with bleeding)	
	Amenable mortality rates (e.g., CV, T2DM)	Where do these currently sit? It can possibly be under effective or equity – i.e., especially because Māori and Pacific people are highly overrepresented on this front.	
Equitable	Pae ora: Better health and wellbeing in our communities	Quality of Life and life expectancy	
		Community connection – Lives alone	
	Kahu Taurima: Maternity and early years (first 2000 days)	Marternity	Enrolment / Engagement with a primary maternity care provider in the first trimester of pregnancy
		Oral Health	Surgical rates and caries in community
			Define an 'acceptable timeframe' and measure what proportion of children get access to a GA & procedure in that timeframe
	Mate pukupuku: People with cancer	Measures around childhood cancer (TBD)	

	Māuiuitanga taumaha: People living with chronic health conditions	Management of Diabetes	HbA1c Glycaemic control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months
			Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is <140mmHg
			Management of Microalbuminuria and macroalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have an elevated ACR recorded on two consecutive occasions at least 90 days apart and are on an ACE inhibitor or Angiotensin Receptor Blocker.
			CVD Primary Prevention: Percentage of enrolled patients with diabetes (aged 25 to 74 years), whose most recently recorded cardiovascular risk score is ≥20% (2003 methodology) OR ≥15% (2018 methodology) and who are on dual therapy (Statin + BP Lowering agent) Exclusions: History of prior CVD event and those identified as “clinically high”
			CVD Secondary Prevention: Percentage of enrolled patients with diabetes (aged 25 to 74 years) with known CVD who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant) Exclusion: History of haemorrhagic stroke
		Management of Cardiovascular Disease (CVD)	CVD Secondary Prevention: Percentage of enrolled patients (aged 25 to 74 years) with known CVD who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant) Exclusion: History of haemorrhagic stroke
			CVD Primary Prevention: Percentage of enrolled patients (aged 25 to 74 years), whose most recently recorded cardiovascular risk score is≥20% (2003 methodology) OR ≥15% (2018 methodology) and who are on dual therapy (Statin + BP Lowering agent) Exclusions: History of prior CVD event and those identified as “clinically high”

	Oranga hinengaro: People living with mental distress, illness and addictions	People under 25 years able to access specialist mental health services within three weeks of referral
		Access to primary mental health and addiction services – developmental measure. Initial reporting of data from integrated primary mental health and addiction services
Timely (Access)	Access in planned care	
	Access in community	Rural and remote community access to care (ranges of care and minimum services available)
		Not registered / engaged
		Not getting first appointment / third available appointment
		Closed GP books (registered population per FTE GP/NP and FTE Nurse. Which could be reported quarterly if sector agreed)
	Faster cancer treatment	Lung cancer screening measures - as per PLCOm 2012?
	Shorter stays in ED	Access block (decision to admit to getting bed)
Te Tiriti & Tikanga based	Te Tiriti Maturity Score	Not currently routinely measured but could develop, adopt/modify using: Te Arawhiti Māori Crown Relations Capability for: Organisations, Individuals, He Ritenga score, Critical Te Tiriti Analysis method

Te Whatu Ora
Health New Zealand

Te Whatu Ora Quality and Safety Measures Framework - Proposed currently accessible measures

Measure domain	Measure category	Measure title	Measure definition	Definition source	Headline or contributory	Data accessible now	Data source/ data owner/steward	Indicator has transparent, unambiguous and consistent definition	Data available over time (maximum quarterly intervals) to allow SPC	Data available at appropriate Geographical level to show variation	Data available for different ethnic groups to show equity	Data accessibility	Data numerator	Data denominator	Frequency of data measured	Data sources	Exclusions
Safe	Complications	Rate of hospital-acquired complications	Hospital acquired complications per 10,000 episodes	HRT	H	Y	HRT	N	?	Y	N	Accessible					
		Rate of major hospital-acquired complications	Hospital acquired complications per 10,000 episodes	HRT	H	Y	HRT	N	?	Y	N	Accessible					
	Mortality	Hospital Standard Mortality Rate	Observed over expected hospital deaths	HRT	H	Y	HRT	N	?	Y	N	Accessible					
		Hospital Standard Mortality Rate	Observed over expected deaths within 30 days of admission to hospital regardless of where death took place	HRT	H	N	Nat Collections	Y	N (technically can be done - issues about seasonality uncertain)	Y	N (can be calculated)	Accessible					
	Infections	Surgical site infection per 10,000 episodes	Surgical complications per 10,000 episodes	HRT	C	Y	HRT	N	?	Y	N	Accessible					
		Surgical site infections Hips and Knees (%)	Percentage of hip and knee cases with a recorded infection within 90 days	HQSC	C	Y	HQSC	Y	Y	Y	Y (requires data linkage)	Accessible	Hip and knee cases with a recoded infection within 90 days	Hip and knee cases		National monitor	
		Surgical site infections Cardiac surgery (%)	Percentage of cardiac cases with a recorded infection within 90 days	HQSC	C	Y	HQSC	Y	Y	Y	Y (requires data linkage)	Accessible	Cardiac cases with a recoded infection within 90 days	Cardiac cases		National monitor	
		Post operative sepsis observed/expected ratio	Observed over expected post operative sepsis	HQSC	C	N	Nat Collections - NMDS	Y (developmental - still some refinement of exclusions)	Y	Y	Y	Accessible					
		Urinary incontinence per 10,000 episodes	Incontinence per 10,000 episodes	HRT	C	Y	HRT	N	?	Y	N	Accessible					
		Staph Aureus per 10,000 episodes	Number of Hospital-Associated Staph Aureus Blood Stream (SAB) infections per 1,000 occupied bed days	HQSC	C	Y	District reporting for Non Nat Collections for Dec	Y	Y	Y	N	Accessible					
	Medications	People aged 65 and over dispensed 5+, 8+, 11+ unique long term medications	All available from https://reports.hqsc.govt.nz/measures-library/_w_bb3eb932/#/measures	HQSC	C	Y	Nat Collections - Pharms	Y	N - annual	Y	Y	Accessible					
		People aged 65+ dispensed the triple whammy (concurrent use of ACE inhibitor or ARB + diuretic/ Diuretic/ NSAID)			C	Y	Nat Collections - Pharms	Y	N - annual	Y	Y	Accessible					
		People who received both a benzo/zzoe and a strone ooioid			C	Y	Nat Collections - Pharms	Y	N - annual	Y	Y	Accessible					
		Medication complications per 10,000 episodes		HRT	C	Y	HRT	N	?	Y	N	Accessible					
	Falls	Falls with fractured neck of femur per 100,000 admissions	Falls with fractured neck of femur per 100,000 admissions	HQSC	C	Y	Nat Collections - NMDS	Y	Y	Y	Y	Accessible	Patients with a Code showing a fall occurred in hospital during the hospital stay and where a fractured neck of femur with a condition onset flag showing this occurred during the hospital stay	100,000 patients aged 15+ admitted to hospital		NMDS	
		Falls resulting in fracture or intrastranial injury per 10,000 episodes		HRT	C	Y	HRT	N	?	Y	N	Accessible					
	Pressure injuries	% patients with a documented and current pressure injury assessment	% patients with a documented and current pressure injury assessment	HQSC	C	Y	District reporting to HQSC	Y	Y	Y	Y - BUT REPORTING QUAL VARIABLE	Accessible	audited patients where assessment carried out	audited patients		HQSC - audit tool	
		% at-risk patients with a documented and current individualised care plan with specific pressure injury actions	% at-risk patients with a documented and current individualised care plan with specific pressure injury actions	HQSC	C	Y	District reporting to HQSC	Y	Y	Y	Y - BUT REPORTING QUAL VARIABLE	Accessible	at-risk audited patients where individualised care plan available	at risk audited patients		HQSC - audit tool	
		% patients with a hospital-acquired pressure injury	% patients with a hospital-acquired pressure injury	HQSC	C	Y	District reporting to HQSC	Y	Y	Y	Y - BUT REPORTING QUAL VARIABLE	Accessible	audited patients with a hospital acquired pressure injury	audited patients		HQSC - audit tool	
		% patients with a non-hospital-acquired pressure injury	% patients with a non-hospital-acquired pressure injury	HQSC	C	Y	District reporting to HQSC	Y	Y	Y	Y - BUT REPORTING QUAL VARIABLE	Accessible	audited patients with a non- hospital acquired pressure injury	audited patients		HQSC - audit tool	
	DVT/PE	Post operative DVT/PE observed expected ratio	Ratio of observed expected post operative DVTs	HQSC	C	Y	National collections - NMDS	Y	Y	Y	Y	Accessible	Patients recorded with a post operative DVT/PE	Patients expected to have a post operative DVT/PE based on ISA model		NMDS	
		Complications (from HRT): incident of VPE/VTE in Ortho operations	Venous thromboembolism per 10,000 episodes	HRT	C	Y											
	Other	In hospital cardio pulmonary arrest	Inpatients cardiopulmonary arrests per 1,000 admissions	HQSC	C	Y	District reporting to HQSC	Y	Y	Y	Y - BUT REPORTING QUAL VARIABLE	Accessible	Patients recorded with a cardiopulmonary arrest	1,000 patient admissions		N - audit (dat pull program'd) - NMDS	
		Rapid response escalations	Rapid response escalations per 1,000 admissions	HQSC	C	Y	District reporting to HQSC	Y	Y	Y	Y - BUT REPORTING QUAL VARIABLE	Accessible	Patients recorded with a rapid response escalation in response to the use od NZEWS	1,000 patient admissions		N - audit (dat pull program'd) - NMDS	
Timely (Access)	Access in planned care	FSPI 2: >120 days and >365 days (Broken down by ethnicity)	% of people waiting longer than reference time	MoH	C	Y	Te Whatu Ora ?	Y	Y	Y	Y?	Accessible					
		FSPI 5: >120 days and >365 days (Broken down by ethnicity)	% of people waiting longer than reference time	MoH	C	Y	Te Whatu Ora ?	Y	Y	Y	Y?	Accessible					
	Access in community	Percentage of children enrolled with a general practice (or a Kaupapa Māori provider delivering general practice care) by age 3 months		SPE	C	?	?	?	?	?	?	Accessible				SPE	
	Faster cancer treatment	Break down by cancer type 31day/62day pathway		TATK	C	?	TATK	?	?	?	?	Accessible					
		Outcome e.g. mortality	This is undefined AND PROBABLY NOT OUTCOME	TATK	C	?	TATK	?	?	?	?	Accessible					
	Shorter Stays in ED	Performance against SSED target	% achieving target		C	Y	Te Whatu Ora ?	Y	Y	Y	Y	Accessible					
	Shorter Stays in ED	50th and 95th percentile of stays	% achieving target		C	Y	Te Whatu Ora ?	Y	Y	Y	Y	Accessible					
Effective	Screening programme measures including bowel, breast cancer etc			MoH	C	YT	MoH	N	?	Y	N	Accessible					
	Potential Atlas measures which cover a range of measures of effective patient management	Fractured Neck Of Femur (NOF) to theatre within 48 hours	HRT?	HQSC	C	YT	HRT?	N	?	Y	N	Accessible				NMDS, NNPAC, NBRS, Pharms	
		% of people with gout regularly dispensed a urate lowering therapy	All available from https://reports.hqsc.govt.nz/measures-library/_w_bb3eb932/#/measures		C	Y	National collections - Pharms	Y	Annual	Y	Y	Accessible					
		% of people with gout dispensed a NSAID without urate lowering therapy			C	Y	National collections - Pharms	Y	Annual	Y	Y	Accessible					
		Serum urate test within six months od urate lowering therapy			C	Y	National collections - Pharms	Y	Annual	Y	Y	Accessible					
		Hospital admissions for people with gout			C	Y	National collections - NMDS	Y	Annual	Y	Y	Accessible					
		People with identified diabetes regularly receiving metformin			C	Y	National collections - Pharms	Y	Annual	Y	Y	Accessible					
		People with identified diabetes regularly receiving CEI or ARB			C	Y	National collections - Pharms	Y	Annual	Y	Y	Accessible					
		People with identified diabetes receiving regular HbA1c monitoring			C	Y	National collections - Labs	Y	Annual	Y	Y	Accessible					
		Peiople with identified diabetes receivine reeular screenine for renal disease			C	Y	National collections - Labs	Y	Annual	Y	Y	Accessible					
		Admissions to hospital for diabetic ketoacidosis, hypoglycaemia and lower limb amputation			C	Y	National collections - NMDS	Y	Annual	Y	Y	Accessible					
		People aged 1-49 with at least two asthma admissions within 90 and 91-365 days			C	Y	National collections - NMDS	Y	Annual	Y	Y	Accessible					
		People aged 0-49 not given a funded influenza vaccine tin the year after and asthma / wheeze admission			C	Y	National collections - Pharms	Y	Annual	Y	Y	Accessible					
		People regularly dispenses SABA and no dispensed (or regularly dispensed) preventer in the year			C	Y	National collections - Pharms	Y	Annual	Y	Y	Accessible					
		% operations completed as day cases															
		% cancelled operations															
		readmission within 7 days (condition and/or service)		TBD?													
Equitable (potential Atlas measures)	Pae ora: Better health and wellbeing in our communities	HPV vaccinations (in both girls and boys) - to consult with Te Aka Whai ora on other measures		MoH	C	Y	Imms	Y	Tannual	Y	Y	Accessible				SPE	
		life expectancies															
	Kahu Taurima: Maternity and early years (first 2000days)	Immunisation rate at 2 years		MoH	C	Y	Imms	Y	Y	Y	Y	Accessible					
	Mate pukupuku: People with cancer	See Faster cancer treatment under Timely		TATK	C	?	TATK	?	?	?	?	Accessible					
	Mauiuiangia taumaha: People living with chronic health conditions	Refer to diabetes and COPD from Effective domain above						N				Accessible					
	Oranga hinengaro: People living with mental distress, illness and addictions	Integrated Primary Mental Health initiative (Access & Choice) either percentage of practices or percentage of target population covered.			C	?		N				Accessible					
Whanau centred experiences of care		Quarterly HQSC patient survey (waiting time and being informed, and being included in their care - MULTIPLE OTHERS AVAILABLE) - important and primary/community	Percentage of respondents giving the most positive response to the question	HQSC	H/C	Y	HQSC	Y	Y	Y	Y	Accessible	respondents giving the most positive response	respondents	Quarterly	HQSC survey data	
		Whanau involvement - patient experience discharge questions		?MoH	C	?N	National collections - NMDS	?Y	Y	Y	Y	Accessible					

