FRANCIS HEALTH

Final Report

Review of the National Mortality Review Function

March 2022

Final report for the review of the National Mortality Review Function

This report has been prepared by Francis Health.

The authors would like to acknowledge the willingness of all participants who gave their time generously to the review.

Final report: 31 March 2022

Table of Contents

1 Acknowledgements

Ka takina anō te kawa	A forward-looking process
Ko te kawa nui, ko te kawa roa	A prevailing, enduring process
Ko te kawa tapu	A sacred, elevated process
Ko te kawa ki a ueuenuku, ki a ueuerangi	Formed in the heavens and on earth
Ko te kawa ora	It is the essence of life,
He manawa ora, he manawa ora	hope, strength and courage.
Ka takina nga karamihi ki ngā pūkenga, ki ngā wānanga, ki ngā mākohakoha, ki ngā apārangi i titoko ai tēnei pūrongo, i tēnei puna kōrero.	We acknowledge the many expert minds and generous hearts who contributed to this report, to this spring of knowledge, experiences and insights.
Nā koutou te whai pūrongo, mā tātou te whai oranga!	This report provides awareness and enlightenment in the pursuit of optimal health and wellbeing.
Nō reira, e ngā kaiwhakairo o te wānanga, e ngā kairaranga o te kōrero, tēnā koutou katoa.	And so, to the master carvers of inquiry and distinguished weavers of conversation, we thank you for your vision, care and commitment to this important work.
Tau mai te pō	As the night settles
Nau mai te Ao!	We welcome the light
Tihei Mauriora!	Tis the breath of life!

In undertaking the review of the National Mortality Review Function (NMRF) the Francis Health team would like to acknowledge both the significant contribution of stakeholders, over the last 20 years, in establishing and developing the national mortality review processes, and the time and honest reflection they have provided to the review team.

2 Executive Summary

2.1 Purpose

The purpose of this review is to explore the value and contribution of the National Mortality Review Function (NMRF) in improving our health system and other social sectors to reduce preventable mortality, and to provide recommendations to strengthen the impact of this function. Francis Health was commissioned by the Health Quality and Safety Commission (HQSC) to deliver a comprehensive 'first principles' review of the NMRF with a particular focus on how the function can give better effect to the Crown's responsibilities to Māori under the principles and obligations contained in Te Tiriti o Waitangi.

The health and disability sector environment and priorities have changed significantly since the inception of the mortality review system in 2002. HQSC would like to understand whether the current mortality review structures and functions are apposite to deliver a mortality review function that will last a generation.

This report summarises the findings and recommendations of the Francis Health review.

2.2 The Review Process

The review commenced in September 2021 and reported to the HQSC Board in April 2022. The review process involved widespread stakeholder consultation ranging from existing Mortality Review Committee (MRC) members, government agencies and consumer groups. A current state 'Critical Review' was undertaken that was informed by a review of international literature, legislation, performance, prior reviews, and outputs from existing MRCs.

The HQSC established an Expert Advisory Group (EAG) to test concepts and provide advice to the Francis Health team over the course of the review. A set of 'first principles' was developed in partnership with the EAG to serve as guiding principles for the future state design and recommendations.

2.3 Background and Current State

The intention of a NMRF is to reduce preventable deaths. This is achieved by collating and systematically analysing information relating to preventable death, bringing together subject matter experts to conduct reviews, and developing recommendations. These recommendations then need to be disseminated and their impact on system change and improvement evaluated.

The mortality review programme was placed in the HQSC when it was established in 2010 and has often been seen as the responsibility of the health sector. It is now accepted that a health lens, while essential, is not sufficient in the context of addressing the key drivers (social determinants[1]) of preventable mortality. Broader, multi-sector partnerships are essential to achieve traction and effect change, particularly across entrenched issues. The significance of effective intersectoral partnerships is set to increase as health system reforms with a focus on delivering for Māori and community-based services come into effect.

[1] The social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. (World Health Organisation definition)

The HQSC hosts five MRCs:

- Child and Youth Mortality Review Committee (CYMRC) established 2002
- Perinatal and Maternal Mortality Review Committee (PMMRC) established 2005
- Family Violence Death Review Committee (FVDRC) established 2008
- Perioperative Mortality Review Committee (POMRC) established 2010
- Suicide Mortality Review Committee (SuMRC) established 2017.

The review team acknowledge the progress that has been achieved over the last twenty years, largely through the dedication and passion of committee members (past and present), which has resulted in Aotearoa New Zealand's mortality review being recognised internationally as being at the forefront[2].

Whilst there was a strong and broad endorsement of the vital importance and value of a mortality review function, it was also acknowledged that there are several factors that inhibit optimal functioning and impact. The increasing appreciation for the complexities driving mortality and the consistently poorer outcomes for Māori that continue to prevail mean it is important to examine the aspects of the NMRF that could be improved while acknowledging and maintaining the existing strengths. The report summarises the key challenges and opportunities relating to:

- Role and scope
- Value and impact
- Equitable outcomes and Te Tiriti
- Structure, processes, and resourcing
- Governance, roles, and responsibilities
- Data and data sovereignty
- Interagency collaboration and accountability
- Legislation.

2.4 Rationale for the Recommendations

The NMRF has made structural and process changes to mortality review in an effort to achieve improved equity for Māori. While these changes have progressed, they are neither sufficient nor consistently applied to eliminate inequities in preventable mortality for Māori. Māori experience significantly higher rates of mortality. As tangata whenua, the rights of Māori are guaranteed under Te Tiriti, and it is therefore incumbent that the NMRF processes, structures and priorities are resourced to eliminate these inequities.

The key findings, first principles, and recommendations for a future blueprint outline a compelling case for change signalling the nature and shape of the blueprint for the future state of an equitable, sustainable, and impactful NMRF. The key areas of change under the future state are grouped and briefly described below:

- Improved Te Tiriti compliance that strengthens the influence Māori have over mortality review, with improved capability across all members so that resourcing is focussed and prioritised to

[2] Coleman, C., Elias, B., Lee, V., Smylie, J., Waldon, J., Hodge, F., & Ring, I. (2016). International Group for Indigenous Health Measurement: Recommendations for best practice for estimation of Indigenous mortality. Statistical Journal of the IAOS, 32, 1-10. https://doi.org/10.3233/SJI-161023

eliminate inequities in preventable morality for Māori

- Expansion of scope to include consideration of all preventable mortality, not only the five areas historically reviewed. This will ensure activity is focussed on areas of highest need and where impact is more likely to be achieved
- Acknowledgement that one of the NMRF's primary roles is one of influence best achieved through increased attention on cross- sector engagement. Effective relationships will better support ownership and implementation through collaboration with other national and local agencies, resulting in greater impact
- A more agile NMRF that can adapt and respond to both changes across sectors and emerging mortality priorities
- Better coordination and alignment of review and related activities at an operational level which will improve efficiencies and enable better sharing of skills and capability across the NMRF
- Improved ownership of the NMRF data to enable improved and appropriate access (within privacy and Māori data sovereignty frameworks) to develop enhanced capabilities to identify causes of mortality
- Improved clarification on the roles and responsibilities of the NMRF, and clarity on the purpose and benefit of independence. This is in relation to both the ability of the HQSC to credibly undertake review independently from government agencies and the value and role of the independent advice provided to the NMRF in support of mortality review
- Modernised legislation giving effect to these changes and incorporating a clear statement of the purpose of the NMRF and ability for the HQSC to request feedback on recommendations from other government agencies.

The recommendations in the next section identify the key activities and considerations that the HQSC will need to progress over time to achieve the benefits summarised above. The recommendations are supported by a blueprint that describes how a new NMRF would work and an implementation pathway to initiate this change.

While much of the journey remains ahead, the review team is confident that if the HQSC can progress these recommendations it will achieve an improved national mortality review function - one that considers all preventable mortality when setting priorities, is Te Tiriti compliant, appropriately resourced, and equipped to last a generation.

3 Recommendations

The recommendations detail the changes required to support the establishment and implementation of the future blueprint for a refreshed National Mortality Review Function described in section 9 of this report. The recommendations reflect a review process that included extensive stakeholder engagement, early establishment of first principles and a current state review (Appendix A).

Francis Health recommends HQSC:

1. **Commits** to continuing a National Mortality Review Function for Aotearoa New Zealand that is based on strong endorsement of this function identified in the review

2. **Adopts** the following principles for the future design of a National Mortality Review Function

    a. In order to eliminate inequities across mortality, particularly in Māori mortality, a prioritised Te Tiriti compliant approach is required (as outlined in the body of the report)

    b. The purpose of this mortality review system is to understand and thereby reduce preventable mortality at a systemic level in Aotearoa New Zealand. This includes the ability to identify and make recommendations relating to causes of preventable mortality and issues of equity as they relate to priority groups

    c. Any review of mortality needs to consider that preventable death is broader than the health system and impacted by a range of social drivers

    d. The mortality review system needs to take an intentional multi-sector and community approach, with significant Māori influence, to succeed

    e. An effective mortality review system needs sufficient independence and influence to critique system performance and ensure credible, impactful review and improved outcomes

    f. A national mortality system needs to include broad surveillance and robust prioritisation for best impact

    g. A credible range and depth of information, expertise, and engagement (incl. lived experience and whānau) at a regional and national level is required to ensure actionable learning and system improvement

    h. Data is a cornerstone of the mortality review function. Its application needs to strike a balance between respecting confidentially and access with clear data governance and sovereignty for Māori data

    i. The national mortality review system needs to be credible, enduring and flexible to enable it to respond to changing and emerging priorities

3. **Adopts** the Te Tiriti framework as described in the report, Ministry of Health's Te Tiriti o Waitangi Hauora Framework and the HQSC's Tauākī Korongā - Statement of Intent 2.as the basis for a Te Tiriti compliant NMRF

4. **Adopts** the future blueprint for the functions, structure, roles and activities of a new National Mortality Review Function within HQSC as described in the report

5. **Establishes** a National Mortality Advisory Group to provide independent advice, support and capability to the National Mortality Review Function within the HQSC

6. **Agrees** to expand the scope to include consideration of all preventable mortality, then prioritise based on need and potential impact of the NMRF

7. **Agrees** to take ownership of and responsibility for the NMRF data management functions. Data is a cornerstone of the mortality review function. Its application needs to strike a balance between respecting confidentially and access with clear data governance and sovereignty for Māori data

8. **Seeks** the legislative changes, detailed in section 9.2, to clarify the purpose of the NMRF, state the Crown's intentions in relation to reflecting Te Tiriti, and strengthen the independence, accountability and impact of the NMRF.

