Health Quality & Safety Commission
Te Tāhū Hauora

Statement of Intent

Tauākī Koronga

1 July 2026—30 June 2030

Health Quality & Safety Commission
Te Tāhū Hauora

Presented to the House of Representatives pursuant to section 149 of the Crown Entities Act 2004

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Foreword
Kōrero takamua

The Health Quality & Safety Commission Te Tāhū Hauora's fifth Statement of Intent sets the strategic direction for the organisation's priorities and activities over the next four years.

Over the last 15 years, our work has helped bring clarity to a complex health system by identifying variation in care, inequitable outcomes and harm and supporting improvement where it is needed most. We have identified and addressed opportunities for improving quality and safety across the health system, driving improvements that have saved lives, reduced harm, freed up resources and saved money.

We continue to ensure our focus is on our core functions under the Healthy Futures (Pae Ora) Act 2022, which defines our role as leading and coordinating work across the health system to improve and monitor the quality and safety of services and support providers to improve.

This Statement of Intent takes a more focused approach than previous publications. It is structured around three strategic priorities to provide a clearer connection between our role, the work we deliver and the impact we seek to achieve. These are:

- strengthening consumer and whānau engagement
- reducing harm and avoidable mortality
- leading health care improvement through data and evidence.

We have also introduced a clearer performance framework, distinguishing between what we deliver directly, how we contribute to system change and the longer-term outcomes we seek to influence, to achieve our overarching goal of improving the quality and safety of health care in Aotearoa New Zealand.

Under the leadership of our chief executive, Professor Sunny Collings, we will continue to deliver tangible benefits to the health system and its users, ensuring our work is tailored to addressing the Government's priorities while providing value for money in discharging our role.

Board statement

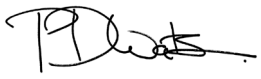
Tauākī a te poari

In signing this statement, we acknowledge that we are responsible for the information contained in the Statement of Intent for the Health Quality & Safety Commission Te Tāhū Hauora.

This information has been prepared in accordance with the Public Finance Act 1989 and the Crown Entities Act 2004 and to give effect to the Minister of Health's expectations of the Health Quality & Safety Commission Te Tāhū Hauora.



Rae Lamb
Chair, Board
30 June 2026



Dr Peter Watson
Deputy Chair, Board
30 June 2026

Introduction
He kupu whakataki

The Health Quality & Safety Commission Te Tāhū Hauora (the Commission) is New Zealand's expert agency for monitoring the quality and safety of health services.

Central to this role is providing independent, authoritative insight into how well the health system is performing, where risks and variation exist and where improvement is needed.

We do not deliver health care directly and are separate from commissioning and regulatory functions. What we have is a clear mandate to monitor quality and safety in the health sector, identify issues affecting people's access to health care, experiences and outcomes, and support system-wide action where unmet need and inequities persist.

We bring together and rigorously analyse data from across the sector, reporting to Ministers, system leaders, providers and the public. This independent monitoring is critical for supporting a well-governed, transparent and high-performing health system.

By making the health sector's performance, outcomes and variation visible, we inform priorities, influence decision-making and strengthen accountability. We also support improvement through system safety leadership, policy frameworks and guidance. In particular, we work with others to enable coordinated responses to risk, support delivery of government priorities, strengthen consumer and whānau[1] voice, foster cultures of learning and improvement, and build sector capability.

The extent of our impact depends not only on what we deliver, but on the conditions we create for the sector to use and act on our work. Our work is credible, trusted and timely, grounded in evidence and shaped through high-trust relationships. We also communicate it clearly and support it by identifying effective approaches to change.

1 Whānau' includes a consumer's immediate and extended family, as well as the wider network of people who support them, which may include friends with no kinship ties. This term reflects inclusive, connected relationships between people.

Through this work, we enable action and improvement across the health system, while maintaining a clear, objective and independent voice that supports progress and provides challenge where needed.

This Statement of Intent is structured into four parts.

Part 1	introduces our organisation's role, purpose and enduring commitments.
Part 2	outlines our strategic intent and priorities for the next four years and how these align with Government priorities.
Part 3	explains our approach to measuring and tracking progress.
Part 4	describes the organisational capabilities that will support us over the next four years and our approach to financial management.

Our purpose

Improving the quality and safety of health care in Aotearoa New Zealand

Our role

Established in 2010, the Commission is the only national agency dedicated to health quality and safety.

Under the Healthy Futures (Pae Ora) Act 2022 (the Act), our objectives are to lead and coordinate work across the health sector to improve and monitor the quality and safety of services and help providers to improve the quality and safety of their services.

We are responsible for:

- advising the Minister of Health and the health sector on quality and safety
- providing trusted quality and safety intelligence, including measurement and reporting
- leading national reviews of avoidable mortality to identify patterns, causes and variation in health need and to inform action
- supporting consumers and whānau to engage in service design and improvement
- leading and supporting quality improvement programmes
- identifying emerging risks and providing rapid insights
- strengthening system safety capability
- supporting transparency, system learning and accountability.

We **'support and facilitate improvement'** across the health system. This work represents our single output class under the Crown funding we receive.

Through our data, evidence and system safety work, we contribute to reducing harm, saving lives and delivering financial savings that can be reinvested in health care for all New Zealanders, while also helping improve their access to care.

As a health Crown entity, we must give effect to the Government's priorities and the objectives set for the health system to the extent that they are relevant to our functions. For more on this topic, see 'Our alignment with Government priorities'. For more on our organisation's objectives and functions more generally, see the appendix.

Our independence from commissioning and regulatory functions enables us to provide impartial, credible insights that identify risks, highlight variation in care and outcomes, and support informed action to improve quality and safety, contributing to a health system that better meets people's needs and delivers more equitable health outcomes.

In performing our functions, we work collaboratively with a wide range of stakeholders. We aim to build and maintain high-trust relationships that support coordinated, system-wide responses to complex quality and safety challenges, working with others on shared priorities and goals that no single organisation can achieve alone. We actively work to strengthen our relationships with:

- **Ministry of Health – Manatū Hauora** (the Ministry of Health) to provide independent advice, share insights and evidence, and support policy development, regulation and monitoring
- **Health New Zealand | Te Whatu Ora** (Health NZ) to provide quality and safety intelligence, support measurement and monitoring and collaborate on improvement initiatives that strengthen service delivery and outcomes
- **Health and Disability Commissioner | Te Toihau Hauora, Hauātanga** through regular engagement to share insights and emerging issues that support system learning and highlight areas of national significance
- **Accident Compensation Corporation** (ACC) to share and align data, insights and best-practice approaches, supporting injury prevention, rehabilitation and improvements in patient safety, enabling a more joined-up understanding of harm across the system and strengthening our collective monitoring role
- **Whaikaha | Ministry of Disabled People** to bring insights on the quality and safety of services for disabled people, supporting system improvement and ensuring disabled perspectives are reflected in our work
- **non-governmental organisations** to share insights, support improvement activity and reflect the realities of frontline services and communities
- **primary care, community providers, hospitals, aged residential care and disability services** through our programmes, tools and improvement initiatives to measure, understand and improve the quality and safety of care
- **consumers and whānau** so lived experience informs system learning, improvement priorities and the design of safer, more responsive services
- **professional bodies, health practitioner regulators (responsible authorities) and sector partners** to embed quality and safety practice, strengthen clinical leadership and support the spread of evidence-based improvement across the health system.

Our enduring commitments

We remain committed to supporting the health sector to meet its obligations under **Te Tiriti o Waitangi** and achieve **equitable[2] health outcomes** for all, shaping how we prioritise our work and contributing to a health system that delivers high-quality, consistent and responsive care.

This requires a clear understanding of who has the greatest health need[3] and where unmet need exists so that efforts can be directed where they will have the most impact.