Te Whatu Ora Quality and Safety Measures Framework - Proposed As

Measure domain	Measure category	
Safe	Complications	
		Other mortalit
	Infections	
	Medications	Inappropriate prescri
	Pressure injuries	
	Cultural safety (application of feedback from Te Aka Whai Ora and Pacific Health) - referencing Te Pare o Toi, Hauora a Toi and Tipu Mahi	
Whanau centred experiences of care	Whanau wellness (application of feedback from Te Aka Whai Ora and Pacific Health)	
Efficient		
Effective		
	Amenable mortality rates (e.g., CV, T2DM)	Where do th
Equitable	Pae ora: Better health and wellbeing in our communities	
	Kahu Taurima: Maternity and early years (first 2000 days)	Maternity
		Oral health
	Mate pukupuku: People with cancer	
	Māuiuitanga taumaha: People living with chronic health conditions	Management of Diabetes

		Management of Cardiovascular Disease (CVD)
	Oranga hinengaro: People living with mental distress, illness and addictions	
Timely (Access)	Access in planned care	
	Access in community	
	Faster cancer treatment	
	Shorter Stays in ED	
Te Tiriti & Tikanga based	Te Tiriti Maturity Score	

spirational Measures

Aspirational measures
Rate of patients admitted acutely for the same condition for which they are currently on the waitlist
y measures as per discussion with Mortality Review Committee e.g. peri-operative mortality, neonatal, maternal, comparison with HSMR in Australia
Surgical site infection per 10,000 episodes for Abdominal site
Surgical site infection per 10,000 episodes for Caesarean site
Surgical site infection per 10,000 episodes for Hysterectomy site
Aged Residential Care (ARC) avoidance
Avoidable ED presentation from Aged Residential Care (ARC) due to infections
bing / Proxy measure of medication reconciliation / Of the top 10 high risk medications, rate of presentation from known complications i.e. anticoagulants, NSAID, insulin, colchicine, AF, heart valve disease, triple whammy
Workforce
Quality improvement work focused on equity
Procurement, Commissioning and Access to services
Primary care is accessible and focused on the needs of Māori and their rights as it pertains to Te Tiriti
Ethnicity Data Integrity and Governance
Authentic partnerships mechanisms
Achieving health equity and giving effect to Te Tiriti
Antiracism - Ao Mai Te Rā / institutionalised racism
Referencing He Pou Oranga - Tangata Whenua Determinants of Toi Ora
Tāngata whaikaha
PREMs/PROMs - This reflected developments in HQSC program - O/P and PROMs emerging - not available for 18 months
Cost of harm associated with delay in care (wait list)
Chronic Kidney Disease
Prescribing for VPE/VTE (balanced with bleeding)
hese currently sit? It can possibly be under effective or equity – i.e. especially because Māori and Pasifika are highly overrepresented on this front.
Quality of Life and life expectancy
Community connection – Lives alone
Enrolment / Engagement with a primary maternity care provider in the first trimester of pregnancy
Surgical rates and caries in community
Define an ‘acceptable timeframe’ and measure what proportion of children get access to a GA & procedure in that timeframe
Measures around childhood cancer (TBD)
HbA1c Glycaemic control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months
Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is <140mmHg
Management of Microalbuminuria and macroalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have an elevated ACR recorded on two consecutive occasions at least 90 days apart and are on an ACE inhibitor or Angiotensin Receptor Blocker.
CVD Primary Prevention: Percentage of enrolled patients with diabetes (aged 25 to 74 years), whose most recently recorded cardiovascular risk score is ≥20% (2003 methodology) OR ≥15% (2018 methodology) and who are on dual therapy (Statin + BP Lowering agent) Exclusions: History of prior CVD event and those identified as “clinically high”
CVD Secondary Prevention: Percentage of enrolled patients with diabetes (aged 25 to 74 years) with known CVD who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant) Exclusion: History of haemorrhagic stroke

CVD Secondary Prevention: Percentage of enrolled patients (aged 25 to 74 years) with known CVD who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant) Exclusion: History of haemorrhagic stroke
CVD Primary Prevention: Percentage of enrolled patients (aged 25 to 74 years), whose most recently recorded cardiovascular risk score is≥20% (2003 methodology) OR ≥15% (2018 methodology) and who are on dual therapy (Statin + BP Lowering agent) Exclusions: History of prior CVD event and those identified as “clinically high”
People under 25-years able to access specialist mental health services within three weeks of referral
Access to primary mental health and addiction services – developmental measure. Initial reporting of data from integrated primary mental health and addiction services
Rural and remote community access to care (ranges of care and minimum services available)
Not registered / engaged
Not getting first appointment / third available appointment
Closed GP books (registered population per FTE GP/NP and FTE Nurse. Which could be reported quarterly if sector agreed)
Lung cancer screening measures as per (PLCOm2012?)
Access block (decision to admit to getting bed)
Not currently routinely measured but could develop, adopt/modify using: Te Arawhiti Māori Crown Relations Capability for: Organisations, Individuals, He Ritenga score, Critical Te Tiriti Analysis method

Te Whatu Ora
Health New Zealand

Proposal for partnering on the Quality Improvement Scientific Symposium – Regional, National and International

Date:	8 January 2024	**Author:**	Shelley Hanifan, Principal Advisor – policy, HQSC/ Tricia Sloan – Director Operations, SI&I
For your:	Note and endorse	**Approved by:**	Dale Bramley, National Lead, SI&I
Seeking funding:	To note funding impact	**Funding implications:**	yes
To:	**Board**		

Purpose

1. This paper proposes a partnership between Te Whatu Ora and Te Tāhū Hauora to deliver a QI programme, four regional Quality Improvement Scientific Symposiums (QISSs) in 2024, a national symposium (showcase). A larger national QISS (with international speakers and profile) in 2025 will be explored.

2. Partnering on the QISSs will be an investment in sector learning and sharing, to support the appropriate adoption and adaption of good quality improvement practice within service delivery.

Recommendations

3. The Operational Performance Group is asked to:

    a) **agree** to a partnership with Te Tāhū Hauora, to deliver 4 regional and 1 national Quality Improvement Scientific Symposiums in 2024.

    b) **note** SI&I will lead a QI programme to stimulate QI initiatives at care delivery level/ coal face. Small pump prime funds will be made available to enable teams to develop tangible initiatives / innovations.

    c) **note** that in 2024, Regional Groups made up of the RIT SI&I Lead (or their nominee) and nominated consumer / whānau voice, commissioning, HSS, Pacific and Te Aka Whai Ora representatives, will work alongside Regional Integration Teams (RITs). The purpose is to co-ordinate the regional and local quality improvement content for four regional symposiums. Connection with the RITs will be facilitated by the SI&I lead on each RIT.

d) **note** that in 2024, Te Whatu Ora will host a national symposium, bringing together a range of innovations and initiatives from the regional symposiums. This will showcase and promote spread of ideas across the motu.

e) **note** that in 2024/25, the National Conference Programme Committee will explore a larger event with international speakers who will provide thought leadership and inspiration for quality improvement in health service delivery.