9. **Notes** the critical phasing and costing issues to address during implementation detailed in Section 10

10. **Notes** that additional funding is likely to be required to broaden the focus on preventable mortality and strengthen national and local stakeholder engagement.

Further details about the development and improvement of the NMRF are provided in the report.

4 Purpose and Scope of the Review

The purpose of this review is to explore the value and contribution of the NMRF on improving our health system and other social sectors in order to reduce preventable mortality, and to provide recommendations to strengthen the impact of this function. The review was commissioned by the Health Quality and Safety Commission (HQSC) to deliver a comprehensive 'first principles' review of the NMRF with a particular focus on how the function can give better effect to the Crown's responsibilities to Māori under the principles and obligations contained in Te Tiriti o Waitangi.

The health and disability sector environment and priorities have changed significantly since the inception of the mortality review system in 2002. HQSC would like to understand whether the current mortality review structures and functions are apposite to deliver a mortality review function that will last a generation.

The scope for the review includes a request to consider changes to the roles and functions of the current NMRF structure and to examine whether the processes are agile and adaptable enough to meet future needs. The assessment and design considerations of the NMRF will inform the advice in response to the Minister of Health's Letter of Expectations for 2021/2022.

This review process included mapping and assessment of the current state and a proposed blueprint for a future state. The scope of the review as set out in the Review Terms of Reference (ToR) by the HQSC is:

- An exploration of the purpose and relevance of national mortality review and withers it's still a required system-level improvement function
- A review of the data and methodologies, including privacy and legal considerations, that provide the current foundations for national mortality review in Aotearoa New Zealand
- An assessment of what has been achieved across the Mortality Review Committees (MRCs) since their inception
- Design of a national mortality review blueprint, including function and structure, which aligns with the Principles of Māori Data Sovereignty and Te Pou rubric and guidelines
- Review of the legislative provisions in the New Zealand Public Health and Disability Amendment Act 2010 (the Amendment Act 2010) and whether these need to be changed to support the revised NMRF identified through the review.

It is the intention of this report to document the review process and findings. As part of that process, the report identifies specific features that enable substantive improvement in outcomes as well as those aspects which do not. When undertaking a review such as this, the strengths and challenges within a system are key aspects that should inform its future design. That can create an impression that the challenges outweigh the strengths and progress that has been made but that is not the case here. The NMRF is internationally regarded as setting the benchmark for a meaningful in-depth mortality review[3]. Supported by high quality data and leading the way in terms of making a positive impact against the broader, socially determined drivers of preventable mortality. This report identifies ways to build on what has been achieved to date.

[3] Coleman, C., Elias, B., Lee, V., Smylie, J., Waldon, J., Hodge, F., & Ring, I. (2016). International Group for Indigenous Health Measurement: Recommendations for best practice for estimation of Indigenous mortality. *Statistical Journal of the IAOS*, *32*, 1-10. https://doi.org/10.3233/SJI-161023

5 Background and Current State

The intention of a NMRF is to reduce preventable deaths. This is achieved by collating and systematically analysing information relating to preventable death, bringing together subject matter experts to conduct reviews, and developing recommendations. These recommendations then need to be disseminated and their impact on system change and improvement evaluated.

Historically, the NMRF has been the responsibility of the health sector. However, mortality is complex and an understanding of the health and social drivers that lead to preventable death is required. To understand and address these drivers, multiple agencies need to work together. The health and disability sector reforms point towards enhanced integration within the sector and externally across the wider social economic environment.

The existing mortality review programme was founded twenty years ago under the New Zealand Public Health and Disability Act 2000 (the NZPHD Act, or the Act), when the responsibility of mortality review was held by ministerial committees reporting to the Minister of Health. Following the enactment of the New Zealand Public Health and Disability Amendment Act 2010 (the Amendment Act), the responsibility for mortality reviews under the Act was transferred to the newly established HQSC.

Since transferring from the Ministry of Health, the NMRF has reported to the HQSC board. The HQSC hosts five MRCs that are responsible for independently undertaking mortality reviews within the parameters determined by the NZPHD Act. The budget and scope for the committees are set by HQSC. The Suicide Mortality Review Committee is funded by the Ministry of Health which approves its budget and scope by annual contract with the Commission. The HQSC provides the overall support and direction for the MRCs to operate effectively and efficiently by way of a Secretariat. The functions of the five MRCs are to provide advice on specific classes of deaths and on improvements to reduce preventable mortality and morbidity.

The five MRCs are:

- Child and Youth Mortality Review Committee (CYMRC) established 2002
- Perinatal and Maternal Mortality Review Committee (PMMRC) established 2005. PMMRC has two working groups, the Maternal Mortality Review Working Group (MMRWG) established in 2006 and the Neonatal Encephalopathy Working Group (NEWG) established in 2007.
- Family Violence Death Review Committee (FVDRC) established 2008
- Perioperative Mortality Review Committee (POMRC) established 2010
- Suicide Mortality Review Committee (SuMRC) established 2017.

A strong directive signalled for the current health and disability reforms is a heightened focus on ensuring Te Tiriti compliance, and a focus on achieving equitable outcomes are evident in the ways that services are designed and delivered.

6 The Review Process

This section describes the process used to conduct the first principles review of the NMRF. It outlines the approach including information gathering, critical review, and the development of the first principles, the blueprint for the future state and the recommendations for a refreshed NMRF.

A mixed methodology approach was used. Qualitative data from interviews and focus groups were used to establish the current state, in conjunction with secondary data from previous reports. A literature review of peer reviewed publications on national approaches to mortality review and review practices relating to Indigenous populations was also undertaken to inform the review. To develop the blueprint and recommendations, an iterative approach was taken with stakeholders providing input and feedback.

During the project initiation, the Francis Health review team together with HQSC identified the key stakeholders to contribute to the review. This included internal HQSC staff, current and previous MRC members and representatives from external agencies across the health and wider social services.

The engagement, analysis and recommendations were underpinned by a Māori centred approach drawing on:

- Historical Māori experiences with, and perceptions about research – ensuring participants feel safe, not over-burdening Māori participants, not repeating past mistakes, ensuring data gathered will benefit the participants
- Māori perspectives about the world – such as ensuring the Te Ao Māori view is accepted within discussions and not dominated, usurped, or demeaned by a western perspective
- Māori values and expectations around ethics – such as knowing what is right within the realm of tikanga and taking steps not to transgress or offend the local kawa of whānau, hapū and iwi
- Māori cultural values and practices – such as honouring and expressing Māori values of whanaungatanga i.e., connecting the members of the review team with key stakeholders through whakapapa links for instance
- Māori knowledge – capturing indigenous knowledge on issues while respecting the intellectual ownership of that knowledge
- The place and status of Māori people, language and culture in society and the world – reflecting the principles of the Te Tiriti o Waitangi in a genuine and authentic way.

As per the Review ToR, a Board Oversight Committee (sub-group of the Board) and an External Advisory Group (EAG) were set up to oversee the review process and provide advice and guidance to the Francis Health review team. The EAG was chaired by HQSC board member, Professor Peter Crampton and was comprised of members with expertise in:

- Undertaking mortality review
- Māori development and Te Tiriti
- Public Health and Academia
- Health and social sectors
- Consumer and lived-experience representatives.

The membership of the EAG included (in alphabetical order):

– Dr Nick Baker	– Dr Peter Jansen
– Professor Jo Baxter	– Professor Alan Merry
– Dr Fiona Cram	– Dr Nina Scott
– Professor Peter Crampton (Chair)	– Mr John Tait
– Dr Felicity Dumble	– Muriel Tunoho
– Denis Grennell	– Professor Denise Wilson
– Dr Aumea Herman	– Professor Alistair Woodward.

The approach to the review process was iterative and collaborative. The review team engaged with HQSC sponsors, the MRCs, EAG and key stakeholders in an ongoing way throughout to ensure that both the review process and the development of the blueprint for the future state were consultative and to gain feedback and insight into the developing models.

The engagement timeline including key phases is shown in Figure 1 and described below.