Through our intelligence, reporting and improvement work, we support greater visibility of the experiences and outcomes of Māori, and others with greater health needs, helping to inform action and direct effort where it can have the greatest impact. We provide reliable data and insights that support continuous learning, adaptation and improvement, informed by evidence and patient experience.

Persistent inequities in health outcomes, particularly for Māori, Pacific peoples and disabled people, continue to be evident in data and evidence from the Commission[4,5,6] and other health organisations and researchers across New Zealand.

We will continue to strengthen our capability to give effect to Te Tiriti o Waitangi by supporting the priorities of the Ministry of Health's *Māori Health Strategy.*[7] In particular, we will support work towards Priority 2, which focuses on quality, safety and accountability for Māori health.

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2 The Ministry of Health's definition of equity is 'In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.' URL: www.health.govt.nz/strategies-initiatives/programmes-and-initiatives/equity (accessed 3 May 2026).

3 Cabinet Office Circular on Needs-based Service Provision CO (24) 5.

4 Te Tāhū Hauora Health Quality & Safety Commission. 2019. *A Window on the Quality of Aotearoa New Zealand's Health Care 2019 – a view on Māori health equity.* Wellington: Te Tāhū Hauora Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/a-window-on-the-quality-of-aotearoa-new-zealands-health-care-2019-a-view-on-maori-health-equity-2 (accessed 3 May 2026).

5 Te Tāhū Hauora Health Quality & Safety Commission. 2021. *Bula Sautu – A window on quality 2021: Pacific health in the year of COVID-19. He mata kounga 2021: Hauora Pasifika i te tau COVID-19.* Wellington: Te Tāhū Hauora Health Quality & Safety Commission. URL: http://hqsc.govt.nz/resources/resource-library/bula-sautu-a-window-on-quality-2021-pacific-health-in-the-year-of-covid-19-bula-sautu-he-mata-kounga-2021-hauora-pasifika-i-te-tau-covid-19 (accessed 3 May 2026).

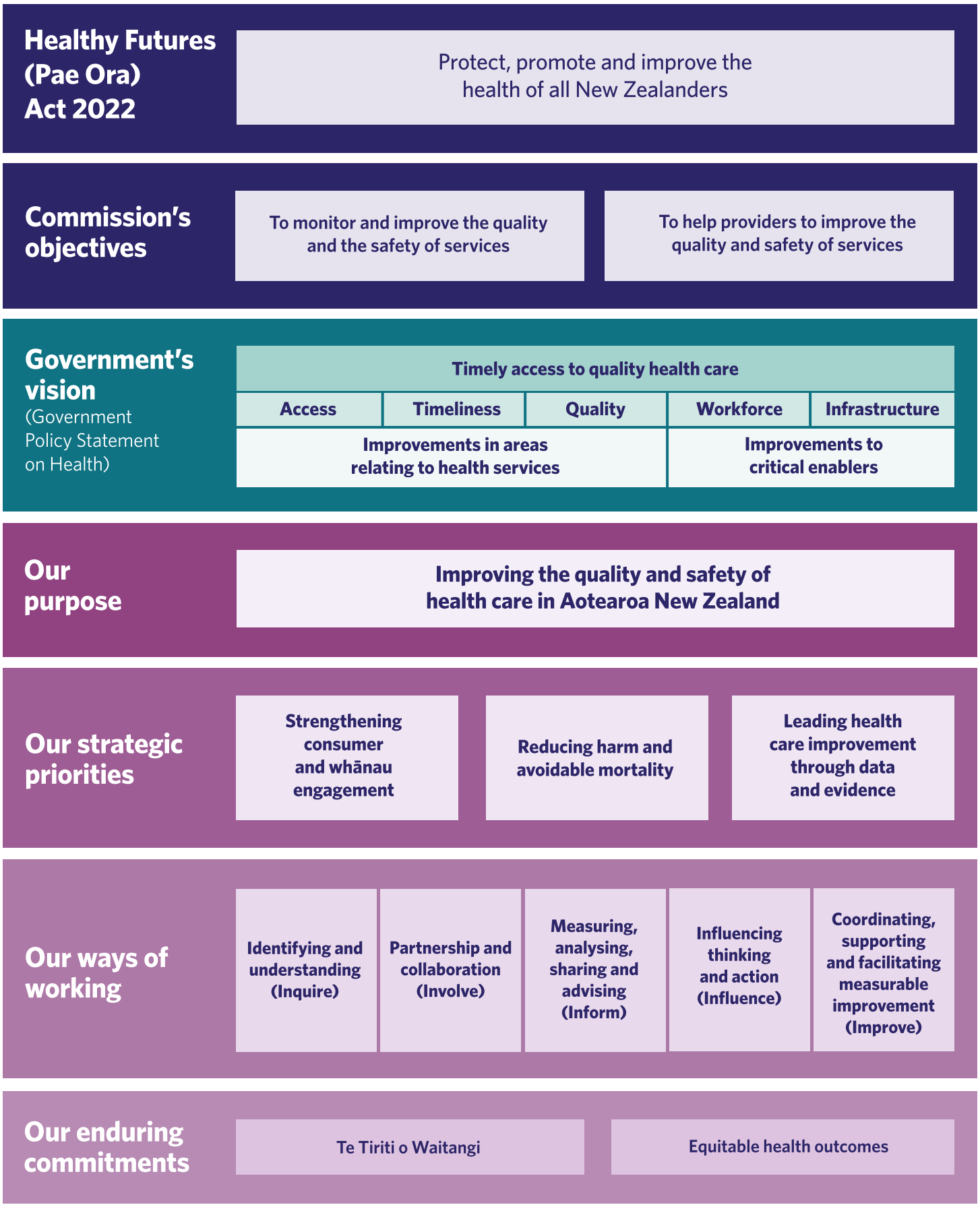
6 Health Quality & Safety Commission Te Tāhū Hauora. 2026. *Window on Disability.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/a-window-on-disability (accessed 8 June 2026)

7 At the time of publication, the Ministry of Health's refreshed *Māori Health Strategy* (2026) had not yet been released.

Our strategic intent and expectations
Te rautaki me ngā kawenga

Our strategic intent sets out how we lead, influence and support system-wide improvement in health quality and safety, aligned with Government direction (see Figure 1).