Contribution to strategic outcomes

a. The QISS will facilitate sharing and learning about improvement efforts and practice within areas relevant to the health sector principles, Te Tiriti o Waitangi relationships, health equity and the six priority action areas of Te Pae Tata, as well as connecting with priorities of Health & Wellbeing Plans. The content of the QISSs will be developed by a National Conference Programme Committee (National Committee) and by regional groups, through the selection of topics, speakers and a range of abstracts for presentation. Content from within areas relevant to key strategic outcomes for the sector and health system will be actively sought.

Executive summary

4. Te Tāhū Hauora coordinates an annual QISS to build knowledge, understanding and share experience of health service quality improvement in action. The QISS is a popular event and attracts a growing number of participants each year, encouraging interest in, and focus on, health quality improvement.

5. This paper proposes that Te Whatu Ora partner with Te Tāhū Hauora to leverage efforts over the next two years, expanding this work to enable greater engagement and participation across the motu. Our partnership would enable:

    a) in 2024:

        i) expansion of the Te Tāhū Hauora plan for one national QISS with 200-220 attendees, to four regional QISSs with 100 to 120 participants within each region.

        ii) one national showcase event in late 2024 to draw from the regional symposiums (up to 400 attendees).

        iii) access to Te Whatu Ora facilities and regional networks, to support the four QISSs to be nationally and regionally led, regionally delivered and locally applied.

    b) In 2024, SI&I will lead a QI programme to stimulate QI initiatives at care delivery level/ coal face. Small pump prime funds will be made available to enable teams to develop tangible initiatives / innovations.

    c) In 2025, proposed expansion of the Te Tāhū Hauora plan for a larger national QISS (with international speakers and profile) with 400 – 500 participants.

Te Whatu Ora
Health New Zealand

Background

6. Te Whatu Ora and Te Aka Whai Ora have responsibility for delivering quality health services to consumers, whānau and population groups across Aotearoa. Te Tāhū Hauora influences and builds quality improvement science knowledge, including measures, methods and practice, throughout the health system.

7. Te Whatu Ora and Te Tāhū Hauora have discussed key opportunities to work in partnership, in order to leverage planned work in quality improvement capability building. Collaboration and coordination will maximise the impact of the work of both agencies, across the health system.

8. In the past, Te Tāhū Hauora has delivered an annual, national QISS to build quality improvement science capability in the health sector. The QISS has involved international speakers, showcased local successful and innovative quality improvement projects and programmes and attracted wide sector participation. Te Tāhū Hauora has budgeted seeding funds of [redacted] and has charged conference fees for attendance, in order to cover costs. As well as providing an opportunity for networking with others interested in quality improvement, the QISS has been a valued opportunity for learning and sharing throughout the motu. The QISS audience has been growing year on year.

Discussion

9. The QISS offers a key opportunity for Te Whatu Ora and Te Tāhū Hauora to work together to maximise reach and impact, in growing good and promising practice. By partnering on the QISSs Te Whatu Ora can leverage and build on the Te Tāhū Hauora planned investment in sector learning and sharing, and support broader understanding, adaption and adoption of aspects of good practice in quality improvement where appropriate.

10. A partnership is proposed, to leverage investment in quality improvement capability building through the QISS in 2023/24 and 2024/25. The goals of the QISS over the two years, will be to enhance improvement efforts and new knowledge, to better support the implementation of strategic priorities in service delivery throughout the motu.

11. The partnership will enable:

    a) expansion of the Te Tāhū Hauora plan for one national QISS with 200-250 attendees in 2023/24, to enable four regional QISS' with 100 to 120 participants within each region. It is expected that the regional QISS's will take place in the 2023/24 financial year, with dates and times to be worked out with Regional Groups and national agencies who will be sharing content.

    b) SI&I will lead a QI programme to stimulate QI initiatives at care delivery level/ coal face. Small pump prime funds will be made available to enable teams to develop tangible initiatives / innovations.

    c) One national showcase event in 2024 to draw from the regional symposiums (up to 400 attendees).

d) In 2025 explore expansion of the Te Tāhū Hauora plan to enable a large national QISS (with international speakers and profile), with 400 – 500 participants.

12. Across the two years, the sector will have the opportunity to learn within and across regions, and from national best practice. The sector will also have the opportunity to learn from national and international thought leaders in quality improvement.

13. The work will involve establishing a National Committee to provide direction and content leadership for the QISS. This will involve setting clear strategic requirements for content that demonstrate linkages to advancing the health sector principles, Te Tiriti o Waitangi relationships, health equity or to one or more of the the six priority action areas of Te Pae Tata.

    a) In the first year, the makeup of the committee will include Te Tāhū Hauora, Te Aka Whai Ora and Te Whatu Ora quality improvement leads and Te Whatu Ora regional relationship leads.

       Te Whatu Ora regional relationship leads will be responsible for facilitating regional partnerships via the RITS with consumers/whānau, IMPBs, commissioning, NGOs and primary care, to advise on content, abstracts and presentations that showcase good work and promote useful learning regionally and locally. This approach will enable national leadership to support regional leadership and delivery through networks and relationships, with the purpose of showcasing locally applied content from within each region.

    b) the national committee will include agencies who provide seed funding to support the symposium, and key national stakeholders.

       A meeting between Te Whatu Ora and Te Tāhū Hauora quality leads will occur early in 2023 to develop a plan for engaging with appropriate agencies who will have an interest in supporting the QISS.

14. The Regional Groups and the National Committee will be responsible for:

    a) agreeing the core strategic drivers, themes and goals for each conference, in engaging the Regional Integration Teams, agencies, partners and stakeholders

    b) establishing the national symposium/ showcase in 2024

    c) identifying and securing appropriate national and international speakers for the larger national QISS in 2024/25

    d) calling for abstracts and speakers, for each QISS.

    e) selecting the successful papers and speakers (in close consultation with stakeholders in 2023/24).

    f) planning the full QISS series of conferences, event management and ensuring that information is available online afterwards, for sector sharing

    g) providing regular reporting to Te Whatu Ora, Te Tāhū Hauora and other agencies as required by each agency

h) evaluation of QISS's and reporting back to Te Whatu Ora and Te Tāhū Hauora ELT and boards at conclusion.

Organisational support from each organisation

15. Both agencies will work together to facilitate the regional QISS's in 2024 through the National Committee. Te Whatu Ora will provide the use of their facilities and regional networks. Staff time will be provided by each organisation, as agreed through the National Committee, to support a successful series of regional QISSs.

16. In 2024/25, it will be necessary to bring in other agencies, with seed funding to support and underwrite the larger conference. Funding will enable international speakers to be sought and secured, and appropriate facilities to be booked. It is expected that a conference fee will be required to cover costs, and this will be factored into planning as required, by the National Committee.

17. This paper has been shared with Te Aka Whai Ora, Commissioning and HSS. The feedback is positive with a willingness to engage and address their priorities via the proposed programme. Te Aka Whai Ora will join the partnership for planning and delivery.

Financial implications

18. For the regional symposiums, resource contributions will be shared, through workforce support, shared expertise and networks, the provision of facilities, equipment and personnel time for planning and delivery. Travel and disbursements for delegates will be met by the directorates in Te Whatu Ora.

    a) An initial budget allowance of [redacted] for the QI programme and the 5 events including administration/event support is recommended with expectation that this will be refined and reduced as event planning and requirements are identified.

    b) The International meetings will require further business case and costing analysis.

Next steps

19. Following your agreement to this partnership, quality improvement leadership staff from Te Whatu Ora and Te Tāhū Hauora will meet early in 2024, to plan and coordinate:

    a) the development of regional groups to facilitate and assist delivery of regional QISSs for 2024

    b) an approach to other agencies which may have an interest in supporting the large national QISS event in 2024/25

20. In early 2024, a National Committee will be established to support the 2024/25 QISS.

21. QISS invitations will be provided to ELT and the board when these are ready, regular reporting will be provided as you direct, and an evaluation will be shared on conclusion of this partnered project.

DRAFT Te Whatu Ora QISS Programme Structure

Chief Executive – Te Whatu Ora & Te Aka Whai Ora

National Steering Group

National Committee

Regional Working Group Northern **Tracey**

Regional Working Group Te Manawa Taki **tbc**

Regional Working Group Te Ikaroa Central **Richie**

Regional Working Group Te Waipounamu **Bernie**

National Steering Group:
- National Director, HSS - Fionnagh Dougan
- National Director, D&D - Leigh Donaghue
- Chief People Officer - Andrew Slater
- Interim Chief Clinical Officer - Richard Sullivan
- National Director, SI&I - Dale Bramley
- Director of Operations, SI&I - Tricia Sloan
- Director of Te Whatu Ora Improve, SI&I - Penny Andrew

National Committee:
- Director of Operations, SI&I - Tricia Sloan
- Director of Te Whatu Ora Improve, SI&I - Penny Andrew
- PMO, SI&I – *Cindy Tuitupou/Marizel Sanchez-Dizon TBC*
- Te Whatu Ora Improve GMs, SI&I – Bernie County, Richie Perry, Tracey Popham
- Event Programme Manager –*TBC*
- Administration/Coordination support - *internal TBC*

Key Responsibilities:
- Deliver national symposium (learning event), including awards night
- Set national themes with CE/ELT e.g. equity, system flow, planned care
- Content e.g. agenda, speakers, topics
- Support RITs & Regional Working Groups by;
  - developing toolkit/how to guide with Te Tāhū Hauora
  - developing brand, marketing/event collateral with Ara Manawa (design team)
- Evaluation
- Logistics e.g. venue, AV, MC, catering, invitations, on the day event management

Regional Working Groups: working alongside RITs
- Te Whatu Ora Improve GMs – Bernie County, Richie Perry, Tracey Popham
- Representatives identified by RIT – *TBC*
- Administration/Coordination support – internal

Key Responsibilities:
- Deliver regional symposiums
- Align with nationally set themes, and those identified by the RIT
- Content e.g. agenda, speakers, topics
- Calling for submissions, selection for presentation at event
- RIT - award seed funding to initiatives in 'Seed' category
- Support, encourage people to take part
- Evaluation – align with National Committee approach
- Logistics e.g. venue, AV, MC, catering, invitations, on the day event management

Regional Integration Team - Northern
Regional Immunisation Structures

Recommendation

It is recommended that the Regional Integration Team:

Receive this paper

Endorse the proposed structures required to provide leadership, strategic direction, co-ordination, and operational support across multiple health entities for immunisation delivery in the Northern region.