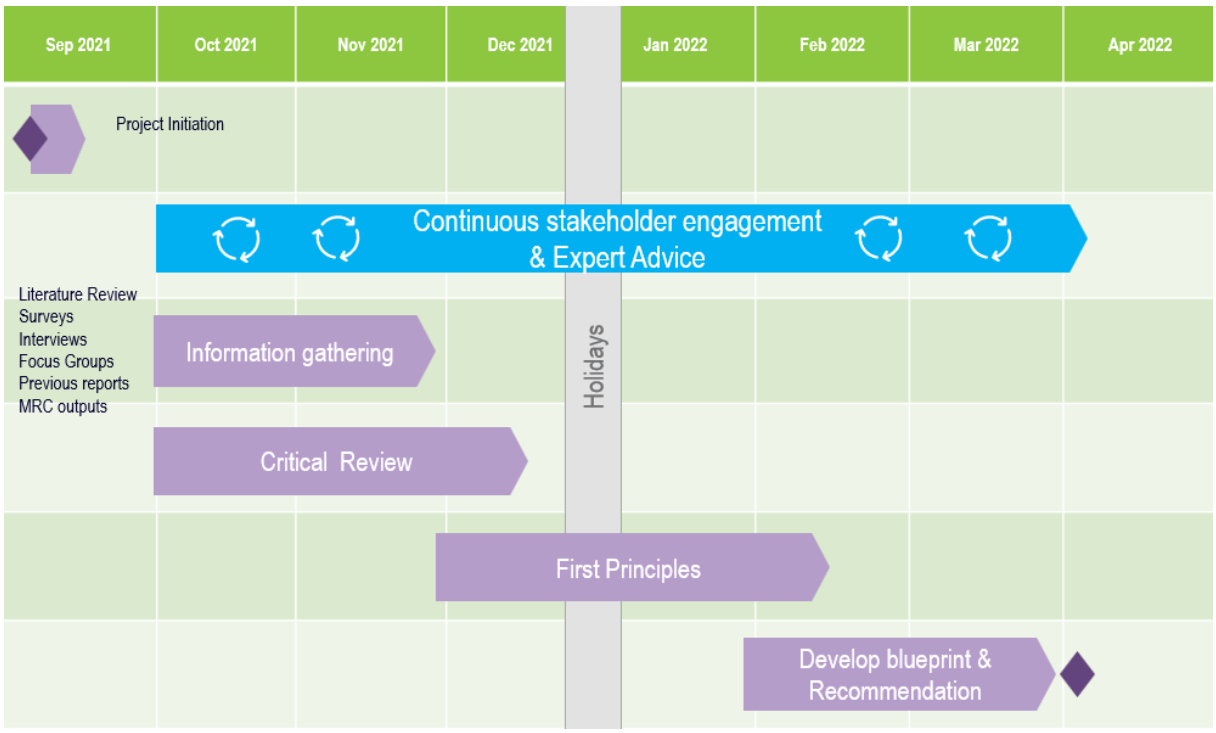


Figure 1: Review Timeline

The Francis Health review team followed the values below during the course of the review:

- Listening and learning from past experience
- Extending beyond the health system
- Upholding rights and valuing voices
- Safe and mana enhancing
- Mahi kotahi
- Compassion and empathy.

6.1 Information gathering

As part of the information gathering phase an in-depth understanding of the landscape of mortality reviews was gained through:

- A literature review of current international and best practice
- Extensive engagement with stakeholder groups familiar with the NMRF
- A stocktake of previous reviews and summary recommendations
- A review of the MRCs ToR and outputs.

The literature review builds on the findings of the previous literature review undertaken in 2012. The review utilised the databases of the University of Auckland library and google scholar to access a variety of health, social and Indigenous Studies research. In addition, the review utilised grey literature from government agencies and professional bodies from Australia, Canada, the United Kingdom (UK) and the United States of America (USA). Literature was also provided by the HQSC secretariat. The scope of the literature review included:

- International models and best practice of mortality reviews
- Indigenous models of mortality reviews and data sovereignty
- Effectiveness of (recommendations from) mortality review findings to achieve tangible system wide changes.

The literature review focussed on recent developments in mortality surveillance and review as well as practices relating to Indigenous populations. The full report of the Literature Review can be found in Appendix B.

Engagement with stakeholders was conducted in tandem with the literature review. The engagement was initially to gather information on the current state, and later to validate and provide feedback as recommendations were developed. A combination of surveys, one-to-one interviews and focus groups were utilised. Open questions were posed to probe the participants on the current functions and processes, strengths and challenges, and opportunities to be considered for any future state. During the course of the review:

- 51 organisations were involved
- 52 interviews and focus groups were conducted
- 11 surveys were returned.

A detailed overview of engagements can be found in Appendix C.

6.2 Critical Review & First Principles

The knowledge, expertise and views on strengths, challenges and opportunities obtained from the engagements were plentiful and provided critical content and context to support the identification of key themes and issues to be considered as part of the review process.

The Critical Review Framework (Figure 2) was used as a diagnostic to assess the current NMRF with specific consideration of Te Tiriti compliance, data sovereignty and legislation. The critical review informed the development of the First Principles and the key recommendations for the proposed future state.

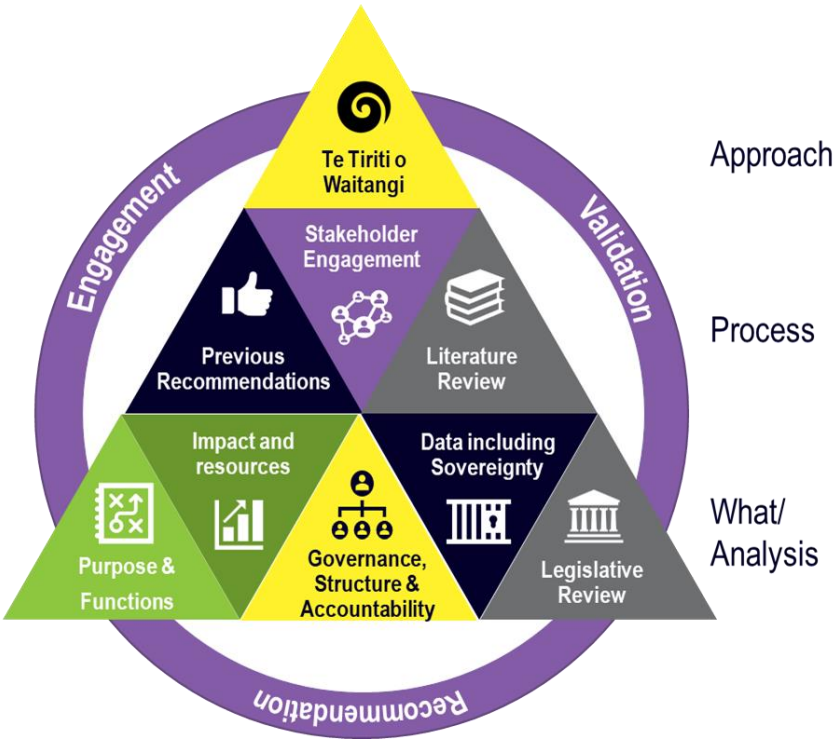


Figure 2: The Critical Review Framework

6.3 Te Tiriti o Waitangi – application in the National Mortality Review Function

A key objective of this review is to identify and assess the NMRF's current ability to effectively implement and uphold Te Tiriti within the design, delivery, and outputs of the national mortality review function.

In the process of this review, a number of frameworks relating to the articulation and implementation of Te Tiriti in an organisational context were considered. All of which provided similar but slightly different perspectives on Te Tiriti compliance within the NMRF in its current state. These frameworks included: He Piringa Waiora, Critical Tiriti Analysis, Ministry of Health's Te Tiriti o Waitangi Hauora Framework, the Waitangi Tribunal report 2019 registered Wai 2575, the NMRF's Te Pou Rubric and Guidelines and the HQSC's Tauākī Korongā - Statement of Intent 2.

For the final report, the review team elected to utilise the Ministry of Health's Te Tiriti o Waitangi Hauora Framework and Tauākī Korongā. These offered a perspective grounded in health, incorporating the wider health sector and an HQSC perspective, providing congruence with the broader sector and internally for HQSC.

The Ministry of Health's Te Tiriti o Waitangi Framework articulates effective implementation of Te Tiriti in terms of mana:

- Mana whakahaere: Effective and appropriate stewardship or kaitiakitanga over the health and disability system. This goes beyond the management of assets or resources.
- Mana Motuhake: Enabling the right for Māori to be Māori (Māori self-determination); to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices including tikanga Māori.
- Mana tangata: Achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.

- Mana Māori: Enabling Ritenga Māori (Māori customary rituals) which are framed by Te Ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy and customary practices) and encapsulated within mātauranga Māori (Māori knowledge).

The second point of reference, the HQSC Tauākī Korongā – Statement of Intent 2 identifies how Te Tiriti underpins the work of HQSC. Similar to the previous framework it is based on the three Te Triti o Waitangi articles, and Ritenga Māori. The four domains of this framework are;

- Kāwanatanga – partnership and shared decision making

  Informed and shaped equally by tangata whenua and tangata Te Tiriti worldviews and perspectives

- Tino rangatiratanga – recognising Māori authority

  Recognising the importance of tangata whenua authority and autonomy. Supporting tangata whenua-led processes, actions and decision-making, through shared power and resources

- Ōritetanga – equity

  Undertaking specific actions to ensure equitable outcomes for tangata whenua and recognising that these actions can also support equitable outcomes for other groups

- Wairuatanga – upholding values, belief systems and worldviews

  Prioritising tangata whenua worldviews, values, and belief systems.

The above points have been used as a framework for reviewing the information gathered as part of the current state assessment of the NMRF and a guide for developing an improved future state prioritising the improvement of Māori health outcomes. (Note: this is different to what is described in the critical review)

6.4 Development of the blueprint and recommendations

The findings and information gathered from the previous steps were translated into a blueprint for a potential future configuration of NMRF. The blueprint and its underpinning concepts were presented to key stakeholders in validation sessions. The feedback and responses influenced the iterative design and recommendations.