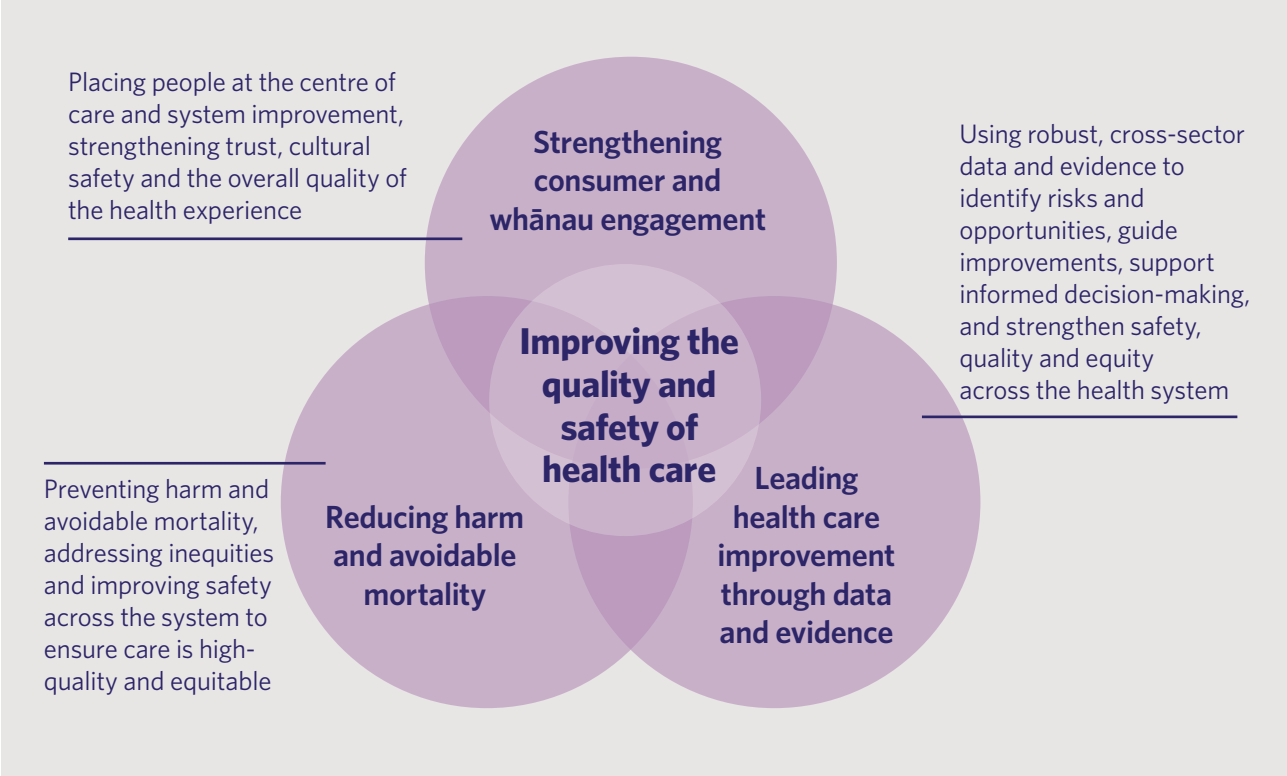
Figure 1: Our strategic framework



Our strategic priorities

Our work is guided by three priorities that reflect our purpose, statutory role and the current and future needs of the health sector (see Figure 2).

Figure 2: Our strategic priorities



Our strategic priorities direct our efforts towards the areas where we can have the greatest impact, giving effect to our legislated role and contributing to better outcomes and experiences for people, whānau and communities. Together, these priorities are mutually reinforcing and guide everything we do. All aspects of our work draw on each priority to achieve the impact and long-term outcomes we seek.

By bringing together data, evidence and the experiences of people receiving and delivering health care, reducing harm and supporting targeted improvement, we help create the conditions for a safer, higher-quality and more equitable health system that places patients at the centre of decision-making and delivers services in an efficient and financially sustainable way.

Through these priorities, we apply our independent insights, expertise and ways of working to strengthen quality and safety and deliver value to both the health sector and the people who use its services. While maintaining our independent perspective, we work closely with health sector partners, recognising that many quality and safety challenges are complex, interconnected and cannot be addressed by a single agency alone.

Priority 1: Strengthening consumer and whānau engagement

We want people to be at the centre of health care, as active partners in improving the health system.

Embedding consumer and whānau voices in the planning and improvement of health services supports better patient experiences, improved clinical outcomes and more equitable care.[8] By placing lived experience at the centre of service design and improvement, we help create a health system that works better for everyone.

We work to strengthen the health sector's ability to engage with consumers and whānau, amplifying lived-experience voices across the system. We support meaningful and trusted relationships by providing opportunities, tools and insights that help organisations capture and understand consumer and whānau perspectives.

Our initiatives include practical **engagement frameworks, tools to capture lived experience, support for consumer partners and capability-building activities** that help health services engage effectively with consumers and whānau.

Working with health agencies and providers, including those in primary and community care, we support the design and delivery of health services that are shaped by the people who use them and grounded in what matters most to them. This supports more patient centred care that is responsive to the needs of people, whānau and communities.

In addition, the importance of the consumer and whānau voices is embedded in our guidance, including *Collaborating for quality: A framework for clinical governance*[9] and *Healing, learning and improving from harm: National adverse events policy 2023.*[10] For more information, see 'Strategic priority 2: Reducing harm and avoidable mortality'.

8 Gerard C, O'Brien I, Shuker C et al. 2024. Patient experience surveys are vital in the twenty-first century: let's put some myths to rest. *New Zealand Medical Journal* 137(1588).

9 Health Quality & Safety Commission Te Tāhū Hauora. 2024. *Collaborating for quality: A framework for clinical governance.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/collaborating-for-quality-a-framework-for-clinical-governance (accessed 4 May 2026).

10 Health Quality & Safety Commission Te Tāhū Hauora. 2023. *Healing, learning and improving from harm: National adverse events policy 2023.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm (accessed 8 June 2026)

What will we do to achieve this? (Our core delivery)	**We will:** • maintain the *Code of expectations for health entities' engagement with consumers and whānau* (code of expectations)[11] so it remains fit for purpose • support the health sector to partner with consumers and whānau in service design, improvement and decision-making • embed patient experience and insights in quality and safety improvement initiatives • support the health sector and providers to use data and patient and whānau experience to inform decision-making and drive continuous improvement • share learning, tools and guidance that support effective engagement and collaboration with consumers and whānau • focus on providing the sector with trusted data intelligence (eg, patient-reported outcomes and insights reporting) and work with providers to improve results.
What do we expect to see happen? (Our contribution indicators)	**We expect to see:** • our consumer experience tools, guidance and frameworks used across services and regions • consumer and whānau insights routinely informing planning, improvement and workforce development • service design and processes reflecting changes based on patient experience data • a diverse range of consumers and whānau actively participating in learning, review and collaboration • trust in, and engagement with, our reporting and intelligence.
What will success look like? (Intended impact)	**We will see success when:** • consumer and whānau voices are heard and influence health service design, decision-making and improvements • health services reflect the needs and experiences of the people who use them • health outcomes are more equitable, with services better addressing unmet need • health service providers, consumers and health partners have strengthened relationships.

11 Health Quality & Safety Commission Te Tāhū Hauora. 2022. *Code of expectations for health entities' engagement with consumers and whānau*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/code-of-expectations-for-health-entities-engagement-with-consumers-and-whanau (accessed 4 May 2026).

The following are some existing examples specific to consumer and whānau engagement where we lead and support improvements.

- The **code of expectations** (initially launched in August 2022) is a key system lever to strengthen consumer partnership across all services. Under the Act, named health entities, including the Commission,[12] are required to implement and report on the code of expectations, which is secondary legislation under the Legislation Act 2019.[13]

- **consumer health forum Aotearoa** promotes and advances the engagement of consumer and whānau voices in the health system. It links health system entities to diverse consumer groups, at the right level, in the right way. For example, it facilitates online and in-person workshops and forums, covers a range of topics and provides regular news and updates. This voluntary network of consumers includes whānau, individuals, groups and organisations and continues to expand as a national forum.[14]

- The **consumer hub Ngā Pae Hiranga (pathways towards excellence)** is an information and resource hub for consumer, whānau and communities. It aims to help the health sector involve consumer and whānau voices in designing, delivering and evaluating health services.[15]

12 Under the Act, the health entities that must give effect to the code of expectations are Health NZ, Pharmac, the NZ Blood and Organ Service and the Commission.

13 In 2026/27, the code of expectations will be refreshed to align with changes to legislation.

14 Health Quality & Safety Commission Te Tāhū Hauora (nd). Consumer health forum Aotearoa. URL: www.hqsc.govt.nz/consumer-hub/consumer-health-forum-aotearoa (accessed 4 May 2026).

15 Health Quality & Safety Commission Te Tāhū Hauora (nd). Consumer hub Ngā Pae Hiranga. URL: www.hqsc.govt.nz/consumer-hub (accessed 4 May 2026).

Priority 2: Reducing harm and avoidable mortality

We want health services that support healing, learning and improvement from harm,[16] save lives and achieve safe, high-quality, effective health care for everyone.

System safety is an approach that focuses on understanding how work is actually done in a complex health system. As well as helping explain how harm occurs, system safety makes it possible to identify solutions that improve the safety of care.

This approach looks beyond individual events to the wider factors that influence health care, making visible the underlying conditions that create ongoing risk. High-quality health care relies on systems that are designed, led and supported to enable safe, people-centred care. Although the health sector performs well on many key indicators, some people are harmed while receiving care and sometimes this has serious and long-term consequences.