Endorse the drafting of Terms of Reference, which will include membership, of the groups proposed in this new structure, if the proposal is accepted.

Prepared and submitted by: Prevention Development & Delivery Lead - Northern

Glossary
DHB - District Health Board
NIP - National Immunisation Programme
NPHS - National Public Health Service
NRIUIG - Northern Region Urgent Immunisation Group
RIGG-N - Regional Immunisation Governance Group - Northern
RIT - Regional Integration Team
ILG – Immunisation Leadership Group
IOG - Immunisation Operations Group

Purpose
The purpose of this paper is to:

1. describe the current state and challenges of the strategic and operational environment for immunisation within the Northern Region; and
2. propose a structure for the Northern Region that supports the functions of effective leadership, strategic direction, integration, resource allocation, coordination and collaboration, and accountability across multiple health entities.

Executive Summary
Achieving high vaccination rates is an important public health intervention to protect the population from the harm of communicable diseases and immunisation coverage is well below the target of 95% at 2 years of age and achieving the targets is a government priority.

Currently there are multiple health entities across the Northern region supporting immunisation service delivery, alongside several groups both nationally and regionally that are involved in planning and delivering initiatives to lift immunisation rates. Added to this is a new national structure across Te Whatu Ora and a revised accountability for immunisation coverage. This requires all entities in the region to work together in a collabroative way to ensure a co-ordinated approach to delivering immunisation services.

The opportunity exists to redefine the immunisation leadership structure in the Northern region to enable prompt decision-making, strategic planning to support operational implementation, and identifying opportunities for a regionalised approach versus when local solutions tailored to communities are necessary. The proposal is to establish a permanent whole of system leadership structure that supports good governance and strategic direction, whilst maintaining effective and efficient operational delivery with

transparency for all parties, and clear communication pathways with the national prevention directorate.

Specifically, it is proposed that an Immunisation Leadership Group (ILG) is established to provide thought leadership, oversight and decision-making for the immunisation programme and an Immunisation Operational Group (IOG) to provide effective coordination of immunisation services and efficient allocation of resources to deliver on priorities. These groups would replace the existing Northern Region Urgent Immunisation Response Group (NRUIRG) and Regional Immunisation Governance Group - Northern (RIGG-N) respectively, but noting the expertise held by those on NRUIRG and RIGG-N would transfer to the new groups.

The four Prevention Development and Delivery Leads (NPHS) are proposing the same immunisation structures within the four regions (Northern, Te Manawa Taki, Te Ikaroa, and Te Waipounamu) to ensure we are aligned nationally in our strategic and operational approaches.

Background

Immunisation is an extremely effective intervention that reduces the morbidity and mortality from a number of communicable diseases. High immunisation coverage has been recognised by successive governments as important and in keeping with this, the newly elected government has identified vaccination coverage at two years as one of their five initial health targets. This means there will be scrutiny on vaccination coverage rates and a requirement for visibility over activity funded to achieve this target. There is particular concern regarding the very low antenatal vaccination rates and the timeliness of the 6-week and 12-month vaccination events as well as the ongoing significant equity gap for Māori at all coverage milestones.

The health system has been undergoing significant structural change since the Pae Ora legisation was enacted in July 2022. This resulted in the consolidation of twenty District Health Boards (DHBs) into one national entity, Te Whatu Ora Health New Zealand, and the establishment of Te Aka Whai Ora Māori Health Authority. These changes have resulted in a change in accountability for vaccination coverage. Instead of DHBs being responsible for achieving vaccination targets for their domiciled population, accountability now sits with the NPHS Regional Directors. Despite these changes, there is commitment across the sector to work together to improve vaccination coverage rates, which requires all entities in the region to work together in a collaborative way to ensure a coordinated approach to immunisation service delivery.

There is a need to articulate a strategic approach to lifting vaccination coverage, create clear processes for decision making and visibility of, and accountability for, service delivery. It is therefore timely to review the way the regional governance structure is currently organised to ensure the structures support the functions required to lift vaccination rates, namely; effective leadership, strategy development, resource allocation**,** coordination, accountability and operational delivery, including monitioring and evaluation.

Current structures

The roles and responsibilities for immunisation sit at multiple places throughout the system (Appendix 1). However, the overall accountability for immunisation service delivery sits with the National Director, NPHS, and regionally with the Regional Directors, NPHS.

National structures and groups

The National Immunisation and Childhood Screening Group (encompassing what was previously the National Immunisation Programme) sits within the Prevention Directorate of NPHS. The function of this team is national programme delivery of an integrated approach across prevention to deliver on Pae Ora. This team will set the national strategy and priorities for immunisation, for regional teams to embed and deliver on. In addition, the following groups provide governance and oversight:

- Oversight Board, which has governance functions, reports directly to Ministers, sets strategy, established priorities, and allocates resources and provides assurance and oversight. Andrew Old, Deputy Director General - Public Health Agency, chairs this group.

- Outcomes Collective, which functions as a steering group and reports to the Oversight Board. The membership of this group is the accountable Directors and GM for immunisation work and the functions include establishing programme settings, directing programme activities and programme implementation, managing operational risks and issues and responsibility for monitoring and reporting including budget management.
- The National Immunisation Technical Advisory Group (NITAG) is being established via an Expression of Interest process.
- The Immunisation Taskforce Group provides advice to the Chief Executives of Te Whatu Ora and Te Aka Whai Ora on action to be taken locally, regionally and nationally to achieve the childhood immunisation targets. This group is co-chaired by Dr Owen Sinclair and Cathy O'Malley. The Immunisation Taskforce Governance Group is chaired by Dr Nick Chamberlain (National Director, NPHS) with representation from Te Aka Whai Ora, PHA, NPHS, Commissioning and the Immunisation Taskforce Co-Chairs.

Regional structures and groups

In the past a Senior Responsible Officer's (SRO) forum, which was chaired by the director of the NIP and attended by the SROs from the regions, GM Clinical, and GM Operations, was the main conduit between national and local planning and delivery. This group has been replaced by a Regional Prevention Development & Delivery Leads meeting, bringing together the Regional Account Managers from the Prevention Directorate (NPHS) and the Regional Development & Delivery Leads (embedded within the regions in NPHS), with a view they will work collaboratively with those engaged in immunisation within their region.

The Regional Immunisation Governance Group - Northern (RIGG-N) was established by Waitematā Planning and Funding team in May 2022. One of the drivers of establishing this group was to create a forum to engage primary care about the low vaccination rates, create regional visibility of current activities, and co-ordinate action to lift vaccination rates. The terms of reference state the purpose of the group is to *"plan and provide strategies to improve immunisation coverage rates for antenatal and children, with particular focus on tamariki Māori. RIGG-N works collaboratively and with urgency with the Metro Auckland Clinical Governance Forum (MACGF) members and across the health and community sector to identify barriers, resources availability and funding streams to achieve immediate immunisation targets"*. The group is co-chaired by Māori Leadership – Dr Owen Sinclair, secondary care paediatrician and Dr Ranche Johnston, Clinical Director of National Hauora Coalition, with secretariat support from Waitematā Planning and Funding Team. There are several working groups that have been established through the RIGG-N progressing work in priority areas.

The Northern Region Immunisation Urgent Response Group (NRIURG) was recently established to urgently address inequitable immunisation rates in the Northern Region. The group comprises of senior regional leaders (including RIT members) alongside provider representatives to provide strategic and operational direction, collective action and thought leadership with the ability to make decisions to achieve the 30 June 2024 immunisation target, focusing on Māori and Pacific tamariki and hapū māmā. The group is intended to support providers and operational teams to implement and develop initiatives that are equitable and sustainable. This group was intended to be supportive and temporary in nature.

Key issues to be solved

As described above there several factors that add complexity to co-ordination and delivery of immunisation within the region. To summarise these are:

- Multiple entities/partners who deliver immunisations services for our communities;
- The change in accountability for immunisation coverage – historically districts funded services and/or provided services themselves, and accountability now sits with the NPHS. The Regional NPHS does not commission or deliver immunisation services;
- Absence of a well-defined strategic plan and regional service delivery framework, focussed on a collective approach to delivering immunisations across the life-course and addressing additional

health and well-being priorities for whānau;

- A number of different groups exist and provide some degree of co-ordination and/or governance, but are not connected to the key regional decision-makers (i.e. the Regional Integration Team);
- A lack of clarity about roles and responsibilities across the Northern Region and potentially significant overlap with functions within the existing groups. Similarly, the national teams share some functions with the regional groups as they are currently articulated.

It is timely to consider redefining the current structure in the Northern region to ensure it is fit for purpose and supports working in a co-ordinated and collaborative way, identifying where it is appropriate to do things once and well for the region and when local solutions tailored to communities are necessary. This regional structure needs to have clear relationships to the national structures supporting immunisation work, including the National Prevention Directorate that sits within the NPHS. In addition, it needs clear line of sight for the developments and commissioning within Te Aka Whai Ora, so that the entire regional strategy is lined up and coordinated effectively.

Proposal

The proposal is to establish a permanent whole of system Immunisation Leadership Group (ILG) and an Immunisation Operational Group (IOG) to enable the Northern Region to work in an effective, efficient and collaborative way. These two groups must have Māori co-chairs, similar to the RIT structure.

The purpose of the ILG would be to provide oversight and decision making for the immunisation programme in the Northern Region. The ILG will develop a well-defined strategic plan and regional service delivery framework, focussed on a collective approach to delivering immunisations across the life-course and addressing additional health and well-being priorities for whānau. This group would be a subcommittee of the RIT, with the addition of strategic regional immunisation roles across the region who have strategic and financial decision-making remits and be permanent in nature. This group would replace the current NRIURG group and the Regional Director, Northern NPHS would co-chair this group.

The core functions of the ILG would be to:

1. Link into the national groups including the Immunisation Taskforce Governance Group and receive direction from the Oversight Board via the Outcomes Collective;
2. Translate national strategy and investment signals into the regional context;
3. Respond to funding requests from the IOG;
4. Accountablility for vaccination activity and achieving vaccination targets to Te Whatu Ora nationally.

The second group proposed to be established is an Immunisation Operations Group (IOG) with a purpose of delivering on the regional strategy and service delivery framework set by the ILG and overseeing operational implementation and commissioning. This group would hold responsibility for operational delivery across the region and would comprise of members who hold operational accountabilities. The current membership of RIGG-N primarily consists of those involved in the operational delivery of services. This group would replace the RIGG-N and include the expertise of those who have been part of this group and working groups. The core functions of the IOG would be to: provide operational coordination, implement new initiatives, report on activity within the established working groups. This group would be accountable to the ILG for the operational delivery of the immunisation strategy and should include key stakeholders such as PHOs, Hauora Māori Partners, Pacific Providers, Pharmacy and Midwifery.