A summary of the key findings (which are reported more fully in the Current State Critical Review) and an initial blueprint were presented to the Board in February 2022.

It is important to note that there is no perfect approach to the structure and design of mortality review and stakeholders, helpfully, held diverse and at times strong opinions on key aspects of a future model. While the review team aimed to incorporate stakeholder feedback within the design, it is important to acknowledge that certain aspects of the blueprint will resonate differently amongst the diverse group of stakeholders.

A high-level implementation approach has been provided in the final report to provide a pathway for how the changes can be employed to meet the future aspirations.

7 Key findings

The findings of the review are summarised in this chapter under the following topics:

- Role and scope
- Value and impact
- Equitable outcomes and Te Tiriti
- Structure, processes and resourcing
- Governance, roles and responsibilities
- Data and data sovereignty
- Interagency collaboration and accountability
- Legislation

The detailed catalogue of the findings of the information gathering phase is contained in the Current State Critical Review is included as Appendix A.

7.1 Role and scope

The NMRF's primary purpose is to identify and reduce preventable mortality through the collection, analysis and review of mortality data to develop and disseminate recommendations that will contribute to systematic change. There is a strong and broad endorsement of the vital importance and value of the mortality review function.

Māori experience significantly higher rates of mortality. As tangata whenua, the rights of Māori are guaranteed under Te Tiriti and it is therefore incumbent that the NMRF processes, structures and priorities are resourced to eliminate these inequities.

The NMRF currently does not have an overarching mortality review process rather it is made up of five MRCs which work discretely to review specific classes of death. Whilst supporting the creation of a wealth of knowledge, expertise and insight in these specific areas, this approach prevents any flexibility to investigate other causes of mortality or address new and emerging priorities.

The MRC's have evolved over time, each have their own terms of reference and have developed distinct systems for data collection and review to meet the particular needs and priorities of the MRC. This has led to unnecessary complexity, duplication of effort and a lack of co-ordination of approaches to mortality reviews, creating significant overhead.

It is well established in both the literature and the Aotearoa New Zealand experience those social determinants are the key drivers of preventable mortality. A health lens, while essential is not adequate to fully understand and effectively address preventable mortality. Broader, multisector involvement is essential to achieve traction, particularly in some of the more entrenched issues. It has been noted that the significance and value of cross sector collaboration will only increase as the health system reforms come into effect. Importantly, acknowledging the impact of social determinants on preventable mortality does not absolve the health system of its responsibility to improve performance and reduce its contribution to preventable mortality, nor does it negate its responsibility to be a lead collaborator with other agencies to address preventable mortality.

The literature reviewed found consistent messages attesting to the value obtained from mortality reviews. However, although partially successful on a local level, the translation of mortality review recommendations into tangible system wide changes, remains a challenge. Countries examined as part of the literature review, for the most part, lacked any national entity responsible for mortality reviews and

like Aotearoa New Zealand struggled with effective interagency influence and accountability.

The strong links between preventable mortality and the broader often social drivers of morbidity can make it challenging to view and treat the two separately. This is particularly true when considered in Aotearoa New Zealand where the effects of colonisation continue to impact health outcomes and wellbeing for Māori. This review recognises that the two are linked but that broad responsibility for considering morbidity under the NMRF (as indicated in the current legislation in relation to MRCs) is neither appropriate nor practical.

Stakeholders identified that morbidity was considered in the course of mortality reviews. The retention of reference to morbidity in the legislation would substantially increase the scope of the NMRF and be very difficult to undertake within the existing structure and scale of the programme.

7.2 Value and impact

Aotearoa New Zealand's mortality review programme is recognised internationally as being at the forefront of approaches to mortality review at a national level and for its output of literature and reports[4]. The effort and dedication of members who have contributed their energy to establish and progress the work of the current MRCs has created a legacy that will continue to contribute to whānau and communities across Aotearoa New Zealand for years to come.

A consistent theme through the engagement process was admiration for the dedication and depth of expertise of committee members and their contribution to the reviews. The calibre of input was evident in both the reviews themselves and in the quality of the reports produced. Examples provided of (cross sector) success include:

- Improved road safety and reduction in driveway death following the release of a report of the CYMRC examining deaths from low-speed runovers and ways of preventing them
- The CYMRC reviewing preventable death from drowning in home pools resulting in legislation requiring fencing of domestic pools
- A revision of criminal law intended to proactively manage risk in family violence was informed by the insights of the FVDRC generated through review of evidence relating to strangulation
- The decision of the government to mandate the fortification of folic acid in non-organic wheat flour used for bread-making, influenced by the work from PMMRC.

The mortality data collected and held over many years is an essential part of the NMRF infrastructure. The data is highly valued and should be regarded as a taonga for future generations; it has created a foundation and will continue to provide important insight to understand preventable mortality.

The quality of data was observed as being a key component of driving change both at a local and a population level. The evidence and recommendations generated by the MRCs were reported by external agencies as supporting their case for change.

The literature review conducted as part of the information gathering phase identified Aotearoa New Zealand as being a leader on approaches to mortality review for indigenous populations. Authors noted the high-quality output of literature, and the improvement in indigenous data sovereignty practice.

[4] Coleman, C., Elias, B., Lee, V., Smylie, J., Waldon, J., Hodge, F., & Ring, I. (2016). International Group for Indigenous Health Measurement: Recommendations for best practice for estimation of Indigenous mortality. *Statistical Journal of the IAOS*, *32*, 1-10. https://doi.org/10.3233/SJI-161023

7.3 Equitable outcomes and Te Tiriti

Stakeholder feedback identified key elements of strength but also some gaps in how the NMRF is delivering for Māori. The review found that more needs to be done by the HQSC, the NMRF, and the wider system to achieve a Te Tiriti compliant function. When evaluated against the reference points outlined in section 6, the findings are described below under the following categories: Strengths, Māori leadership - Tino Rangatiratanga, Equitable Outcomes, Partnership, Engaging with Māori and Mana Māori.

Strengths

The current NMRF has a number of elements that support a commitment towards achieving health equity for Māori.

Firstly, the depth and breadth of knowledge and experience the Māori committee members bring to the review function. Many of the Māori committee members have many years of experience serving on committees and in the activity of undertaking mortality reviews. Equally, many of the members have professional backgrounds either as academics, practitioners of Māori health and Māori health development; often all of these. Not only is this level of experience hard to come by, but it is also critical in ensuring the review and recommendations made by the committees are focussed on improvements in outcomes for Māori.

Ngā Pou Arawhenua is the Māori caucus of the MRCs, all Māori committee members are invited to be members of Ngā Pou Arawhenua whose role is to provide advice to the committees. Another area of strength of the current programme has been the development of Te Pou rubric and guidelines:

'The Te Pou rubric provides the committees with a tool to assist with the interpretation, and reporting of, Māori mortality. The tool enables Ngā Pou Arawhenua to provide committees with support and consistent feedback, and to strengthen a Māori perspective in mortality review committee reports.'

Tools that translate Te Ao Māori understandings into meaningful activity within health-related services are scarce. Te Pou rubric and the associated practice expectations if utilised can support the NMRF to embed culturally appropriate responses in mortality reviews, reports, and recommendations to influence better outcomes for Māori.

Māori leadership - Tino Rangatiratanga

Māori leadership is the expression of self-determination for Māori. Within the current mortality review function, there are five committees with a total of thirty members (not including the working group members) as of 31 May 2021. Of those, there were nine Māori committee members, which equates to 30 percent Māori representation. Proportionately, therefore, from a membership perspective the current structure does not promote Māori leadership and mana motuhake. However, of the five committees, there were two that had only one Māori committee member. Of the remaining three, the FVDRC is the only MRC which has been able to build a critical mass of Māori expertise.

Throughout engagements, some stakeholders described feeling isolated and reported difficulty in promoting Te Ao Māori perspectives on mortality. The absence of a collegial understanding of cultural perspectives among colleagues was a key challenge.

Part of the purpose in the commissioning of this review for the HQSC was to signal a clear mandate for change with a vision for 'a quality, Te Tiriti based, mortality review system to last a generation.' The HQSC has in recent years also committed significant resource and effort into upholding its responsibilities as a Crown agency through the development of culturally appropriate processes to give effect to the principles of Te Tiriti and to produce outputs that are meaningful for Māori.

Within the NMRF there is no clear evidence of systemic (function wide) adoption of a strategy outlining the way forward towards Te Tiriti compliance. The structural separation and, at times, isolated way in which both the activity of the MRCs and key functions are carried out impedes a joined-up approach to embedding Te Tiriti principles and having a unified or coordinated focus on Māori health equity.

At present there is variability in the range of capability and expertise when it comes to cultural intelligence and knowledge of Te Ao Māori across the membership of the MRCs and the wider function. What this means is that the burden of responsibility for upholding this work falls on the shoulders of the few. Ongoing cultural capability training for employees would assist the implementation and sustainability of the HQSC/MNRF's existing processes and frameworks across the function and its outputs.

Equitable outcomes

Despite the good work of the NMRF and the recommendations of the MRCs, preventable death continues to remain significantly higher for Māori when compared with non-Māori. The gap between Māori and non-Māori life expectancy at birth was 7.5 years for males and 7.3 years for females in 2017–2019[5]. Health inequities for Māori persist and our health and the social systems more broadly continue to fail to deliver for Māori. "The slow progress towards eliminating the inequities in outcomes between Māori and non-Māori [6] tells us that what we have been doing to address health inequities is not working and that a change of approach is required. Two key questions were identified in the course of this review that need to be addressed:

1. What is the key strategy and accompanying priorities that will support the NMRF to focus on Māori health equity?
2. What is the pathway from review and recommendations, to impact a reduction of preventable mortality among Māori?