Evidence from New Zealand and internationally demonstrates that potentially avoidable harm remains a significant challenge across health systems. The World Health Organization estimates that around 12 percent of patients experience harm during health care, with more than half of this harm considered preventable.[17] This aligns with historical New Zealand research showing that a similar proportion of hospital admissions were associated with harm, reinforcing the importance of continued focus on patient safety, learning from harm and system improvement.[18]

We support the health sector to reduce potentially avoidable harm through **frameworks, capability building, independent intelligence, national measurement, monitoring and targeted quality improvement initiatives**. A core part of this work is our function of **national mortality review**, which generates evidence and recommendations to help the sector identify avoidable risks and prioritise improvement. Some deaths continue to occur that may have been preventable through earlier intervention, safer systems or more effective care. Mortality review helps identify these risks and supports learning and improvement to reduce avoidable mortality over time. Through ongoing monitoring, the function enables the health sector and other agencies to identify trends, understand contributing factors and take action to prevent future deaths. Our statutory recommendation mandate is an important lever for change, turning insights into practical actions that contribute to safer care.

16 Health care harm is a physical, psychological, social or spiritual injury or experience that occurs as a result of providing or receiving health care.

17 World Health Organization. 2024. *Global patient safety report 2024*. Geneva: World Health Organization.

18 Davis P, Lay-Yee R, Briant R, et al. 2022. Adverse events in New Zealand public hospitals I: occurrence and impact. *New Zealand Medical Journal* 13;115(1167).

What will we do to achieve this? (Our core delivery)	**We will:** • identify and highlight avoidable harm and risks to improve health quality and safety • provide evidence, guidance and support for improvement to reduce potentially avoidable harm and mortality • support the implementation of *the New Zealand Health and Disability System Safety Strategy*[19] • support the system and individual organisations to apply *Collaborating for quality: A framework for clinical governance* • build health sector capability and drive quality improvement by facilitating and promoting evidence-based safety initiatives and improvement programmes.
What do we expect to see happen? (Our contribution indicators)	**We expect to see:** • increased understanding of, and action in response to, potentially avoidable harm, mortality review findings and recommendations • services implementing changes through our programmes, including by adopting quality improvement tools and frameworks • services taking timely action in response to our quality alerts, signals and rapid insights • reduced harm through focused quality improvement programmes.
What will success look like? (Intended impact)	**We will see success when:** • policy, commissioning and service design reflect our mortality review findings and our recommendations on quality and safety more broadly • services have embedded evidence-based safety practices • services trust national intelligence on quality and safety and use it for learning, accountability and decision-making • a shared understanding of key quality and safety risks is evident across the health system • the health sector demonstrates improvements in system safety and has stronger capability • outcomes are more equitable, with health services addressing unmet need more effectively and reducing potentially avoidable harm and mortality.

19 Health Quality & Safety Commission Te Tāhū Hauora. 2026. *The New Zealand Health and Disability System Safety Strategy.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resource-library/new-zealand-health-and-disability-system-safety-strategy (accessed on 24 June 2026).

The following examples illustrate some areas in which we lead and support improvements.

- ***The New Zealand Health and Disability System Safety Strategy*** sets out a system-wide approach to strengthening quality and safety. It defines what we expect of the system and how we will act collectively to reduce potentially avoidable harm, support learning and provide safe, people-centred care that supports equal health outcomes for everyone. Over the next few years, we will work with partner agencies to implement the strategy, establishing clear ownership, defined timeframes and measurable actions.

- ***Collaborating for quality: A framework for clinical governance*** is a high-level framework for clinical governance in health services in New Zealand to improve care and reduce harm. We support both the health system in general and individual organisations, including Health NZ, to apply this framework and actively drive improvements in safety, accountability and outcomes across all levels.

- ***Healing, learning and improving from harm: National adverse events policy 2023*** provides a national framework to help health providers improve quality and safety for consumers, whānau and health care workers. It supports a consistent approach to reporting, reviewing and learning from harm. We build system safety capability across the sector by delivering nationwide workshops, while tailoring them to organisational needs, to strengthen practice and support a more proactive approach to safety.

- **Harm (adverse) events reporting** involves monitoring and publicly reporting on quality and safety through indicators such as Severity Assessment Codes (SAC), which record both serious (SAC2) and sentinel (SAC1) events. We support providers with accessible reporting tools, including a national submission portal and dashboards that enable analysis of trends and patterns at national, regional and local levels.

- **Our national mortality review** function drives efforts to reduce avoidable deaths.[20] Under section 82 of the Act, we oversee this function through the **National Mortality Review Committee – He Mutunga Kore**,[21] a committee appointed by the Commission's board to provide a system-wide view of mortality and prioritise areas for in-depth review. Its work includes a focus on perinatal and maternal mortality, deaths related to family violence, and the experiences of families and whānau. Working with communities, clinicians, health services and other health and social agencies, we identify patterns, causes and inequities related to these deaths to support system-wide learning and action.

- **Strengthening quality improvement in community and home-based care** involves facilitating and supporting targeted quality improvement initiatives that strengthen the safety and quality of care delivered in community settings, including aged residential care, home-based support and disability services. These initiatives focus on early recognition of deterioration, response to risk, prevention of harm and improving continuity of care across settings (closing the loop). A particular focus is on populations with higher unmet health need, such as Māori, Pacific peoples and disabled people, as evidence shows these groups have poorer access to care, greater unmet or higher clinical need, and inequitable health outcomes.

- The **Trauma programme** works in partnership with the Trauma National Clinical Network and ACC to provide data-driven intelligence, quality improvement, research and system coordination.[22] Its work supports more consistent, higher-quality, safer care and improved outcomes for people across New Zealand who experience major physical trauma.

20 Health Quality & Safety Commission Te Tāhū Hauora (nd). National review of avoidable deaths. URL: www.hqsc.govt.nz/our-work/national-review-of-avoidable-deaths/ (accessed 4 May 2026).

21 Health Quality & Safety Commission Te Tāhū Hauora (nd). About the National Mortality Review Committee. URL: www.hqsc.govt.nz/our-work/national-review-of-avoidable-deaths/national-mortality-review-committee/ (accessed 4 May 2026).

22 Health Quality & Safety Commission Te Tāhū Hauora (nd). Trauma work programme. URL: www.hqsc.govt.nz/our-work/trauma-work-programme/ (accessed 4 May 2026).

Priority 3: Leading health care improvement through data and evidence

We want a health system that facilitates and supports information sharing, learning, early identification of quality and safety concerns, and appropriate solutions at all levels.

Timely, trusted and actionable information is essential to improving the quality and safety of care and achieving better outcomes for consumers and whānau. This information reflects real people, their experiences and what matters most to them.

Evidence consistently demonstrates that health systems that use robust data, measurement and transparent reporting are better able to understand performance, identify variation and risks, drive improvement activity where it is most needed and improve patient outcomes . In New Zealand, variation continues to exist in access, experience and outcomes across population groups and geographic areas, reinforcing the importance of strong national quality and safety intelligence.

Through rigorous analysis of cross-sector data from primary care, aged residential care and hospital settings, we take a **whole-of-system view of quality, safety and consumer experience**. We gain this perspective through formal data-sharing arrangements, including a refreshed memorandum of understanding with ACC, the Health and Disability Commissioner, Health NZ and the Ministry of Health, which lead to more effective, joined-up use of data to improve frontline services and deliver health targets.

With our unique mandate to look across the sector, we provide authoritative oversight by tracking trends over time and identifying variation and inequities in health outcomes. This makes performance visible, strengthens accountability and supports the Government, sector leaders and health services to respond effectively to quality and safety risks.

We disaggregate data[23] to better understand health need, inequities and variation in outcomes. These insights help the sector to target improvements that will lead to safer, higher-quality and more equitable care.