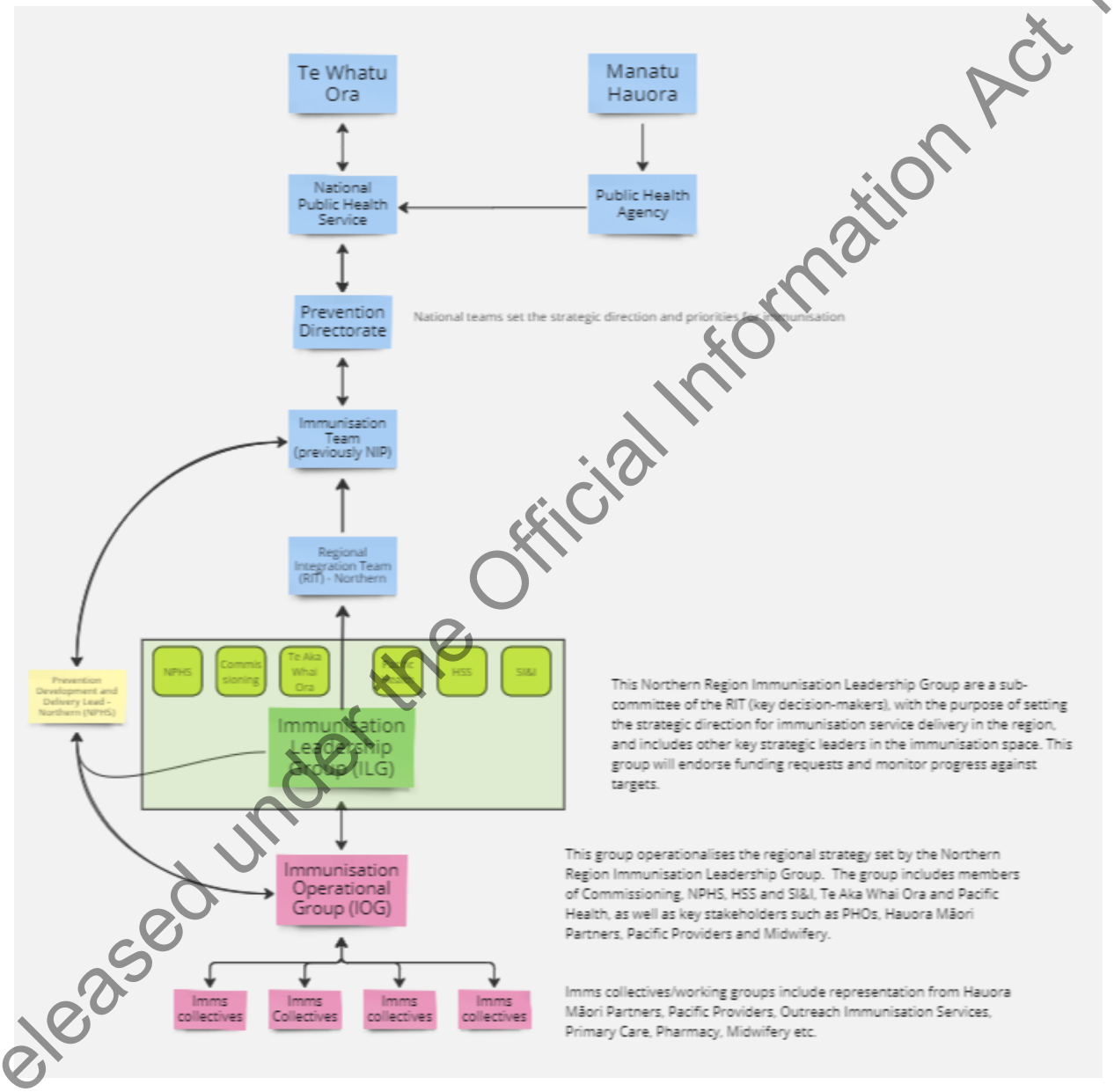
A new role, Prevention Development and Delivery Lead – Northern, has been established within the regional NPHS structure. This role connects to the national prevention teams and regionally across all Te Whatu Ora, Te Aka Whai Ora and key stakeholders. It is proposed that this role will support the regional ILG and IOG within the Northern Region.

A review of membership of the ILG should be undertaken to ensure strategic representation from those responsible for the delivery of key services.

Next steps

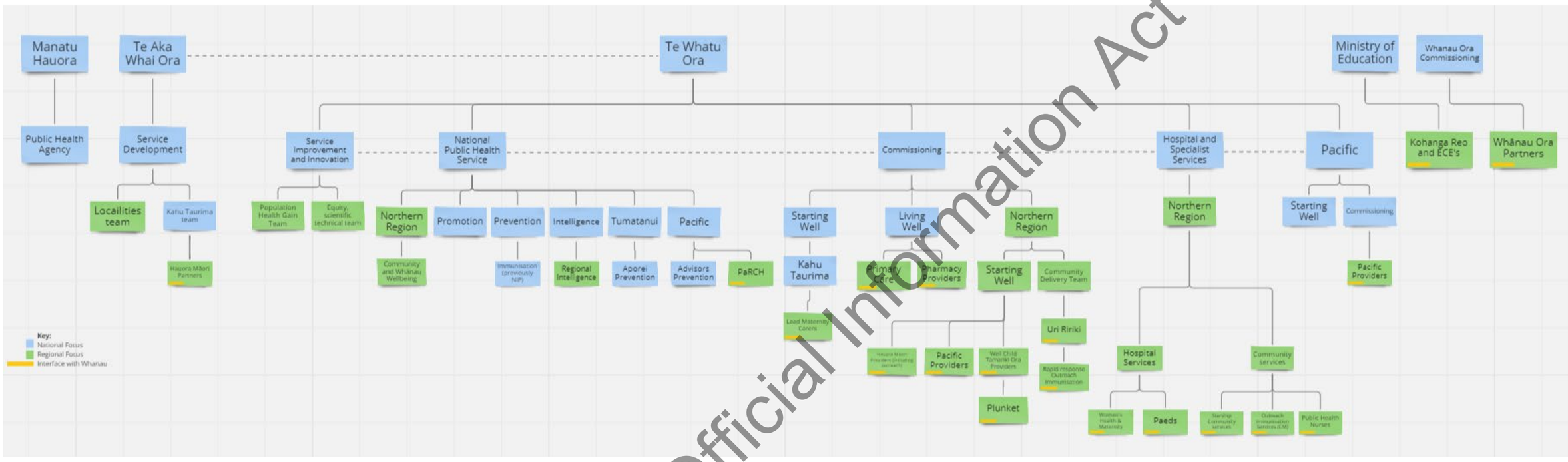
(1) Endorsement of the proposal with the Northern RIT;
(2) Discuss the proposal with chairs of NRIURG and RIGG-N and consider the chairs of RIGG-N as members of the ILG and IOG;
(3) Draft the terms of reference for the ILG and IOG, articulating the purpose and membership for each group by 1st March 2024;
(4) Review and transition work in progress to the appropriate groups.

Figure 1. Proposed structure of Northern Region Immunisation Leadership and Operational Groups



Appendices

Appendix 1: <u>Draft</u> systems map - Immunisation



Te Whatu Ora
Health New Zealand

Memorandum to the Regional Integration Team: Northern

Quality Improvement Scientific Symposium

Date:	15 February 2024
From:	Tricia Sloan, Director of Operations – Service Improvement & Innovation (SI&I) Penny Andrew, Director Te Whatu Ora Improve, SI&I

Purpose

1. The purpose of this memo is to inform the Regional Integration Team (RIT) of ELT's (Te Whatu Ora) decision to deliver 4 regional and 1 national Quality Improvement Scientific Symposiums (QISS or 'symposiums'), in partnership with Te Aka Whai Ora andTe Tāhā Hauora (Health Quality & Safety Commission), in 2024 (see ELT paper Appendix 1).

2. Seek support from the RIT to facilitate delivery of the Northern regional symposium.

Recommendations

3. The RIT is asked to:

   a) **note** ELT's decision (see ELT paper Appendix 1) to run 4 regional quality improvement scientific symposiums (QISS)and 1 national symposium, and for the RIT to facilitate delivery of the Northernregional symposium in 2024.

   b) **note** proposed structure of the National QISS Programme (Appendix 2).

   c) **nominate** members from your teams to form a Regional Working Group (Appendix 2) to facilitate delivery the Northern regional symposium.

   d) **discuss/ agree** key milestones - date and venue location.

   e) **note the** symposium themes will determined by Te Whatu Ora ELT. Themes are likely to be equity, consumer and whānau engagement, system flow planned care. There will also be the opportunity for regional priorities to be included.

   f) **discuss** themes specific to the Northern region that could feature in the regional symposium.

   g) **note** SI&I will lead a programme to stimulate improvement & innovation initiatives at care delivery level. Small seed funds will be made available to enable teams to develop tangible initiatives.

   h) **note** SI&I and Te Tāhū Hauora will develop a 'toolkit' to support the RITs and Regional Working Group to facilitate delivery of the symposium.

Partnership with Te Aka Whai Ora

4. This programme of work is being developed and delivered in partnership with Te Aka Whai Ora. Te Aka Whai Ora Mātauranga Māori Directorate guidelines for engagement and relationship management[1] provide Mātauranga Māori Directorate representatives and Te Whatu Ora representatives with clarity and expectations of strengthening tō tātou whaka hourua as we navigate th programme of work together to achieve agreed outcomes and to mahi tahi. Through the guidelines each partner represents our respective expertise, mana and expertise with respect knowledge systems and worldviews, moving together in a common direction of achieving Pae Ora.

5. The guideline places the principle of mana at the centre of our living relationship to manage expectations, roles and responsibilities of the partners working together. It places obligation on all the partners to uphold with integrity their partnership obligations.

Principles underpinning our relationship

The Kawenata set out in the guideline defines the fundamentals of the relationship between Te Whatu Ora and Te Aka Whai Ora for this mahi. The Kawenata values are:

- **Mana Ōrite**: Respective views will be heard, considered, and afforded equal explanatory power.
- **Kotahitanga**: An operational culture of moving together with solidarity towards a common purpose.
- **Manaakitanga**: Derives from two words - 'mana' and 'aki'. Mana is a condition that holds everything in the highest regard. Aki means to uphold or support. Therefore, manaakitanga in this context means a governance and operational culture that its respectful and supportive and does not confuse accountabilities.
- **Whanaungatanga**: Strong transparent governance and operational relationships through respect, integrity, empathy, and commitment to the kaupapa of achieving Pae Ora for whānau.
- **Tū maia me mātātaki**: Brave, bold, capable, confident decision-makers - unafraid of free and frank advice and who are courageous in the face of the challenge.
- **Tū Waatea**: Inclusiveness through self-awareness. This means being open to others' views because we operate in good faith and are willing to be unencumbered by our own experiences.