Partnership

The Te Tiriti principle of partnership requires the Crown and Māori to work in partnership on the governance, design, delivery, and monitoring of health and disability services. In terms of the HQSC governance there a number of leverage points that provide opportunities to support Māori leadership. There are currently three Māori board members including the Chair. These board members are supported by Te Rōpū Māori, a Māori advisory group that also supports the Chief Executive. Te Rōpū is comprised of six Māori health sector experts, recognised for their skills and knowledge. The Chair of Ngā Pou Arawhenua is also a member of Te Rōpū.

It is unclear how much influence these Māori governors and advisors have over the operations and activity of the NMRF. As previously stated, the MRCs operate largely at arm's length from the HQSC.

Engaging with Māori

There are challenges for the NMRF in relation to engaging with Māori communities regarding the findings and efforts to improve Māori health equity and reduce mortality. Currently, there are no established pathways to disseminate data and information to Māori communities, including hapū and iwi. There are concerns and a range of views about the appropriateness of engaging whānau or communities with information that is produced by the NMRF. Concerns relate to privacy implications,

[5] Stats NZ National and subnational period life tables: 2017–2019

[6] Hobbs M., Ahuriri-Driscoll A., Marek L., Campbell M., Tomintz M., Kingham S. (2019) Reducing health inequity for Māori people in New Zealand, The Lancet, 394 (10209) , pp. 1613-1614.

prohibitive legislation, issues around data sovereignty and sensitivity to grieving whānau. As the health reforms aim to bring Māori communities closer to health services design and delivery, this provides an opportunity to build stronger channels of engagement to share information and build relationships that foster improved communication and partnership.

Mana Māori

There has been investment by the NMRF in supporting the integration of mātauranga Māori and Te Ao Māori in how it approaches mortality review, including the development of the Te Pou rubric and guidelines. However, implementation of the rubric is not complete and requires prioritisation and appropriate resourcing to ensure its use becomes embedded within the NMRF operating model and all MRC processes. Work has also been undertaken to begin to apply Māori data sovereignty principles to the PMMRC data flow, with the intention that this becomes integrated across the MRCs.

The Maōri committee members play a key role in ensuring the NMRF is supported by the principles of Te Tiriti, including mana motuhake. These positions are difficult to uphold, and it is vital that Māori members are well supported to ensure they can continue to bring the critical lens and expertise the NMRF requires. However, this should not be their responsibility alone. All HQSC and NMRF staff and committee members should be responsible for upholding the principles of Te Tiriti. Māori committee members need to be supported by aligned policies, processes, and methods; as well as having colleagues who are committed to reflecting, learning and improving.

Overall, the review highlights a prevailing tension between the methods of the NMRF, inherently a western medical model and Te Ao Māori perspectives of wellbeing. However, as there is a desire to develop a NMRF that is more responsive to Māori, it is imperative to find effective ways to privilege the voices of Māori staff within the NMRF and tools used to apply that perspective.

7.4 Structure, processes and resourcing

A commitment to true partnership with Māori creates an imperative to examine whether the current structure best reflects the revised and emerging approach to tackling significant health inequities that persist in Aotearoa New Zealand. In addition, there is the need to consider how to best position the MRCs and their outputs to leverage for impact across the soon to be reformed health sector as well as across government and other relevant agencies.

The five MRCs are independent advisors to the Commission, the terms of reference enable MRCs to obtain information and undertake independent analysis, based on strategies and methodologies it designs, to inform and assist the Commission to reduce morbidity and mortality. On an individual basis it makes sense that each committee has therefore developed its own process specific to its area of focus. However, this has created inefficiencies and a lack of cohesion across the NMRF caused by siloed methodologies, scopes of practice and outputs, duplication and lack of shared infrastructure and information.

Feedback from engagement showed that committees were generally unaware of the processes and methods of each other. This internalised, siloed focus and disconnect extends to the relationships between the local and national functions. This was generally accepted to be a consequence of how the structure and processes of the MRCs had evolved over time and not a conscious practice of exclusion.

Each MRC is supported by the secretariat function, with dedicated specialist expertise, provided by the HQSC. Common capabilities and capacities are not shared across the scopes of mortality review. As well as preventing sharing of intelligence and insights this further contributes to the resource burden of the current structure.

Within the local review structure there is considerable value in the collaboration between the local

committee and local cross sector agencies (e.g. local CYMRC and regional FVDRC groups). The activity of the local committees is recognised as being well-networked into local agencies and impactful in terms of achieving change.

It was widely agreed that a lack of alignment, consistency and coordination exists between the national and local review functions as well as between local groups (specific to the local CYMRC groups).

In terms of process, there was an absence of any coherent, systemic approach to setting and aligning priorities across the scopes of the MRCs. Similarly with regard to the development, testing and assessment for impact of recommendations. This is not insignificant as the recommendations are essentially the vector for change of the NMRF and without robust and established tracking and evaluation the true success and value of the work remains unknown.

In terms of methodologies and approach to review, there was strong agreement around the value of being able to take an in-depth (life course) approach, as undertaken by the FVDRC. Feedback reflected a resounding desire to retain the ability to work in this way as it yields rich insights and improvement opportunities. For the most part the committees worked separately, on the rare occasion collaboration took place on specific reviews (looking at the same 'death') the learnings were seen as being productive and worthwhile.

Relationships with key stakeholders from across sectors exist within the Secretariat, particularly specialists, but are not set up to support co-ordinated systemic engagement. In addition to key government agencies, this includes pathways for Iwi partners and community groups to provide input into setting priorities, and for the review and agreeing of recommendations. The inequitable distribution of resources across the MRCs highlighted in the earlier 2012 review continues today. There is a need to fairly and adequately fund both the resource intensive processes required of mortality reviews and also to enable the development and aspirations of the NMRF articulated by the HQSC to be achieved.

The structure of the NMRF, and available resource capacity, were found to limit the ability of the secretariat to formalise and further build and develop strategic relationships across the health and social sector. These relationships with both individuals and agencies are critical to support system and service level change. It should be noted that this needs to include appropriate resourcing and clear pathways to engage with Iwi partners and the community to provide meaningful input into strategic and decision-making activity (setting priorities, reviewing and agreeing on the recommendations) of the function.

Well networked, developed and adequately resourced stakeholder relationships are essential to support and inform the overarching work of the NMRF (in contrast to siloed relationships dependent on scope of mortality) particularly as the health system undergoes transition and moves towards increased community-based commissioning and care.

Resourcing for the overall function has recently been reduced in line with budget constraints. The reduction of the size of the Secretariat that occurred as a result of a consultation and subsequent change process during the 2020/21 created additional pressure on an already overloaded and under resourced secretariat function which has been evident across the MRCs.

An additional point to note is that SuMRC has a ring-fenced annual budget provided by the Ministry of Health which is different from the way in which the four other MRCs are funded. Neither the duration nor level of this funding is guaranteed.

7.5 Governance, roles and responsibilities

Operational and governance links between the NMRF and HQSC are structured in a way that does not serve either party well. The complexity and duplication within the current structure allows for ambiguity around key areas of responsibility and accountability, undermining governance and, overall

effectiveness of the NMRF on reducing preventative deaths. Issues relating to structure, roles and governance compound capacity and resourcing issues particularly for the Secretariat, which has a flow on effect for the entire review function. Each MRC (and Ngā Pou Arawhenua and PMMRC working groups) requires a high level of support, coordination and oversight from the Secretariat which has been described as the engine room keeping the function going.

Due to there being no overarching national programme for mortality review, any alignment and coordination across or between the individual committees are lacking in relation to the overall strategic direction and operational activity of the NMRF. Collaboration across review functions is therefore difficult to instigate, and opportunities to capitalise on synergies and achieve impact across MRCs are diminished.

To effectively influence change across multiple agencies, the NMRF needs to be seen as credible by both agencies and the public. As a crown agency, HQSC has minimal independence from the Minister of Health, and therefore may not be seen as being able to provide an independent critique of system performance. Without this independence, there is a risk to the influence and leverage of the NMRF in achieving change across agencies in addressing the key drivers of preventable mortality.

7.6 Data and data sovereignty

Access to and proper management of good quality data is a key component of a NMRF. The data collection and management processes of each MRC are separate, with variations in approaches and methodologies. Data sharing between MRCs is limited, resulting in duplication of processes and effort as well as missed opportunities for collaboration from which shared learning and insights may be derived. In addition, data sharing between MRCs requires a formal data request which creates a further barrier and delays.

The New Zealand Mortality Review Data Group (NZMRDG) hold a significant amount of institutional knowledge around MRCs and host the largest and most mature data set utilised by the HQSC. Over time NZMRDG have directed the management and use of MRC data and analytical resource, toward a predominantly academic and research audience. The mortality data collection and research produced by NZMRDG is highly regarded internationally. It is important that this be retained but not at the expense of providing a high-quality, agile service to HQSC that helps to more directly achieve their goals.

Stakeholders frequently spoke of problems that arise due to an enforced segregation of data. Their feedback highlighted the limitations in data sharing between the MRCs, and the resultant friction this has created in the relationship with NZMRDG. Across all MRCs there are found to be core common drivers of preventable mortality, therefore there would be considerable benefit in looking at the data as a whole, allowing a systems perspective on the opportunities to reduce mortality.