Beyond monitoring, we translate insights into actionable intelligence and practical tools that support change in policy and practice. These include **quality and safety alerts, a national measures library, patient experience surveys and other intelligence tools** (for more information, see page 23) that build a shared understanding of quality and safety and support system-wide improvement.

We also strengthen system-wide oversight by convening cross-agency groups. For example, the **National Quality Forum**[24] brings together senior representatives from across the health and disability sector to identify, prioritise and respond to quality and safety issues informed by shared data and insights. This shared oversight supports coordinated action, escalation where required and collective accountability for improving quality and safety outcomes.

23 We break down data by ethnicity, age, gender, region and disability status where possible, and work with the sector to improve the availability and quality of this data over time.

24 Members of the National Quality Forum consist of consumer representatives, Commission executive team members, senior leaders from the Ministry of Health (including the Office of the Chief Clinical Officers), the Office of the Health and Disability Commissioner, Whaikaha | Ministry of Disabled People, ACC, Pharmac, primary care representatives, Health NZ, and Health NZ district professional groups.

What will we do to achieve this? (Our core delivery)	**We will:** • provide independent, high-quality data, intelligence and indicators on quality and safety • support the effective use of data and evidence for learning, improvement and decision-making • convene agencies to identify and escalate risks, enable coordinated action and strengthen accountability through shared insights • highlight variation in care and unmet health need to inform and target improvement • strengthen health system capability to measure, understand and improve quality and safety through data insights and reporting.
What do we expect to see happen? (Our contribution indicators)	**We expect to see:** • our data and intelligence informing decision-making across the system • health services using our guidance, tools and measurement frameworks in practice • services and health professionals participating in capability building, improvement programmes and learning activities • services adjusting practice and taking timely action in response to insights, quality alerts and emerging risks • greater awareness of safety risks and variation, supported by strengthened surveillance and system learning.
What will success look like? (Intended impact)	**We will see success when:** • variation in care and persistent inequities, including those related to emerging quality and safety issues, are identified and addressed • health outcomes become more equitable, as services address unmet need more effectively • health practice and policies reflect learnings from our data and intelligence, recommendations and education • the health sector has a stronger capability to improve quality and safety • the public and sector have strong trust in independent reporting.

The following highlights key data, intelligence and measurement tools that we use to monitor system performance and provide to the health sector to support improvement and decision-making.

- **Analytical tools and reporting**
  - » **Quality alerts** measure the quality and safety of health services.
  - » **The Atlas of Healthcare Variation** shows variations in the health care that people in different geographical regions receive.
  - » The **dashboard of health system quality** brings together a range of measures in one place, including quality priorities at a national level.
  - » **Quality and safety markers** focus on driving improvement in key safety priorities: consumer engagement, falls, health care-associated infections, surgical harm and medication safety.
  - » **Harm (adverse) events** reporting provides national oversight to identify system-level risks and issues and support consistent, transparent public reporting and system learning.

- **Patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs)**
  - » National **patient experience surveys** regularly collect information on and measure patient experience. The findings can then be used to improve services in ways that centre on the patient. The surveys are the adult hospital experience surveys (inpatient and outpatient), the adult primary care patient experience survey and the home and community support services experience survey.

- **Publications**
  - » Public reporting within the **Window on the quality of health care** reports draws on national data sets that use robust and validated indicators and other evidence to provide insight into the quality and safety of New Zealand's health care.
  - » **Regular reporting** to the Minister of Health provides an independent, evidence-based assessment of the quality and safety of health services. It highlights complex issues that we can only progress through further analysis and collaboration with our partner agencies.

- **Capability building**
  - » The **measures library** is a centralised reference 'library' that publishes a range of quality- and safety-focused measures and resources to create a common understanding of health system and service measurement.

Our ways of working

We use a set of interconnected ways of working, together with our statutory levers, to drive health system performance and support improvement.

We work with others by identifying and understanding issues and opportunities (Inquire), building strong partnerships and engaging consumers and whānau (Involve), measuring, analysing and sharing insights (Inform), shaping thinking, setting expectations and supporting action in response to evidence (Influence), and coordinating, supporting and facilitating measurable improvements across the system (Improve).

Through these approaches, we not only make quality and safety performance visible but also support the health system to respond to insights, strengthen capability and implement improvements that reduce harm and improve outcomes and experiences for people receiving care.

Our ways of working	What this means
Identifying and understanding issues and opportunities (Inquire)	We generate trusted intelligence, analyse data and identify system-level risks to understand what is happening in the health sector and why. In this way, we generate clearer expectations and a shared understanding of what needs to change.
Building strong partnerships and engaging consumers and whānau (Involve)	We work alongside consumers, whānau, clinicians, communities and the wider health sector so that health care reflects what matters to people, grounding system change in those priorities and supporting shared ownership of improvement.
Measuring, analysing and sharing insights (Inform)	Our robust data and intelligence about safety, harm, mortality and consumer experience lifts transparency and expectations, strengthens trust and public accountability, and supports evidence-informed decision-making and improvement across the health system.
Shaping thinking, setting expectations and supporting action in response to evidence (Influence)	We support leadership, practice change, capability building and system learning so insights are actioned and improve safety and quality across the health system.
Coordinating, supporting and facilitating measurable improvements (Improve)	We enable and accelerate improvement so that safer, higher-quality practices are implemented, sustained and shared across the health system.

Our alignment with Government priorities

We support the Government's priority of timely access to safe, high-quality health care for all New Zealanders by strengthening the conditions for quality improvement, safer care and more equitable health outcomes.

The *Government Policy Statement on Health 2024–2027* sets the priorities and health targets for the health system. Through our strategic priorities and programmes of work, we help to achieve these by:

- focusing on improving patient experience, access and outcomes
- reducing potentially avoidable harm and mortality and strengthening quality and safety of health care
- enhancing system performance and capability by providing high-quality, objective data measurement, reporting and learning.

We contribute to the Government's priorities related to access, timeliness, quality, workforce and infrastructure in the following ways.

The following provides further detail on how our work supports each of the Government priorities.

Government priorities	Commission contribution
Access	• We provide independent system intelligence that highlights variation in access to services and outcomes across the health system. • Through national quality measurement and reporting, including quality alerts and the Atlas of Healthcare Variation, we identify variations in health need, access to care and health outcomes for different population groups. • Our analysis brings together lived experience, data and evidence to help leaders understand where barriers to access exist and where to focus improvement efforts. • Through our national improvement programmes and tools, we support the sector to redesign care and improve access to appropriate services.
Timeliness	• Our quality alerts help the health sector understand where delays in care affect outcomes and experience. • We identify emerging risks and trends through our independent analysis of national health data and insights. • Our improvement programmes support clinicians and services to improve processes that affect the timeliness, reliability and coordination of health care. • By providing trusted information and practical ideas for improvement, we help the health sector learn from variation and improve performance over time.
Quality	• We are the independent agency responsible for monitoring and reporting on the quality and safety of health services across New Zealand. • We provide trusted, accessible information that helps the health sector understand performance, identify risks and prioritise improvement. • Through national quality improvement programmes, we support the sector to adopt evidence-based practices that reduce harm and improve outcomes. • We bring consumer, whānau and community perspectives into system design and improvement efforts, focusing services on what matters most to people. • Our mortality review and other learning systems generate insights that support the sector to prevent harm and improve care.
Workforce	• Guided by the *Healing, learning and improving from harm* policy, we build capability for clinicians and health sector teams to respond to harm, embedding a learning and improvement culture and safer care. • We provide tools, guidance and learning opportunities that help the workforce to use data, evidence and improvement methods in everyday practice. • Our programmes enable clinicians and leaders to learn from variation, as well as to test improvement approaches and spread successful ones across the health system. • By strengthening improvement capability and culture, we help build a more resilient health sector that is focused on continuous improvement.
	• Our data and intelligence highlight infrastructure, service design and digital system factors that affect quality and safety. • Our reporting and analysis help decision-makers understand how system settings influence the quality, outcomes and patient experience of care. • We support the effective use of data and information systems to enable transparency, learning and improvement. • By bringing together and collaborating with sector partners, we help infrastructure and system design support safer, higher-quality care.

