

Health NZ's Clinical Quality and Safety

Response to the review into quality and safety of services

March 2025

Purpose

The purpose of this document is to provide a Health New Zealand | Te Whatu Ora (Health NZ) management response to a review of the quality and safety of health care. The review examined quality and safety, patient experience and harms data over the decade 2014 – 2024, and assessed trends over time.

Introduction

The Commissioner of Health New Zealand Te Whatu Ora (Health NZ) requested a review of the quality and safety of health care and services across Health NZ, which was completed in November 2024. It analysed longitudinal data from a range of sources to assess how results of care have changed over the last 10 years and where we are today.

Findings

The review identified four key findings:

1. Outcomes of healthcare show a mixed picture, with some indicators showing sustained improvement while others have stayed the same or deteriorated.
2. Access to healthcare in both primary and hospital settings is getting worse. National patient experience surveys and complaints to the Health and Disability Commissioner identify that timely access to services across the community and hospital settings is the issue of most concern for patients and the most significant quality and safety issue for our health system.
3. There are quality and safety alerts occurring in specific areas that need to be addressed. Deterioration in some quality and safety indicators more recently form part of Te Tāhū Hauora Health Quality & Safety Commission's (HQSC's) quarterly Quality Alerts reporting. This reporting identifies regional and district variation in these indicators and particular areas that need to be addressed.
4. Internationally in broad terms of quality and safety of care, New Zealand performs reasonably. A report published in September 2024 comparing the performance of 10 high-income countries health systems across 70 performance measures, ranked New Zealand fourth overall in performance across five domains, and first for the domain of 'care process' which encompasses attributes that most experts around the world consider essential for high quality care.

Change in indicators over time

| Improved | Stayed the same | Deteriorated |
|---|--|--|
| Falls (2014-2024) (2012/13 – 2023/24) | Perinatal & Maternal Mortality (2004-2021) | Healthcare-associated Staphylococcus aureus bacteraemia (2016-2024) |
| Surgical Site Infections (orthopaedics) (2015-2024) (2012/13-2023/24) | Patient experience (once accessed services) primary care 2020-2024 | Patient experience access to primary & secondary care (2020-2024) |
| Surgical Site Infections (cardiac) (2017-2024) | Hospital Standardised Mortality (2020-2024) | People waiting for more than 4 months for a first specialist appointment |
| Patient Deterioration (cardiac arrests) (2019-2024) | | Pressure Injuries (hospital and non-hospital acquired) (2021-2024) |
| Perioperative Mortality (2012-2024) | | Postoperative deep vein thrombosis / pulmonary embolus (2021-2024) |
| Mental Health Inpatient Services Seclusion (2019-2024) | | Health and Disability Commissioner nationwide rate of complaints (2014-2024) |
| Patient experience (once accessed services) adult inpatients (2014–2019; and 2020-2024) | | Self-discharge ED mortality (2016-2023) |
| | | |

Our response

Health NZ is sharply focused on improving patient outcomes including achieving government health targets.

Health NZ takes a systematic approach to the improvement of quality and safety of health care. This takes into account a wide range of data, including the findings of the Clinical Quality and Safety Review.

We are taking a range of steps to address wait times – both in primary and secondary care settings. This includes directing additional funding to increase urgent and after-hours care, boost elective surgery and enable faster access to primary care.

Enhanced clinical involvement and engagement

Ensuring quality and safety of healthcare is central to our Delivery Plan, which was issued in March 2025. We are increasing clinical leadership and partnerships at all levels of the organisation to enhance clinical perspectives in decision making.

At a local level, processes to appoint permanent local Chief Nurses, Chief Allied Health, Science and Technical, and Chief Medical Officers are nearing completion.

Regional clinical partnerships are being established through a portfolio model to strengthen links between local and regional clinical leadership and expand the opportunities for clinical leaders to develop and contribute.

Nationally, we have the following clinical leads in place: National Chief Midwife; National Chief Mental Health and Addictions; National Chief Nurse, National Chief, Quality and Patient Safety; National Chief Allied Health, Scientific and Technical; National Director Pacific Health and National Chief Medical Officer.

To bring together expertise on a particular service or care pathway and drive change, we now have 13 national clinical networks in place, with co-leads and members appointed.

The networks cover cancer, cardiac, diabetes, eye health, infection services, maternity, mental health and addiction, oral health, radiology, renal, rural health, stroke, and trauma, and are responsible for:

- Developing national core standards, guidelines and models of care for their specialist areas, so everyone knows what is expected and what Health NZ should be planning for in terms of best practice and consistent access and delivery of healthcare nationwide.
- Providing clinical leadership and advice on national service configuration for their specialty.
- Identifying areas of variation in healthcare delivery across their specialty area and developing innovative solutions to address these.

Health NZ has also recently announced two new clinical groups to provide independent advice on a wide range of topics.

The New Zealand Clinical Senate (NZCS) will include and engage clinicians from across the health sector and provide strategic, system-wide clinical advice and leadership on issues affecting the quality, affordability and efficiency of delivery of patient care.

NZCS will bring together leading clinicians from a mix of professions and specialties, nominated by their districts, together with appointed clinical network co-chairs.

Membership of NZCS will ensure strong representation from primary care and mental health and addiction, Māori and Pacific health and nursing and allied health.

The Clinical Advisory Board will provide rapid robust independent advice and a clinical frame of reference for issues, challenges and opportunities in support of front-line clinical teams.

Systematic approach

HQSC has established a framework for the ongoing improvement of clinical quality and safety ([Clinical governance framework | Te Tāhū Hauora Health Quality & Safety Commission](#)).

Health NZ is aligning clinical governance with this framework. It has established and continues to develop governance structures and systems for monitoring and improvement of clinical quality and safety. This includes the Executive Clinical Quality and Safety Committee (CQASC). This committee:

- Oversees performance against this framework, including a monitoring report updated quarterly, in collaboration with HQSC, which is used to monitor the safety of the system.
- Ensures there is an appropriate response to quality and patient safety concerns (by the Chief Clinical Officer or their delegate) that are identified or escalated to the committee.
- Oversees the development and use of a tool to assess clinical priority for investment, on advice of the Chief Clinical Officer.
- Receives reports and updates from the National Clinical Governance Group.

The National Clinical Governance Group (NCGG) is the principal clinical governance committee for Health NZ. The NCGG's purpose is to provide national stewardship for clinical governance activities across Health NZ, ensuring that clinical governance is implemented, embedded, consistent and supported at all levels, regions, local networks and localities. The primary responsibility of the NCGG is to provide assurance to the

Commissioners/Board that Health NZ has robust quality systems in place to provide healthcare services that are safe, effective and equitable.

The findings of the Clinical Quality and Safety Review will be incorporated, alongside other data, reports and alerts, into ongoing clinical quality and safety monitoring and improvement.

A national Health NZ clinical governance framework that aligns with the HQSC's new framework will be in place by mid-2025.