The configuration of the MRCs, variation between data infrastructures used, and the range of stakeholders involved creates barriers to complete data access by MRC specialists. Distinct methodologies of the MRCs aside, the differences across their specialist areas also mean they can have different requirements of and approaches to the use of the same datasets.

The MRCs report issues with collecting data. Access is delayed and information is incomplete or insufficient as in the case of Tier 1 data (Demographic data from multiple government departments) which is frequently relied on but does not support the collection of good quality ethnicity data. In practice this means there is currently no or limited access to data on Iwi affiliation, health outcomes, morbidity or social determinants of health. There are no standardised processes to decide which data to collect.

As a direct consequence of concerns raised internally by MRCs and Ngā Pou Arawhenua, there has been valuable work done to improve the NMRF's alignment with the principles of Māori Data

Sovereignty, developed by Te Mana Raraunga.

Te Pou rubric and guidelines are regarded as a valuable tool for checking Māori responsiveness within the work of the NMRF. It does not appear that it is used consistently across the lifecycle of reviews or in MRC reports. Te Pou needs to be part of a stronger governance framework reflective of a stronger commitment to Te Tiriti compliance.

The HQSC contracted a piece of work to apply Māori Data Sovereignty principles to the PMMRC data flow. A draft framework was developed that provides very good guidance on meeting appropriate data governance and sovereignty requirements. The framework remains in draft and significant change in the structure and processes of the NMRF would be required before it could be implemented. Approaches to data management and data sovereignty have advanced considerably since the NZPHD Act was passed, and the NMRF updated through the Amendment Act in 2010. It is important that any modernisation of the legislation contains specific provisions in relation to data sovereignty, noting that such provisions would supplement (and, where necessary override) the controls imposed by the Privacy Act 2020 (including by the Health Information Privacy Code made under that Act).[7]

7.7 Interagency collaboration and accountability

The NMRF sits within the health sector and has traditionally been predominantly focussed on the health sector. This review has identified that a structured intersectoral approach is needed to effectively address the drivers of preventable mortality. Under the current structure, the NMRF has insufficient leverage and authority to drive system and service level change beyond health, where there is significant untapped opportunity for change. Given the NMRF does not have authority to drive system change it must have strong influence to drive change. This is achieved through the quality of the recommendations, the credibility of its membership and the strength of its relationships. Relative to the absence of any real authority to enforce change; advocacy is a critical role of the HQSC.

At present, the NMRF has little ability to compel agencies to provide feedback on the recommendations made or the actions taken as a result. An effective mechanism to follow through on recommendations is an essential element of any improvement framework. The authority to require government agencies to provide information as well as report back on progress made against recommendations made during mortality reviews would strengthen HQSC's reporting powers in relation to mortality review outcomes, as well as clarifying the accountability of other agencies involved.

A further area that highlights the challenges in working with external agencies is the difficulties commonly experienced when requesting access to data. Subject to meeting data sovereignty and whānau/community information interests (which should be an element of the modernisation of the legislation) it is important that the NMRF retains the power to request information required for mortality review.

The literature review found consistent messages about the perceived value of the contribution mortality reviews make to developing recommendations for change. However, the translation of mortality review recommendations into tangible system wide changes, in which relevant agencies are held to account on progress and uptake, remains a challenge. This has also been the case for the NMRF. Whilst it is acknowledged that there is genuine difficulty in capturing the impact of a NMRF (supported by the literature review and the 2013 report), neither the complex nature of the health system nor the challenges in acting on recommendations should be accepted as justification for not being held accountable for delivering a measurable impact. An effective NMRF therefore needs to provide

[7] Privacy Act 2020, section 24(2).

evidence informed insights and identify recommendations for measurable improvement.

The lack of alignment and coordination between the MRCs constitutes a significant barrier to achieving change. Stakeholders reported they felt that the impact and traction of recommendations has lessened over time and that under the current structure there is no framework for accountability or action. An example being low implementation meaning some MRCs made the same recommendation year upon year. In addition to reduced impact, this creates missed opportunities for sharing the expertise and value produced at the local and regional level.

7.8 Legislation

The current state review has assessed the suitability and adequacy of the legislation that sets out the functions and powers of HQSC in relation to the NMRF, which are found in ss.59C to 59E of the NZ PHD Act (as amended by the Amendment Act in 2010).

The current legislation requires HQSC to advise the Minister of Health on any matter related to mortality and enables it to appoint one or more MRCs to advise HQSC on specified classes of mortality. MRCs are required to consider both mortality and morbidity. HQSC is required to report to the Minister on the progress of its MRCs and to complete an annual report. Schedule 5 of the NZPHD act requires provision of information to MRCs and protection of confidentiality of the information (and the Act includes fines for breaches of these requirements).

The following issues have been identified with the current legislation:

- The NZPHD Act lacks a clear overarching statement of the purpose of the NMRF. It is now good legislative practice for legislation to contain purpose sections (a current example being clause 3 of the Pae Ora [Healthy Futures] Bill), which inform the specific functions and powers conferred on a public agency to give effect to that purpose.
- The Act does not sufficiently incentivise a coordinated approach to the implementation of the NMRF. To the contrary, the legislation appears to have resulted in the siloed nature of the MRC operational functions discussed earlier in this report.
- As discussed earlier, the HQSC has minimal independence from the Minister in undertaking the NMRF. This is a significant defect in the current legislation, perhaps arising from a lack of symmetry between HQSC's other responsibilities (which may or may not justify its 'Crown agency' status) and its mortality review functions which inherently need a high level of independence such as that of an "autonomous Crown entity" or specifying that this function is 'statutorily independent'. The reasons why the function needs sufficient independence include enabling HQSC to critique system performance and ensure credible, impactful review and improved outcomes on this critically important, highly sensitive issue.
- The review has noted that the single greatest point of frustration with the current NMRF lies with a perceived lack of action and accountability for following up on and measuring the impact of recommendations made by the committees. The review has also found high levels of agreement around a lack of certainty and assuredness of the 'journey' of recommendations once made by committees. Additionally, the absence of a clear process for managing, tracking and monitoring recommendations, and the resource to undertake this, lends itself to duplication as well as dilution of purpose and effect. These types of problems are widely recognised as matters that can constrain the independence of a public function. An effective mechanism to follow through on recommendations is an essential element of any independence framework, ensuring independence in practice as well as in name. The legislation could usefully be more specific on this, with reference to the NMRF's purpose.

The issues identified above are considered in the development of the legislative recommendations (see section 9.2) and drafting of the future blueprint.

8 First Principles

The first principles were developed iteratively in parallel to the Current State Critical Review, tested with a number of stakeholders and have served as guiding principles for the development of the future state and recommendations. The first principles are:

1. In order to eliminate inequities across mortality, particularly in Māori mortality, a prioritised Te Tiriti compliant approach is required
2. The purpose of this mortality review system is to understand and thereby reduce preventable mortality at a systemic level in Aotearoa New Zealand. This includes the ability to identify and make recommendations relating to causes of preventable mortality and issues of equity as they relate to priority groups
3. Any review of mortality needs to consider that preventable death is broader than the health system and impacted by a range of social drivers
4. The mortality review system needs to take an intentional multi-sector and community approach, with significant Māori influence, to succeed
5. An effective mortality review system requires sufficient independence and influence to critique system performance and ensure credible, impactful review and improved outcomes
6. A national mortality system needs to include broad surveillance and robust prioritisation for best impact
7. A credible range and depth of information, expertise and engagement (incl. lived experience and whānau) at a regional and national level is required to ensure actionable learning and system improvement
8. Data is a cornerstone of the mortality review function. Its application needs to strike a balance between respecting confidentially and access with clear data governance and sovereignty for Māori data
9. The national mortality review system needs to be credible, enduring and flexible to enable it to respond to changing and emerging priorities.

9 Blueprint for a refreshed national mortality review function

As identified earlier in this report, preventable mortality is caused by a range of complex social determinants that government agencies and communities collectively have a role in addressing. In designing a new model (blueprint), it is important to recognise that successful mortality review creates positive change by influencing the system. The NMRF nor the HQSC have the authority to direct the actions of others. Whilst the blueprint proposes structural and legislative changes, its success (influence) will be based on the strengths of the relationships it can foster to create shared understandings of the drivers of mortality and commitment from agencies and communities to implement and collaborate on recommendations that deliver impact.

The blueprint recognises the progress made and builds on the approach established by the current MRC structures in leveraging skills, expertise and understanding from a range of stakeholders across society and recognises their mana. Having subject matter and consumer expertise, members that have strong relationships across government and community agencies, as well as recognised leaders who can 'front' recommendations is fundamental to building the credibility and trust of mortality review and enables greater influence.

While legislative reform is a key aspect of the blueprint, many of the elements of the blueprint could be implemented without having to wait for the NZPHD Act to be amended. A strategy for promoting legislative reform (which, as discussed later, would involve HQSC working with the Minister and Ministry of Health to obtain the necessary policy approvals and legislation priority) should include taking what steps are possible under existing legislative settings but, in turn, highlighting the benefits of a strengthened legislative framework.

The blueprint is a result of an iterative engagement and design process with stakeholders and experts across the health and disability sector, consumers, and wider government entities. It builds on the achievements of the existing national mortality review programme and addresses the issues identified by the review findings. Fundamental to the blueprint is the intention to embed a Te Tiriti compliant approach where the elimination of preventable mortality for Māori. It has been developed to support a NMRF to last a generation and should be considered as a starting point for the HQSC alongside the first principles as it implements the final recommendations.