Measuring our performance
Te ine i tā mātou mahi

We measure our performance through the contribution we make to improving the quality and safety of health care, supporting a health system that is safer, more equitable and better able to learn and improve.

Many of the outcomes we seek – such as improved patient outcomes, reduced harm and avoidable mortality, and more equitable access to services – are influenced by the actions of multiple organisations across the health system and sit outside the Commission's direct control. The system as a whole works towards realising these outcomes over time.

Our performance framework reflects this role (see Figure 3). It links the outputs we deliver to the changes we expect them to produce across the health system over time.

Our contribution

Our information, data intelligence and evidence help identify quality and safety challenges and potential solutions, and support the health sector to implement changes that improve outcomes.

This range of outputs promote learning, improvement and accountability across the health sector. They include:

- system intelligence that draws on quantitative data, qualitative insights and lived experience
- mortality review programmes and support for sector responses to recommendations
- safety insights, quality alerts and learning resources
- consumer experience measurement and reporting
- tools, frameworks and guidance to support safer care
- convening opportunities for, and supporting, sector learning and collaboration.

We assess the quality and effectiveness of these outputs through conditions that enable impact, including the robustness, independence and timeliness of our evidence and insights, the strength of our relationships and credibility across the sector, and the reach and uptake of the tools and programmes we provide.

How we know our work is making a difference

To understand how our work influences the health system, we monitor a range of **contribution indicators**, recognising that realising the changes we seek depends on actions taken across the wider health system.

These indicators help us assess whether the sector is using, valuing and trusting our high-quality outputs and whether they are contributing to the intended impacts and real-world improvements.

Our contribution indicators include, for example:

- uptake of tools, frameworks and guidance across the sector
- actions taken in response to mortality review recommendations
- use of our data intelligence in decision-making
- participation in our capability and improvement programmes
- inclusion of consumer and whānau input in health sector activities
- evidence of practice change and usefulness, supported by survey and evaluation feedback.

Each year, our Statement of Performance Expectations sets out the specific outputs and measures that we will use to track our performance.

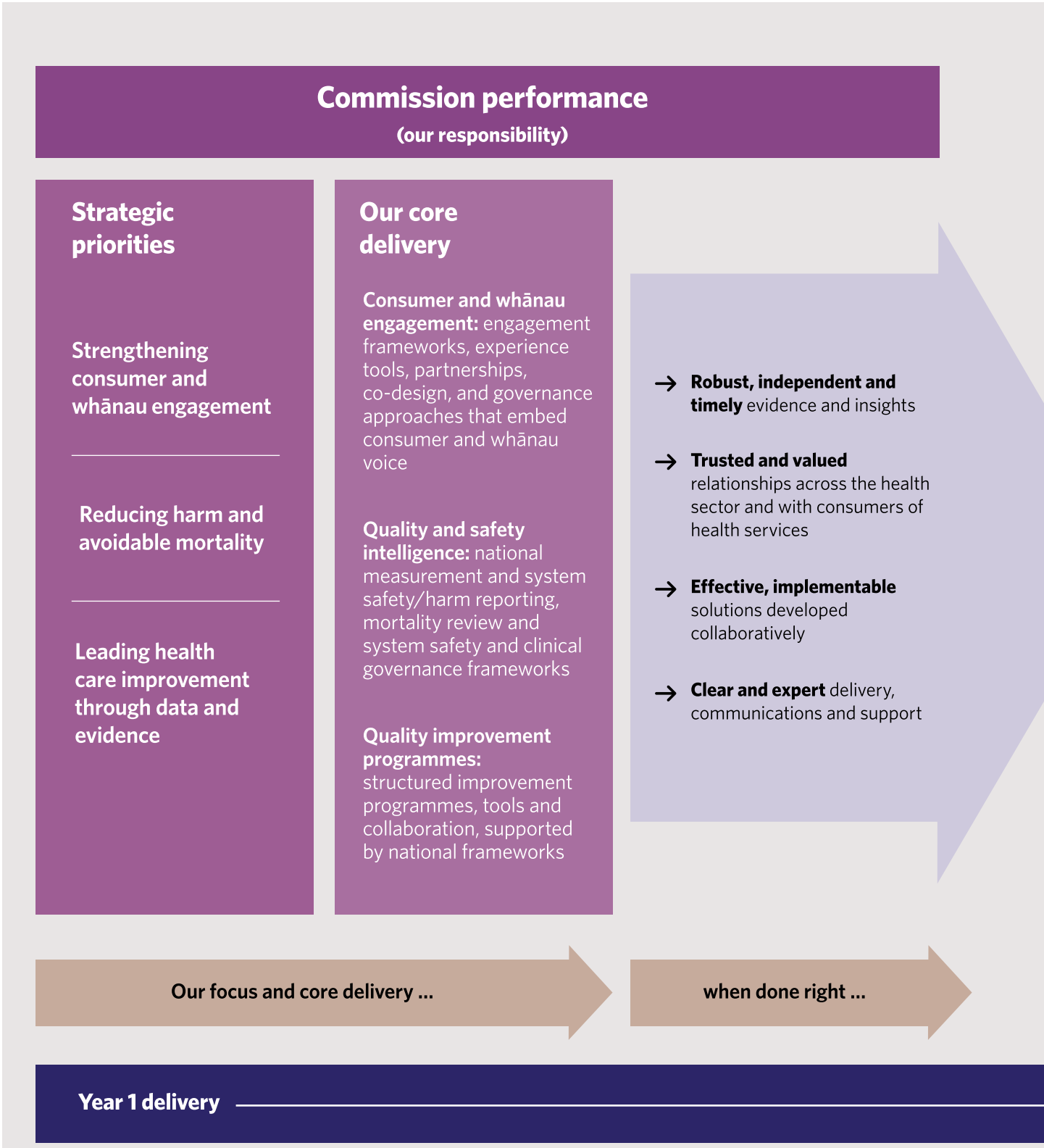
How our work drives system change and impact