Contribution to strategic outcomes

6. The symposiums will facilitate sharing and learning about improvement and innovation efforts and practice within areas relevant to the health sector principles, Te Tiriti o Waitangi relationships, health equity and the six priority action areas of Te Pae Tata, as well as connecting with priorities of Health & Wellbeing Plans. The content of the symposiums will be developed by a National Conference Programme Committee (National Committee) and by Regional Groups, through the selection of topics, speakers and a range of abstracts for presentation. Content from within areas relevant to key strategic outcomes for the sector and health system will be actively sought.

[1] Mātauranga Māori Directorate Guidelines for Engagement and Relationship Management

Background

7. Te Tāhū Hauora has hosted annual quality improvement scientific symposiums featuring keynote speakers, peer-reviewed papers, interactive sessions and learning and networking opportunities. The 2023 symposium focused on the science of improvement, by highlighting improvement methodology. Themes for the presentations were based on the Wai2575 principles.

8. Health professionals showcased initiatives at the QISS symposium - posters and presentations. Initiatives could be at different stages; 'Seed' (promising ideas and ways for improving care, too young to have results), 'Sprout' (some early results but not yet showing sustained improvement), 'Plant' (complete, demonstrates changes in processes and outcomes and shows sustained improvement with potential for, or has achieved, spread).

9. Te Whatu Ora and Te Tāhū Hauora will work in partnership on the symposiums to build quality improvement capability.

10. Partnering on the symposiums will be an investment in sector learning and sharing to support the appropriate adoption and adaption of good quality improvement practice within service delivery.

11. Four regional symposiums will be run in 2024 with up to 120 people attending each.

12. Funding has been approved to run the symposiums and to provide some stimulus funding to early ('Seed') initiatives.

Discussion

13. The goals of the symposiums will be to enhance improvement and innovation efforts and new knowledge, to better support the implementation of strategic priorities in service delivery throughout the motu.

14. The sector will have the opportunity to learn within and across regions, and from national best practice. The sector will also have the opportunity to learn from national and international thought leaders in quality improvement and innovation.

15. The proposed National QISS Programme structure includes a National Committee (reporting to ELT Steering Group) and Regional Working Groups.

16. The National Committee provides direction and content leadership for the symposiums aligned with ELT/CE direction. This will involve setting clear strategic requirements for content that demonstrate linkages to advancing the health sector principles, Te Tiriti o Waitangi relationships, health equity or to one or more of the six priority action areas of Te Pae Tata.

17. In addition to delivering the national symposium and awards evening, the National Committee will be responsible for:

    a) planning the full QISS series of symposiums, event management and ensuring that information is available online afterwards, for sector sharing

    b) supporting the RITs & Regional Working Groups by:

i) developing a toolkit/how to guide with Te Tāhū Hauora

ii) developing branding, marketing/event collateral with Ara Manawa (SI&I design team)

c) evaluation of QISSs and reporting back to Te Whatu Ora and Te Tāhū Hauora ELT and boards at conclusion.

18. The Regional Working Groups will be responsible for facilitating regional partnerships via the RITs with consumers/whānau, IMPBs, commissioning, NGOs and primary care, to advise on content, abstracts and presentations that showcase good improvement and innovation work and promote useful learning regionally and locally.

19. Regional Working Groups will work closely alongside the RITs to facilitate the delivery of the regional symposium. Proposed membership include representatives from the following;

a) Te Aka Whai Ora

b) Pacific Health

c) Commissioning

d) HSS

e) National Public Health Service

f) SI&I (RIT lead or nominee)

g) Consumer / whānau voice

20. The Regional Working Groups will be responsible for:

a) ensuring themes and goals for each conference align with nationally set themes, and those identified by the RIT

b) Content e.g. agenda, speakers, topics

c) Calling for abstracts and speakers, selecting papers and speakers with the RITs

d) RIT - award funding to initiatives in 'Seed' category

e) Support, encourage people to take part

f) Evaluation – align with National Committee approach

g) Logistics e.g. venue, AV, MC, catering, invitations, on the day event management.

21. Seed funding has been approved to support initiatives. These funds are to be awarded by the RIT to initiatives in the 'Seed' category to feature in 2025 symposiums and national event.

Financial Implications

22. For the regional symposiums, resource contributions will be shared, through workforce support shared expertise and networks, the provision of facilities, equipment and personnel time for planning and delivery.

23. Travel and disbursements for sdelegates will be symposium met by the directorates in Te Whatu Ora.

Key next steps

24. Form the Regional Working Group with nominees to deliver the Northern region symposium in 2024. This group will meet weekly and partner with the National Committee to ensure alignment of approach.
25. Develop and execute programme, including identifying key stakeholders, communication channels, risks and mitigations and evaluation.
26. Action time critical elements - book a venue in the agreed location, identify and book speakers, stakeholder analysis, calendar placeholders.
27. Regular reporting will be provided to the RIT by the SI&I lead on the Regional Group, and evaluation shared on conclusion of this initiative.

Attachments

- Appendix 1: ELT paper. Proposal for partnering on the Quality Improvement Scientific Symposium –Regional, National and International. Dated 8 January 2024.
- Appendix 2: Proposed QISS National Programme Structure.

Te Whatu Ora
Health New Zealand

Agenda

Regional Integration Team: Northern Region

Date:	27th February 2024		
Start Time:	16:00	**Finish Time:**	17.00
Location:	**Microsoft Teams Meeting:** Click here to join the meeting		

Members: Danny Wu, Regional Wayfinder – Northern Region (Co-Chair)
Tracee Te Huia, Regional Director (Co-Chair)
Hayden McRobbie, Regional Director – National Public Health Service
Harriet Pauga, Regional Director - Pacific
Mark Shepherd, Regional Director – Hospital and Specialist Services
Penny Andrew, Executive Director
Sanjoy Nand, Regional Clinic Lead
Daniel Gotz, Senior Advisor
Janine Pratt – Group Manager, Office of the Regional Wayfinder
Rochelle Bastion – Regional Integration Team Lead

Quinton Grey, Executive Assistant to the Regional Wayfinder (Secretariat)

Guests: Richard Sullivan, Lavinia Perumal, Stuart Jenkins, Charles Tutagalervao

Apologies:

Time	Item	Method	Purpose	Lead
4.00pm	**Commencement** • Karakia • Apologies • Introductions • Other business			Danny Wu
4.05pm	Review of Previous Meeting minutes and Action Points	MIN 20240220 - NR RIT - 20 February 20		Danny Wu
4.10pm	**Quality Governance and Clinical Leadership** • Clinical Governance and Quality and Safety System	National Clinical Governance Norther	Update	Richard Sullivan
4.35pm	**Strategy Planning and Review** • Health Status Report	Health Status Report – Te Whatu Ora - Health New Zealand	Note	Janine Pratt

4.40pm	**National and Regional Activities** • Quality Improvement Scientific Symposium	Draft QIIS programme structur Northern RIT - QISS Programme 1902202	Approval of recommendations	Penny Andrew
4.50pm	**Management and Administration** • Interests register • Planning for RIT work programme & ways of working session	Declaration of Interests form - RIT.c	Action Update	Janine Pratt
4.55pm	**General Business**			All
5.00pm	**Karakia whakamutunga**			All

Actions	Assigned to	Due date
Forward minutes from Steering Group meeting 14 February 2024 to RIT	Quinton Grey	27/02/2024
Discuss with RIT co-chairs the process on aligning our plans and board priorities before submitting to ELT	Danny Wu / Tracee Te Huia	27/02/2024
Penny Andrews to provide links to Quinton Grey to disseminate	Penny Andrew / Quinton Grey	27/02/2024

Te Whatu Ora
Health New Zealand

Meeting Minutes

Meeting	Regional Integration Team, Northern Region
Date & time	27 February 2024 – 4:00pm to 5.00pm
Present	Penny Andrew, Rochelle Bastion, Hayden McRobbie, Sanjoy Nand, Harriet Pauga, Janine Pratt, Mark Shepherd, Danny Wu
Guests	Lavinia Perumal, Richard Sullivan, Charles Tutagalevao
Apologies	Tracee Te Huia, Daniel Gotz

Item	Agenda Item	Lead

1.	**Commencement**
	• Karakia (Hayden McRobbie)
	• Welcome and whakawhanaungatanga.
	  ○ Introductions from guests
	• Previous meeting minutes:
	  ○ Not read.
	• Matters Arising:
	  ○ Nil.
	• Additional agenda items:
	  ○ Nil.
		Chair

2.	**Clinical Governance and Quality & Safety System** • Focus for discussion should be link between RIT and regional clinical governance. • RIT to note a regional clinical governance group and work to do to connect sub-groups into it. • ACTION POINT: Penny to circulate terms of reference to group	**Richard Sullivan**
3.	**Strategy, Planning and Review** • Health Status Report is out.	**Janine**
4.	**QI Scientific Symposium** • Request for RIT to take the lead. • Penny and Rochelle to put together a plan offline and return it to RIT at a later date.	**Penny**
5.	**Declaration of Interest form** • Please complete and return.	**Janine**
6.	**RIT work programme** • The team are putting together a forward work programme to present at the next face-to-face.	**Janine**

The meeting was closed by the chair at 5:12pm.