This section provides a brief outline of the blueprint, detail on how the blueprint is envisioned to operate, and a summary of the difference between the existing programme and the blueprint NMRF.

9.1 Overview and components

This section outlines the proposed structure and roles for the future state blueprint. An important aspect of the blueprint is that the HQSC will be accountable for the NMRF. It will be important that a future model does not have the ambiguity that has existed between the HQSC and the existing MRCs regarding roles and responsibilities.

The HQSC will be responsible for mortality review which will be delivered through an internal NMRF business unit. The NMRF business unit is depicted in the organisation chart (Figure 3) alongside the existing HQSC business units.

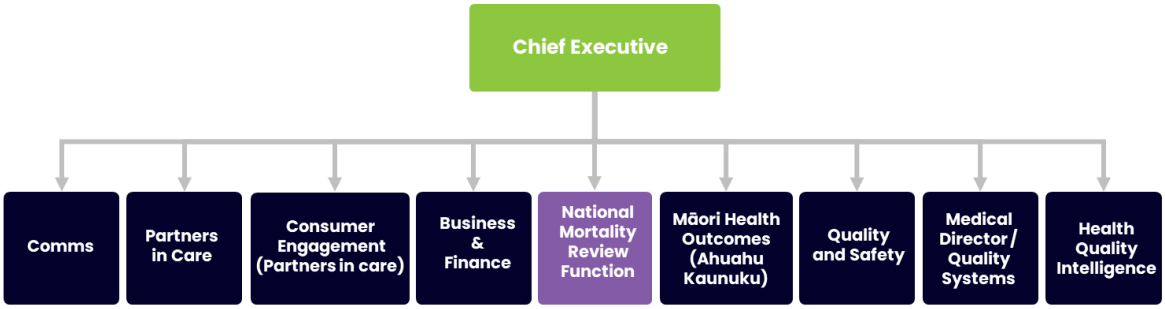


Figure 3: NMRF within HQSC organisational chart

To deliver on these responsibilities of the NMRF, it will be compromised of:

- A National Mortality Advisory Group (NMAG) – providing independent expert advice and input (required under proposed legislative change),
- Subject matter and representative experts (SMRE) and Consumers contributing to subject matter areas and working groups, and
- Suitably skilled, trained and experienced staff with the capability to guide mortality review and support the functions of the NMAG and SMRE.

Figure 4 provides a pictorial schema of these components as the future blueprint in context of key stakeholders and functions.

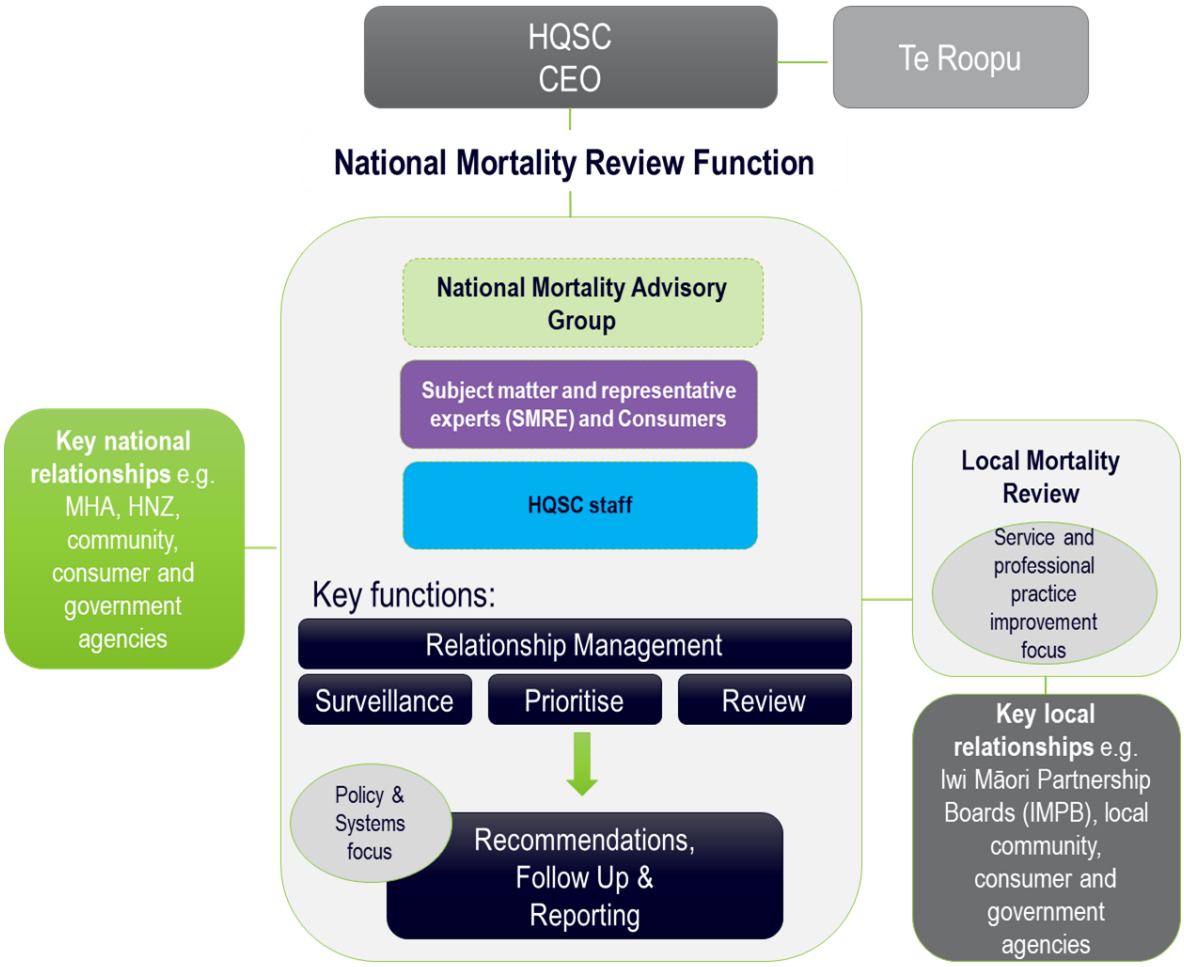


Figure 4: Schema of the future NMRF

National Mortality Review Function (HQSC Business Unit)

The internal business unit is operationally responsible for the delivery of the NMRF within the HQSC. It will:

- Ensure a Te Tiriti compliant approach is embedded within all aspects of mortality review and that all members have access to develop their skills and understanding
- Undertake surveillance and analysis of mortality data and information
- Prioritise preventable mortality areas of highest need, potential impact, and strategic importance
- Conducting in-depth review of prioritised topics
- Disseminate recommendations that positively impact the drivers of preventable mortality
- Monitor uptake and progress on recommendations including annual reporting
- Collaborate and proactively manage stakeholder relationships with key organisations, communities, consumers, and subject matter experts
- Manage the storage, analysis, and access to data required to undertake mortality reviews
- Build national and local capability to undertake mortality review.

To carry out and deliver the functions outlined above as part of the blueprint, the business unit should include the right mix of skill and capability across the team with key areas being analysis, data management, epidemiology, policy, cultural expertise, writers, stakeholder management, evaluation, engagement and communications support.

The exact composition and resourcing will need to be determined as part of the transition process, in consultation with current staff and stakeholders.

National Mortality Advisory Group (NMAG)

The HQSC will establish a NMAG and report to the Minister of Health on the advice provided by the NMAG and the actions taken by HQSC to act on this advice. The NMAG will provide strategic and independent advice to the HQSC on all matters related to preventable mortality – particularly on eliminating inequities for Māori. The advice of the NMAG will provide guidance on Te Titiri compliance, strengthening cross sector collaboration, and ensuring mortality reviews and resources are prioritised according to need, potential impact or strategic importance.

The membership of the NMAG will include a Māori Chair and a minimum of 60 percent Māori membership. In addition to strong Māori membership and influence, the NMAG will be comprised of subject matter experts and members representing cross sector agencies, consumers, whanau and the community.

To ensure the interest of consumers are reflected in line with the Code of Consumer Participation being developed by the HQSC, as proposed in the Pae Ora (Healthy Futures) Bill, it is suggested the NMAG will have two consumers (Māori and non-Māori) as members.

The NMAG will be responsible for supporting the HQSC:

- On strategic oversight of the mortality review function
- To ensure Te Tiriti compliance across all aspects of mortality review
- To coordinate advice on priority areas for potential in-depth reviews, analysis or surveillance.
- On data governance including Māori data governance

- To identify any additional expertise required for mortality review working groups
- To ensure recommendations made by the NMRF are clear, coordinated and impactful
- To engage and manage key sector relationships and interagency collaboration.

Subject matter and representative experts (SMRE) and Consumers

In the context of the NMRF, SMREs are subject matter experts in the broadest sense and include representation of consumer, whānau, lived experience from a range perspectives, disability and minority groups. This area of expertise can refer to subject matter expertise, knowledge of Te Ao Māori, specific clinical or academic expertise and expertise from other social sectors (e.g., education, justice).

HQSC Staff

The NMRF staff are employed by the HQSC as 'the engine room' of the NMRF. Under the proposed future blueprint and recommendations contained in this report the role of the current secretariat will change significantly.

In the future state, the NMRF staff will have an increased role, providing consistent and integrated support for the NMAG, including all of the review groups and individual SMREs. The NMRF staff will have additional responsibility for data management and surveillance functions, which it is recommended to be centralised within HQSC. Noting that both the transition and the future state will need to be scoped, planned and implemented according to the outcomes of any resulting change processes. Additional resourcing to support the establishment of the future state may be required.