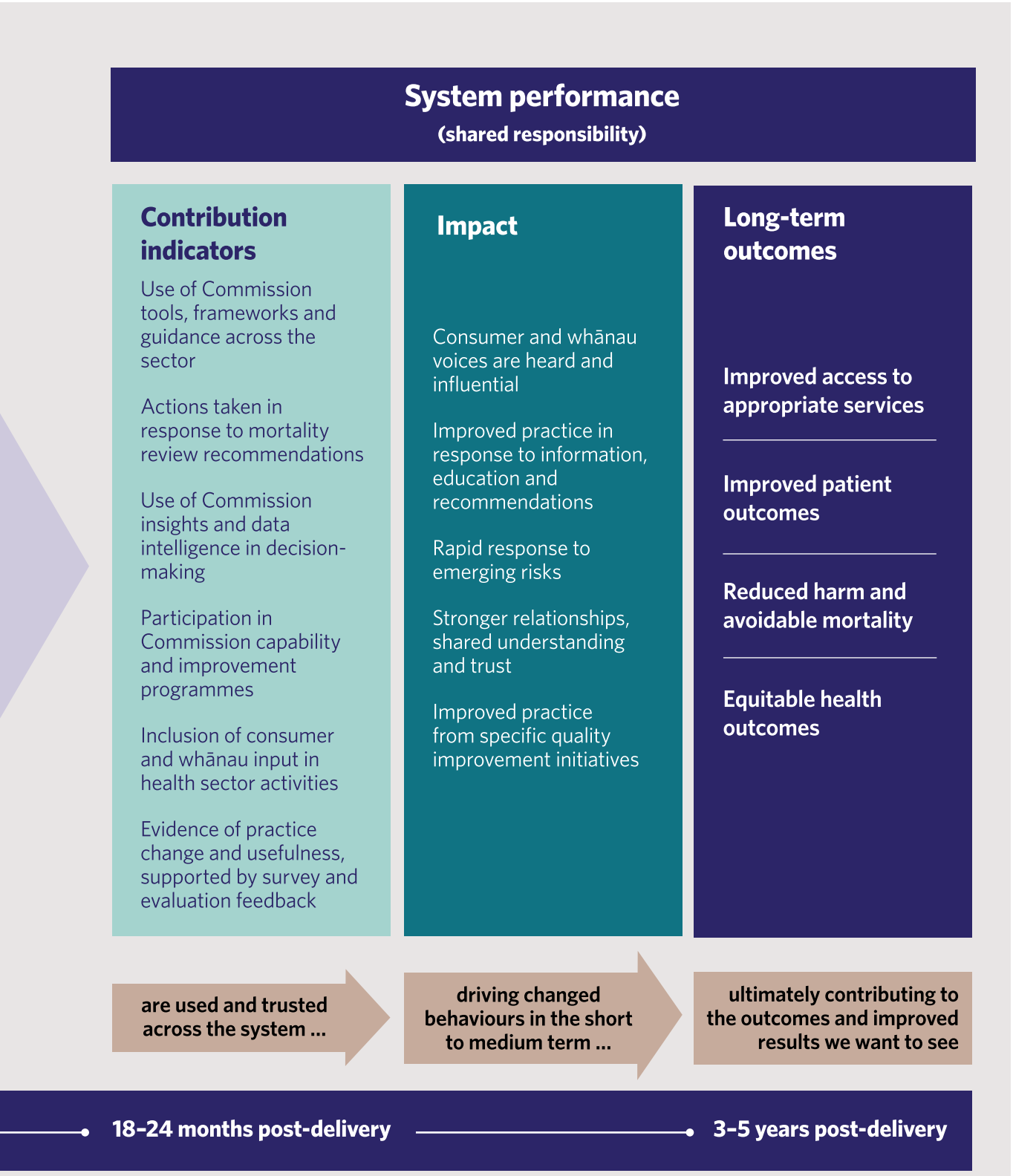
When applied effectively, our work contributes to observable shifts in how the system operates, improves outcomes and drives **system change**. That is, the sector is using trusted, accessible information for learning and accountability; an understanding of key risks and opportunities for improvement is widespread; and independent reporting informs decision-making at national, regional and local levels. These changes enable more timely responses to emerging risks, support evidence-informed policy and practice, and strengthen targeted improvement initiatives.

Alongside this, consumer and whānau experiences are actively incorporated into service design and improvement, so that their voices are heard and more influential. Together, these shifts build system resilience, trust and collaboration, and foster a culture of continuous learning and accountability that supports safer, more responsive care.

Monitoring of long-term outcomes is an important part of our statutory role as the health system's expert monitoring agency of quality and safety. Together with our health sector partners, it helps us to assess whether the system is becoming safer, is improving in quality and is more equitable.

Figure 3: Our performance framework




System performance
(shared responsibility)
Contribution indicators
Use of Commission tools, frameworks and guidance across the sector
Actions taken in response to mortality review recommendations
Use of Commission insights and data intelligence in decision-making
Participation in Commission capability and improvement programmes
Inclusion of consumer and whānau input in health sector activities
Evidence of practice change and usefulness, supported by survey and evaluation feedback
Impact
Consumer and whānau voices are heard and influential
Improved practice in response to information, education and recommendations
Rapid response to emerging risks
Stronger relationships, shared understanding and trust
Improved practice from specific quality improvement initiatives
Long-term outcomes
Improved access to appropriate services
Improved patient outcomes
Reduced harm and avoidable mortality
Equitable health outcomes
are used and trusted across the system ...
driving changed behaviours in the short to medium term ...
ultimately contributing to the outcomes and improved results we want to see
18–24 months post-delivery
3–5 years post-delivery

Our organisational health and capability
Te whakahaere hauora me te matatau

Our ability to deliver our statutory functions depends on strong organisational capability, effective stewardship of public resources, and a culture that supports independence, learning and continuous improvement.

We invest in our people and systems so we can provide trusted intelligence, support improvement across the health and disability system.

The areas we consider essential to our effectiveness include: our governance structure our relationship with Ministers and our people, capability and culture. In addition, a strong foundation of careful financial management and a focus on environmental sustainability support our organisation.

Our governance

We are governed by a board of no fewer than seven members, who are appointed by the Minister of Health. Rae Lamb is our board chair.[25]

The board provides strategic oversight, ensures our work aligns with our statutory functions and maintains the Commission's independence at the level needed to provide credible intelligence and advice. It has established clear processes for managing conflicts of interest, safeguarding the integrity of our reporting, and undertaking work that is evidence based and free from undue influence.

The board has an audit sub-committee, which provides assurance and assistance with our financial statements and internal control systems. A range of expert advisory groups and the National Mortality Review Committee also support and direct our work.

25 Health Quality & Safety Commission Te Tāhū Hauora (nd). Board members | Ngā kanohi o te Poari. URL: www.hqsc.govt.nz/about-us/our-people/board-members (accessed 7 May 2026).

Our people and culture

Our people are central to the Commission's ability to deliver high-quality intelligence, improvement expertise and engagement support. We employ around 80 staff whose skills and commitment underpin the Commission's performance.

We maintain a culture that values collaboration, integrity and learning. Our people uphold the Public Service Code of Conduct, which sets clear expectations for integrity, behaviour and engagement across the public sector.

We invest in their capability and wellbeing so that they have the support they need to grow and sustain their contribution over time. By developing our people and creating a supportive environment, we strengthen the Commission's capability, enhance our independence and remain an organisation where talented people want to contribute and thrive.

Areas where we focus on building capability are data and analytics, quality improvement, consumer and whānau engagement, cultural safety and Te Tiriti o Waitangi competencies. We support staff to balance their work with their whānau and personal commitments.

Equal opportunities

We are committed to providing equal employment opportunities and to fostering a workplace that is safe, inclusive and respectful for everyone. We value diversity and are committed to supporting Māori, Pacific peoples, disabled people, rainbow staff and all other people from all kinds of backgrounds within our workforce.

Our focus is on creating an environment where people feel supported, heard and able to contribute fully and where we use equitable employment principles to recruit, develop and support our staff.