Next meeting: Wednesday 6 March 2024

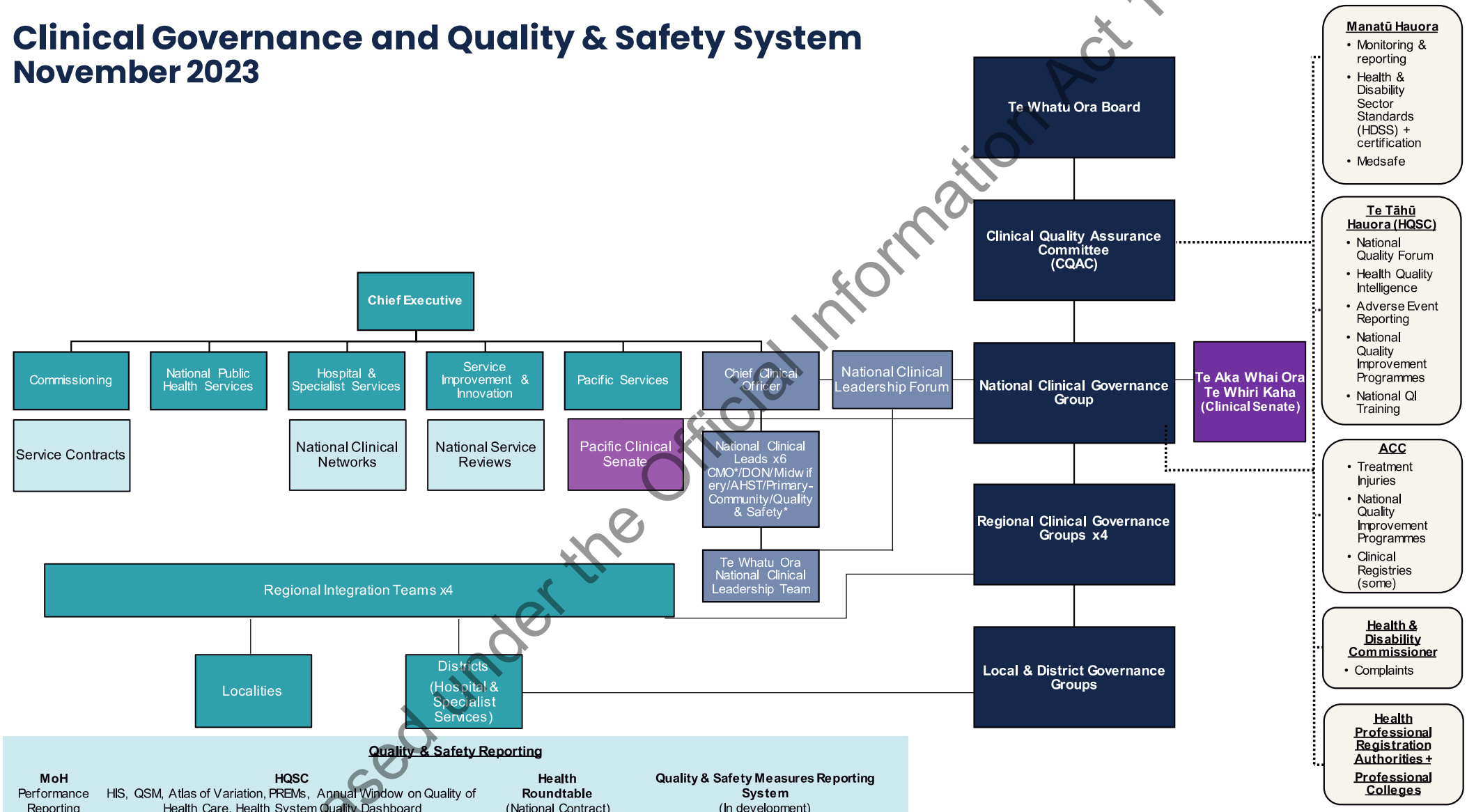
Actions	Assigned to	Due date
Clinical Governance and Quality & Safety System terms of reference to be circulated to the group	Penny Andrew	06/04/2024

Te Whatu Ora
Health New Zealand

Clinical Governance and Quality and Safety System

February 2024

Clinical Governance and Quality & Safety System November 2023

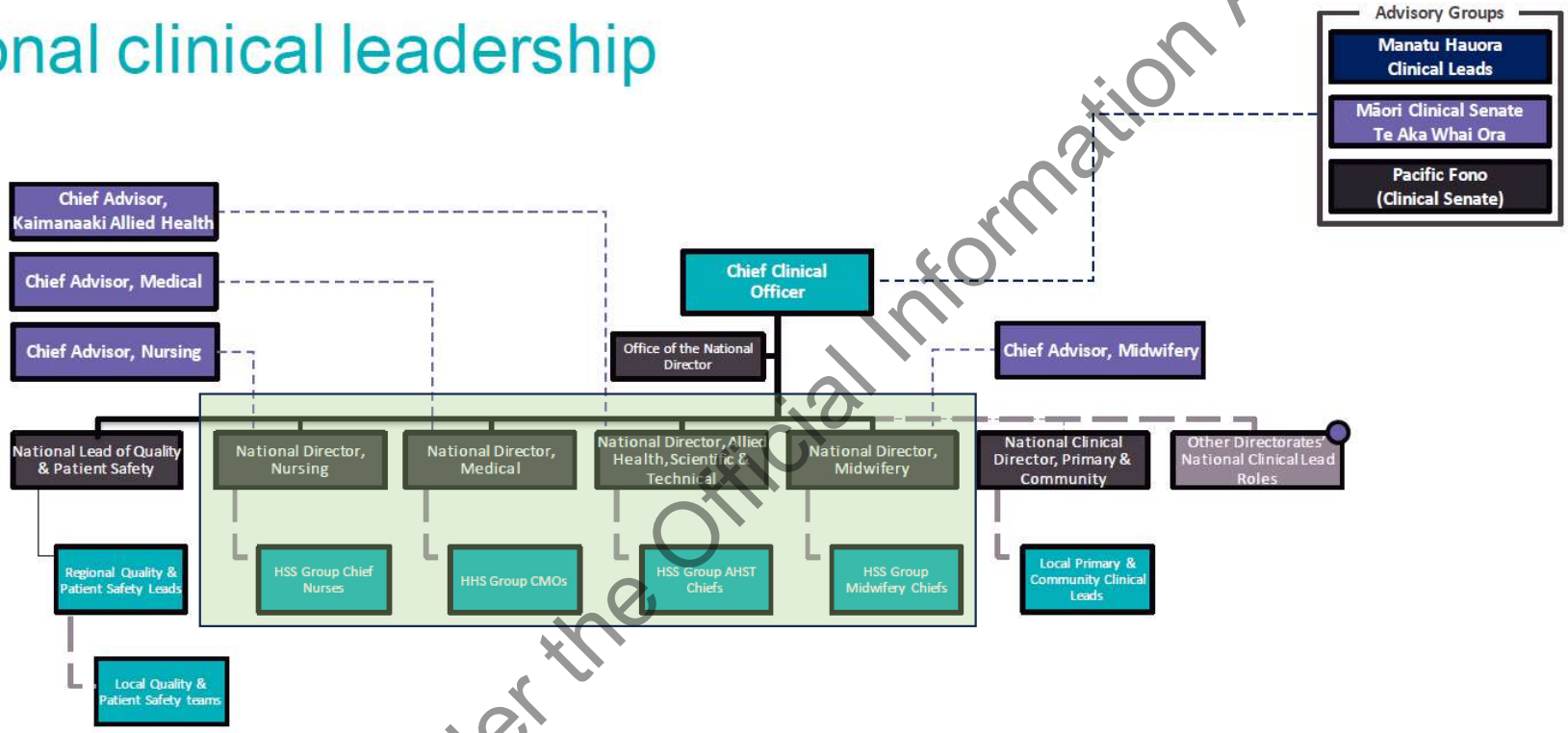


Appendix Two – Potential Membership of Regional Clinical Governance Group -

1. Member	Connections and Representation	Comment
1. Māori Clinician	• Te Akai Whai Ora	• Same person as on RIT?
2. Pacific Health	• Links regional Pacific Health and local teams	•
3. Consumer 1	•	• Links to local and national
4. Consumer 2	•	• Links to local and national
5. National Clinical Lead	• Office of Chief Clinical Officer	• Links to NCGC, CQAC
6. HSS 1	• Link and overlap with the Clinical Governance structure of HSS and Directors office	• Need to consider balance of representation from sites across the whole region
7. HSS 2		
8. HSS 3		
9. HSS 4		
10. Community 1	• Link and overlap with the Clinical Governance structure of commissioning and way-finders office	
11. Community 2		
12. Community 3 (Mental Health)		
13. Public Health Service	• Overlap with PHS Clinical Governance Team	• Represents the PHS Clinical leaders
14. Service Improvement and Innovation	• Links to regional governance of I&I and local service delivery	• Same person as on RIT?
15. Data and Digital	• Represents regional team	• Local and national links

Membership shall be comprised to gain appropriate representation based on geography and professional skills. Membership shall include kaimahi at different career stages.

National clinical leadership



All directorates' clinical leader roles align with roles and functions of clinical leadership and clinical governance
All directorates' clinical leaders report (dotted line) on their clinical governance role and function to relevant clinical national director

What Clinical Leaders Do

Clinical Leadership

- Quality improvement
- Strategic vision
- Driving change
- System connectivity
- Improving ways of working
- Delivering outcomes

Professional Leadership

- Support and mentoring
- Relationship with regulators
- Covers employment issues
- Managing performance issues
- Ensuring training and service planning works in the local area

Operational Leadership

- Inter-disciplinary collaboration
- Defining who can do what at local level
- Local service delivery
- Implementing safe staffing
- Ensuring staff wellbeing

Clinical Governance

- Drives quality assurance and risk management assurance and monitoring
- A fit for purpose, whole of system quality assurance function
- This is assurance for the system, not just convening groups

Networks

- **Service Delivery Networks** are groupings of existing services
  - Small number of dedicated positions to drive integration of services
  - Supporting a joined-up experience for patients from anywhere within a region
  - Clinical leaders within Service Delivery Networks provide a regional voice for their particular services.

Regional Service Delivery Networks

- Drive the integration of H&SS service delivery across a region
- Organise and manage care delivery across a region for the service, operationally
- Empowers local clinicians to deliver care more efficiently

National Clinical Networks

- Set national guidelines and models of care to be implemented by H&SS teams
- Design and propose national solutions for models of care
- Enables local clinicians to align to national models

- **National Clinical Networks** are different
  - standalone structures (distinct from service provision)
  - created to set guidelines and models of care

Tranche 2 Clinical Network Priorities

Forward planning for establishing networks over the next 12 mos is in progress

A plan will be presented at the Oversight Group on 29 February

The following decisions are required to finalise the plan and ensure work can continue:

- Final list of the priority networks for tranche 2
- Clarification of the scope of the priority networks

Tranche 1a
Trauma
Stroke
Cardiac
Renal

Tranche 1b
Eye Health
Infection services
Critical Care
Radiology

Tranche 2
Urology
Vascular Surgery
Paediatrics
Maternity & Neonates (Incl NICU)
Rural Health
Dermatology
Mental Health & Addictions
Rheumatology
Respiratory
ENT (Ear, Nose, Throat)
Pathology
Cancer

Tranche 3
Diabetes
Sexual Health
Dementia
Gynaecology
Orthopaedics
Neurology
Oral Health
Immunology

DRAFT Te Whatu Ora QISS Programme Structure

Chief Executive – Te Whatu Ora & Te Aka Whai Ora

National Steering Group

National Committee

Regional Working Group Northern **Tracey**

Regional Working Group Te Manawa Taki **tbc**

Regional Working Group Te Ikaroa Central **Richie**

Regional Working Group Te Waipounamu **Bernie**

National Steering Group:
- National Director, HSS - Fionnagh Dougan
- National Director, D&D - Leigh Donaghue
- Chief People Officer - Andrew Slater
- Interim Chief Clinical Officer - Richard Sullivan
- National Director, SI&I - Dale Bramley
- Director of Operations, SI&I - Tricia Sloan
- Director of Te Whatu Ora Improve, SI&I - Penny Andrew