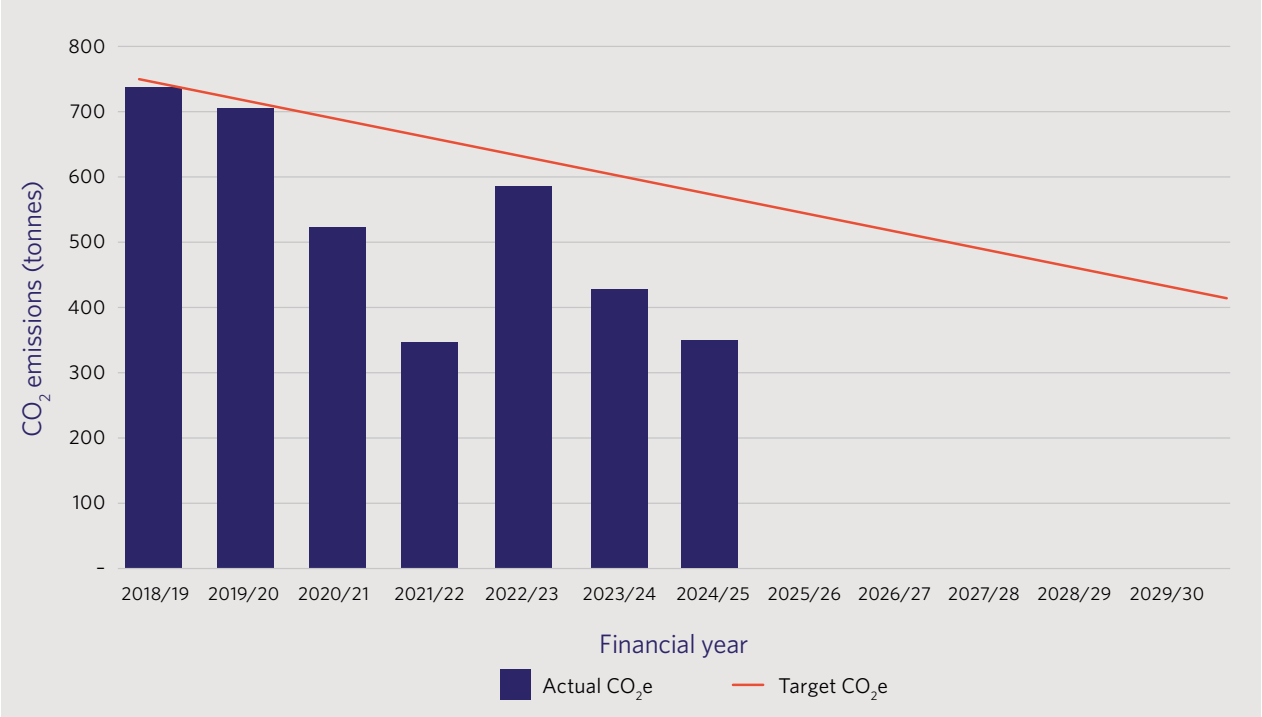
Environmental sustainability

We remain committed to reducing our carbon footprint and maintaining our Toitū carbonreduce certification,[26] which we have held since our 2018/19 base year. Through Toitū Envirocare, we measure and independently audit our annual carbon emissions, track progress against our reduction targets and maintain a clear emissions profile.

We have already achieved significant reductions. These began initially with lower travel during the COVID-19 pandemic and have continued with ongoing changes such as a more sustainable electricity supply, reduced paper use and improved reporting of freight and waste. Our move into a building shared with other health agencies has further reduced our environmental footprint through more efficient use of space, shared infrastructure and improved energy performance.

Over the period 2026–2030, our focus is on maintaining performance as activity levels evolve, while continuing to identify and implement further opportunities to reduce emissions, particularly in travel, procurement and office operations. We will support the Carbon Neutral Government Programme target of a 42 percent reduction in gross emissions, as measured by carbon dioxide equivalent (CO_2e), by 2030 (from a 2018/19 baseline) (see Figure 4), taking an approach that reflects responsible stewardship of public resources.

Figure 4: Actual and targeted progress towards the 2030 target of 42 percent reduction in carbon emissions



26 The Toitū carbonreduce certification mark is a voluntary climate impact programme that helps organisations measure, manage and reduce their greenhouse gas emissions. It is the only certification in New Zealand that is accredited by the Joint Accreditation System of Australia and New Zealand to certify to international standards (ISO 14064-1:2018). Achieving and maintaining certification is an annual requirement for participating organisations, which must demonstrate they are meeting the certification rules.

Information technologies security

Our information technology (IT) systems and Cyber Security Policy support the secure management and protection of our information assets. Our cyber security practices focus on preventing unauthorised access and safeguarding critical information across both digital and physical formats.

We continue our move to the New Zealand-based Microsoft 365 Cloud. Hosting data locally supports stronger data governance, aligns with Māori Data Governance principles[27] and contributes to a more sustainable, ethical and future-focused digital environment.

Operationally, we maintain all computers with Microsoft Intune and Defender for Endpoint, improving visibility and protection across our network. Our organisation-wide phishing education programme, KnowBe4, remains in place to reduce human risk and support ongoing cyber awareness. Recognising the sensitivity of the data we manage, we regularly review our IT systems and processes so they continue to be fit for purpose.

Managing our finances

We manage public resources in a responsible, clear and accountable way. Our financial management practices enable us to deliver our statutory functions within available funding, invest in priority areas and maintain the capability required to support system improvement. We monitor cost pressures, plan for future needs and focus our investments on delivering value to the health system.

We maintain a proactive approach to identifying and managing organisational and system risks, working prudently within our funding levels and consistently delivering on the Government's expectations. We have a clear understanding of our cost drivers and performance against key outcomes, and we account for these in reporting to our responsible Minister, monitoring department and the public.

Recognising that cost pressures are not automatically funded through the Budget process, we continuously seek opportunities to drive greater value-for-money and maintain financial sustainability. We support sound management of public funding by complying with the Public Service Act 2020, the Public Finance Act 1989 and applicable Crown entity legislation.

The annual audit review from Audit New Zealand provides useful recommendations on areas for improvement. We implement these recommendations, with oversight from our audit sub-committee, to strengthen our systems, processes and stewardship of public resources.

27 Te Mana Raraunga. 2018. *Principles of Māori Data Sovereignty* (Brief #1). URL: www.temanararaunga.maori.nz/nga-rauemi (accessed 7 May 2026).

Compliance

We meet our good employer requirements and obligations under the Public Finance Act 1989, the Public Records Act 2005, the Public Service Act 2020, the Health and Safety at Work Act 2015, the Crown Entities Act 2004 and other applicable Crown entity legislation through our governance, operational and business rules.

We continue to use the ComplyWith cloud-based legislative compliance information, monitoring and reporting programme, which shows that we have a consistently high level of overall legislative compliance. We comply with all legislative requirements and proactively implement processes wherever possible to address any issues that arise.

Risk management

Our risk management framework supports early identification of emerging issues, clear escalation pathways and regular board oversight.

Our staff are aware of the processes for risk identification and management. The board, chief executive, senior management and programme managers regularly identify strategic and operational risks in consultation with their teams. Programme managers recognise that they are accountable for raising the risks in their programme areas with management.

Risk management is a standing agenda item at each board and executive leadership team meeting. Our audit sub-committee provides the board with independent assurance on and assistance with our financial statements and the adequacy of systems of internal controls.

Appendix: Our legislative objectives and functions

Āpitihanga: Ko ā mātou whāinga me ā mātou āheinga

Our objectives

The objectives of the Health Quality & Safety Commission Te Tāhū Hauora (the Commission)[28] are to lead and coordinate work across the health sector for the purposes of –

(a) monitoring and improving the quality and safety of services; and

(b) helping providers to improve the quality and safety of services.

Our functions

1. The functions of the Commission are –
   (a) to advise the Minister on how quality and safety in services may be improved; and
   (b) to advise the Minister on any matter relating to –
      (i) health epidemiology and quality assurance; or
      (ii) mortality; and
   (c) to determine quality and safety indicators (such as serious and sentinel events) for use in measuring the quality and safety of services; and
   (d) to provide public reports on the quality and safety of services as measured against –
      (i) the quality and safety indicators; and
      (ii) any other information that the Commission considers relevant for the purpose of the report; and
   (e) to promote and support better quality and safety in services; and
   (f) to disseminate information about the quality and safety of services; and
   (g) to support the health sector to engage with consumers and whānau for the purpose of ensuring that their perspectives are reflected in the design, delivery, and evaluation of services; and

28 The Health Futures (Pae Ora) Act abbreviates Health Quality & Safety Commission Te Tāhū Hauora as HQSC.

(h) to develop a Code of expectations for consumer and whānau engagement in the health sector for approval by the Minister; and

(i) to make recommendations to any person in relation to matters within the scope of its functions; and

(j) to perform any other function that –

(i) relates to the quality and safety of services; and

(ii) the Commission is for the time being authorised to perform by the Minister by written notice to the Commission after consultation with it.

2. In performing its functions, the Commission must, to the extent we see as appropriate, work collaboratively with a wide range of stakeholders: the Ministry of Health; the Health and Disability Commissioner; Health New Zealand; providers, professional bodies; consumer groups and any other organisations, groups or individuals with an interest in our work.



New Zealand Government
Te Kāwanatanga o Aotearoa