National Committee:
- Director of Operations, SI&I - Tricia Sloan
- Director of Te Whatu Ora Improve, SI&I - Penny Andrew
- PMO, SI&I – *Cindy Tuitupou/Marizel Sanchez-Dizon TBC*
- Te Whatu Ora Improve GMs, SI&I – Bernie County, Richie Perry, Tracey Popham
- Event Programme Manager –*TBC*
- Administration/Coordination support - *internal TBC*

Key Responsibilities:
- Deliver national symposium (learning event), including awards night
- Set national themes with CE/ELT e.g. equity, system flow, planned care
- Content e.g. agenda, speakers, topics
- Support RITs & Regional Working Groups by;
  - developing toolkit/how to guide with Te Tāhū Hauora
  - developing brand, marketing/event collateral with Ara Manawa (design team)
- Evaluation
- Logistics e.g. venue, AV, MC, catering, invitations, on the day event management

Regional Working Groups: working alongside RITs
- Te Whatu Ora Improve GMs – Bernie County, Richie Perry, Tracey Popham
- Representatives identified by RIT – *TBC*
- Administration/Coordination support – internal

Key Responsibilities:
- Deliver regional symposiums
- Align with nationally set themes, and those identified by the RIT
- Content e.g. agenda, speakers, topics
- Calling for submissions, selection for presentation at event
- RIT - award seed funding to initiatives in 'Seed' category
- Support, encourage people to take part
- Evaluation – align with National Committee approach
- Logistics e.g. venue, AV, MC, catering, invitations, on the day event management

Te Whatu Ora
Health New Zealand

Memorandum to the Regional Integration Team: Northern

Quality Improvement Scientific Symposium

Date:	15 February 2024
From:	Tricia Sloan, Director of Operations – Service Improvement & Innovation (SI&I) Penny Andrew, Director Te Whatu Ora Improve, SI&I

Purpose

1. The purpose of this memo is to inform the Regional Integration Team (RIT) of ELT's (Te Whatu Ora) decision to deliver 4 regional and 1 national Quality Improvement Scientific Symposiums (QISS or 'symposiums'), in partnership with Te Aka Whai Ora andTe Tāhā Hauora (Health Quality & Safety Commission), in 2024 (see ELT paper Appendix 1).

2. Seek support from the RIT to facilitate delivery of the Northern regional symposium.

Recommendations

3. The RIT is asked to:

   a) **note** ELT's decision (see ELT paper Appendix 1) to run 4 regional quality improvement scientific symposiums (QISS)and 1 national symposium, and for the RIT to facilitate delivery of the Northernregional symposium in 2024.

   b) **note** proposed structure of the National QISS Programme (Appendix 2).

   c) **nominate** members from your teams to form a Regional Working Group (Appendix 2) to facilitate delivery the Northern regional symposium.

   d) **discuss/ agree** key milestones - date and venue location.

   e) **note the** symposium themes will determined by Te Whatu Ora ELT. Themes are likely to be equity, consumer and whānau engagement, system flow planned care. There will also be the opportunity for regional priorities to be included.

   f) **discuss** themes specific to the Northern region that could feature in the regional symposium.

   g) **note** SI&I will lead a programme to stimulate improvement & innovation initiatives at care delivery level. Small seed funds will be made available to enable teams to develop tangible initiatives.

   h) **note** SI&I and Te Tāhū Hauora will develop a 'toolkit' to support the RITs and Regional Working Group to facilitate delivery of the symposium.

Partnership with Te Aka Whai Ora

4. This programme of work is being developed and delivered in partnership with Te Aka Whai Ora. Te Aka Whai Ora Mātauranga Māori Directorate guidelines for engagement and relationship management[1] provide Mātauranga Māori Directorate representatives and Te Whatu Ora representatives with clarity and expectations of strengthening tō tātou whaka hourua as we navigate th programme of work together to achieve agreed outcomes and to mahi tahi. Through the guidelines each partner represents our respective expertise, mana and expertise with respect knowledge systems and worldviews, moving together in a common direction of achieving Pae Ora.

5. The guideline places the principle of mana at the centre of our living relationship to manage expectations, roles and responsibilities of the partners working together. It places obligation on all the partners to uphold with integrity their partnership obligations.

Principles underpinning our relationship

The Kawenata set out in the guideline defines the fundamentals of the relationship between Te Whatu Ora and Te Aka Whai Ora for this mahi. The Kawenata values are:

- **Mana Ōrite**: Respective views will be heard, considered, and afforded equal explanatory power.
- **Kotahitanga**: An operational culture of moving together with solidarity towards a common purpose.
- **Manaakitanga**: Derives from two words - ‘mana’ and ‘aki’. Mana is a condition that holds everything in the highest regard. Aki means to uphold or support. Therefore, manaakitanga in this context means a governance and operational culture that its respectful and supportive and does not confuse accountabilities.
- **Whanaungatanga**: Strong transparent governance and operational relationships through respect, integrity, empathy, and commitment to the kaupapa of achieving Pae Ora for whānau.
- **Tū maia me mātātaki**: Brave, bold, capable, confident decision-makers - unafraid of free and frank advice and who are courageous in the face of the challenge.
- **Tū Waatea**: Inclusiveness through self-awareness. This means being open to others’ views because we operate in good faith and are willing to be unencumbered by our own experiences.

Contribution to strategic outcomes

6. The symposiums will facilitate sharing and learning about improvement and innovation efforts and practice within areas relevant to the health sector principles, Te Tiriti o Waitangi relationships, health equity and the six priority action areas of Te Pae Tata, as well as connecting with priorities of Health & Wellbeing Plans. The content of the symposiums will be developed by a National Conference Programme Committee (National Committee) and by Regional Groups, through the selection of topics, speakers and a range of abstracts for presentation. Content from within areas relevant to key strategic outcomes for the sector and health system will be actively sought.

[1] Mātauranga Māori Directorate Guidelines for Engagement and Relationship Management

Background

7. Te Tāhū Hauora has hosted annual quality improvement scientific symposiums featuring keynote speakers, peer-reviewed papers, interactive sessions and learning and networking opportunities. The 2023 symposium focused on the science of improvement, by highlighting improvement methodology. Themes for the presentations were based on the Wai2575 principles.

8. Health professionals showcased initiatives at the QISS symposium - posters and presentations. Initiatives could be at different stages; 'Seed' (promising ideas and ways for improving care, too young to have results), 'Sprout' (some early results but not yet showing sustained improvement), 'Plant' (complete, demonstrates changes in processes and outcomes and shows sustained improvement with potential for, or has achieved, spread).

9. Te Whatu Ora and Te Tāhū Hauora will work in partnership on the symposiums to build quality improvement capability.

10. Partnering on the symposiums will be an investment in sector learning and sharing to support the appropriate adoption and adaption of good quality improvement practice within service delivery.

11. Four regional symposiums will be run in 2024 with up to 120 people attending each.

12. Funding has been approved to run the symposiums and to provide some stimulus funding to early ('Seed') initiatives.

Discussion

13. The goals of the symposiums will be to enhance improvement and innovation efforts and new knowledge, to better support the implementation of strategic priorities in service delivery throughout the motu.

14. The sector will have the opportunity to learn within and across regions, and from national best practice. The sector will also have the opportunity to learn from national and international thought leaders in quality improvement and innovation.

15. The proposed National QISS Programme structure includes a National Committee (reporting to ELT Steering Group) and Regional Working Groups.

16. The National Committee provides direction and content leadership for the symposiums aligned with ELT/CE direction. This will involve setting clear strategic requirements for content that demonstrate linkages to advancing the health sector principles, Te Tiriti o Waitangi relationships, health equity or to one or more of the six priority action areas of Te Pae Tata.

17. In addition to delivering the national symposium and awards evening, the National Committee will be responsible for:

    a) planning the full QISS series of symposiums, event management and ensuring that information is available online afterwards, for sector sharing

    b) supporting the RITs & Regional Working Groups by:

i) developing a toolkit/how to guide with Te Tāhū Hauora

ii) developing branding, marketing/event collateral with Ara Manawa (SI&I design team)

c) evaluation of QISSs and reporting back to Te Whatu Ora and Te Tāhū Hauora ELT and boards at conclusion.

18. The Regional Working Groups will be responsible for facilitating regional partnerships via the RITs with consumers/whānau, IMPBs, commissioning, NGOs and primary care, to advise on content, abstracts and presentations that showcase good improvement and innovation work and promote useful learning regionally and locally.

19. Regional Working Groups will work closely alongside the RITs to facilitate the delivery of the regional symposium. Proposed membership include representatives from the following;

a) Te Aka Whai Ora

b) Pacific Health

c) Commissioning

d) HSS

e) National Public Health Service

f) SI&I (RIT lead or nominee)

g) Consumer / whānau voice

20. The Regional Working Groups will be responsible for:

a) ensuring themes and goals for each conference align with nationally set themes, and those identified by the RIT

b) Content e.g. agenda, speakers, topics

c) Calling for abstracts and speakers, selecting papers and speakers with the RITs

d) RIT - award funding to initiatives in 'Seed' category

e) Support, encourage people to take part

f) Evaluation – align with National Committee approach

g) Logistics e.g. venue, AV, MC, catering, invitations, on the day event management.

21. Seed funding has been approved to support initiatives. These funds are to be awarded by the RIT to initiatives in the 'Seed' category to feature in 2025 symposiums and national event.

Financial Implications

22. For the regional symposiums, resource contributions will be shared, through workforce support shared expertise and networks, the provision of facilities, equipment and personnel time for planning and delivery.

23. Travel and disbursements for sdelegates will be symposium met by the directorates in Te Whatu Ora.

Key next steps

24. Form the Regional Working Group with nominees to deliver the Northern region symposium in 2024. This group will meet weekly and partner with the National Committee to ensure alignment of approach.
25. Develop and execute programme, including identifying key stakeholders, communication channels, risks and mitigations and evaluation.
26. Action time critical elements - book a venue in the agreed location, identify and book speakers, stakeholder analysis, calendar placeholders.
27. Regular reporting will be provided to the RIT by the SI&I lead on the Regional Group, and evaluation shared on conclusion of this initiative.

Attachments

- Appendix 1: ELT paper. Proposal for partnering on the Quality Improvement Scientific Symposium –Regional, National and International. Dated 8 January 2024.
- Appendix 2: Proposed QISS National Programme Structure.