As a government agency, the HQSC and therefore the NMRF have a responsibility to ensure mortality reviews deliver for Māori. This aspect is discussed more fully in Section 6. As part of achieving Tet Tiriti compliance, it will be important to make Te Tiriti everyone's business and increase capability and capacity through ongoing cultural capability training and awareness.

Increasing Māori membership is discussed elsewhere in this report Section 9.3). Succession planning and leadership development for Māori staff should also be considered as part of the broader organisational training and development programme.

The NMRF staff are responsible for the delivery, coordination and integration of the following key activities:

- Planning (surveillance and analysis, prioritising)
- Implementation (in-depth reviews, developing and dissemination of recommendations)
- Evaluation (tracking, monitoring and reporting on recommendations).

These are further described in section 9.4, the operating model.

Local mortality review function

The local review function is seen as being highly valued within the future state, with its success being paramount to the overall effectiveness and impact of the national function. There is significant benefit in the contribution made at a local level by dedicated members who have close links with the community. Local mortality reviews promote local service improvement and inform professional practice.

Specific areas where the contribution of the local functions add value and should be retained and strengthened include:

- Death notification and high-quality data collection

- Maintain existing local reviews (CYMRC and PMMRC) and consider additional local reviews (all-mortality) as prioritised nationally
- Strong local engagement across disciplines and sector, including Iwi Māori Partnership Boards (IMPB)
- Reciprocity in sharing of data, learnings, trends and recommendations
- The local function needs to be appropriately recognised in the legislation and resourced – for example, the allocation of funding for local coordinators
- NMRF staff to engage closely with the local mortality review groups, building local capability and support the local review function, provide protocols and guidance
- Engage HNZ and the MHA to coordinate and align activities and to further develop the local function and ensure broader local mortality input.

9.2 Proposed legislative changes to support the blueprint

The review has identified that the HQSC is well placed to host and hold the statutory responsibility for the future mortality review. Legislative change is proposed to provide clarity and strengthen the ability of HQSC to deliver on its responsibilities.

The legislative review has been conducted against good legislative practice, drawing on established legislative frameworks (such as the Crown Entities Act) as well as the anticipated health reforms as currently encapsulated in the Pae Ora (Healthy Futures) Bill. The review team does not see any of the suggestions for legislative reform as being out of step with good practice as it has developed since the NZPHD Act was enacted and the NMRF provisions were updated in 2010.

The proposed legislative changes are described below:

1. It is commonly accepted that the purpose of the NMRF is to reduce preventable mortality, and the Act should reflect that. In doing so, it should also delete the current reference to morbidity review to ensure the focus of the function is both clear and manageable.
2. It is important that the establishment of the NMAG be provided for in legislation (rather than established administratively), both to signal Parliament's wish for and to encourage a more coordinated approach, as well as to ensure transparency (Although it would also be possible to establish the Advisory Group under the existing legislation pending any further reform). Updated legislation could also encapsulate the importance of local mortality responsiveness, but again this could be achieved under the current Act pending a legislative reform.
3. The review notes that a change in the status of HQSC from a "Crown agent" to an "autonomous Crown entity" would enhance the level of independence in the mortality review functions. Irrespective of whether HQSC's Crown entity status is changed, however, the legislation can separately specify that the NMRF function is 'statutorily independent', meaning that it must be carried out independently and that it is free from ministerial direction (as is made clear by the Crown Entities Act 2004, sections 10, 113).
4. An effective mechanism to follow through on recommendations is an essential element of any independence framework, ensuring independence in practice as well as in name. While the Public Service Act 2020 and the Crown Entities Act both impose generic duties of collaboration on departments and Crown entities, specific provisions would help to reinforce the application of those duties in relation to the NMRF and give the system much-needed 'teeth'. This should include power for the HQSC to require government agencies to provide information and report

back on recommendations made during mortality reviews and on the impact of the recommendations. This would enable HSQC to then report regularly to the Minister and to Parliament on progress in implementing recommendations, while also clarifying the accountability of the agencies involved.

5. The legislation should expressly enable the provision of independent expert advice to support the mortality review system. Specifying this will give visibility to the need for such advice (and help ensure that the function can be appropriately funded), while also helping maintain public credibility in the quality of critique.

6. Any modernisation of the legislation should also address the question of data management and data sovereignty, as discussed earlier. Retention of a requirement to provide information required for the mortality review and to protect that information is important (subject to addressing data sovereignty and whānau/community information interests).

7. HQSC can expect that the Te Tiriti provision in the Pae Ora (Healthy Futures) Bill will apply to it, as well as other entities in the health system. Clause 6 of the Bill takes the modern approach to legislating Te Tiriti responsibilities, i.e., by listing the specific functions and responsibilities in the Act which "provide for the Crown's intention to give effect to the principles of Te Tiriti". It is important that any modernisation of the NMRF legislation addresses this need by pointing to those provisions which are designed to reflect the Crown's intention specifically in relation to the NMRF. That in turn will help ensure the provisions themselves are fit for purpose and that Te Tiriti is appropriately recognised and embedded in the mortality review system for the future.

In summary, the modernised legislative design for the future state of the NMRF will:

- Provide a clear overarching statement of the purpose and scope of the NMRF
- Provide for the Crown's intention to give effect to the principles of Te Tiriti in relation to the NMRF and specific elements of it (consistent with the drafting approach of clause 6 of the Pae Ora (Healthy Futures) Bill)
- Ensure transparency as well as a coordinated approach to implementation of the recommendations emerging from the work of the NMRF with the establishment of the NMAG
- Increase independence from the Minister/Ministry of Health ensuring that the NMRF functions are classed as "statutorily independent" for the purposes of the Crown Entities Act, thereby allowing the NMRF to independently critique system performance and provide credible, impactful reviews with associated improvement in outcomes in key priority areas without external influence or pressure
- Create an environment where there is the ability to enforce the follow through on recommendations and give the NMRF much needed 'teeth'. Give visibility to the need for and value of independent expert advice on mortality
- Reconcile the outstanding data management and data sovereignty issues which have advanced considerably since the NZPHD Act was passed. Also, to supplement (and, where necessary override) the controls imposed by the Privacy Act 2020 to ensure that both the integrity of the data and cultural safety are upheld.

9.3 Achieving a Te Tiriti compliant approach

The revised structure and changes outlined in the recommendations are intended to equip the NMRF with the means and enhanced capability to contribute towards positive change and equitable outcomes for Māori.

To improve the focus of the NMRF on improving health outcomes for Māori, the review team recommends the following:

1. Establish a NMAG with 60% or more Māori membership. A NMAG of this nature and makeup will be able to,
   - Facilitate Māori influence of the design, delivery and monitoring of the NMRF
   - Provide the necessary leadership and strategic intelligence to prioritise equitable health outcomes for Māori
   - Support the integration and implementation of Te Ao Māori initiatives for the benefit of the NMRF
   - Support the development of Māori capability in mortality review, including Māori subject matter experts
   - Engage with key Māori stakeholders in relation to NMRF
2. Elect a Māori Chair for the NMAG. This will enable Māori leadership of the design, delivery and monitoring of the NMRF, and elevate the voice of Māori
3. Recruit Māori Subject Matter Experts, including mātauranga Māori experts, to be central to all mortality review processes. These Māori subject matter experts will be able to:
   - Provide critical cultural and clinical Māori expertise to reviews, and to inform analysis
   - Support the development of Māori capability in mortality review
   - Contribute to a Māori caucus that provides support to the NMAG and HQSC in terms of mortality review.
4. Adequately prioritise and resource the key Māori health initiatives such as the implementation of the Te Pou rubric and adoption of Māori data sovereignty principles. This would be supported by:
   - Recruiting Māori data sovereignty expertise
   - Ensuring Māori data sovereignty principles are adhered to
   - Supporting the development of Māori capability in mortality review.

In summary, the recommendations above aim to build on the current capability and capacity within the NMRF to drive towards equitable health outcomes for Māori. The recommendations around increased Māori membership as well as leadership roles will support an enhanced commitment to partnership and provide the opportunity for expression of mana Motuhake. The establishment of the NMAG will ensure adequate representation on a core operational and oversight body of the refreshed NMRF.

The desire to have Māori experts, including Māori data sovereignty expertise, needs to be coupled with the actions and measures that will support Māori members to hold those positions, provide critical advice and, most importantly, feel safe.

Te Pou, the Māori responsiveness rubric, provides guidance to the NMRF for interpreting and reporting on matters relating to Māori mortality. The guidance is structured around the four key aspects linked with Māori values: Tika, Manākitanga, Mana, Mahi tahi. The accompanying guidelines articulate what good practice looks like:

- Tika – Getting the story and the interpretation right
- Manākitanga – Being culturally and socially responsible
- Mana - Advancing equity, self-determination, and social justice
- Mahi tahi – Establishing relationships for positive change.

Te Pou rubric and guidelines, developed with the input of Ngā Pou Arawhenua for the HQSC, provide clear guidance on culturally appropriate interpretation and reporting of Māori mortality. The rubric serves as an excellent foundation for Te Tiriti compliance and is another tool to support the work towards quality implementation and sustainability of the values and practices that will contribute towards the equitable health outcomes for Māori.

9.4 The operating model

To help describe how the NMRF will be delivered, a framework of key activities has been created (Figure 5), which shows the key activities, (planning, implementation, and evaluation) of the mortality review cycle, supported by data management and including the input key stakeholders have into the review process.

The newly establish integrated support function will be funded by a singular annual budget allocated to fund the activities of the NMRF to be distributed in accordance with the workplan and priority areas.

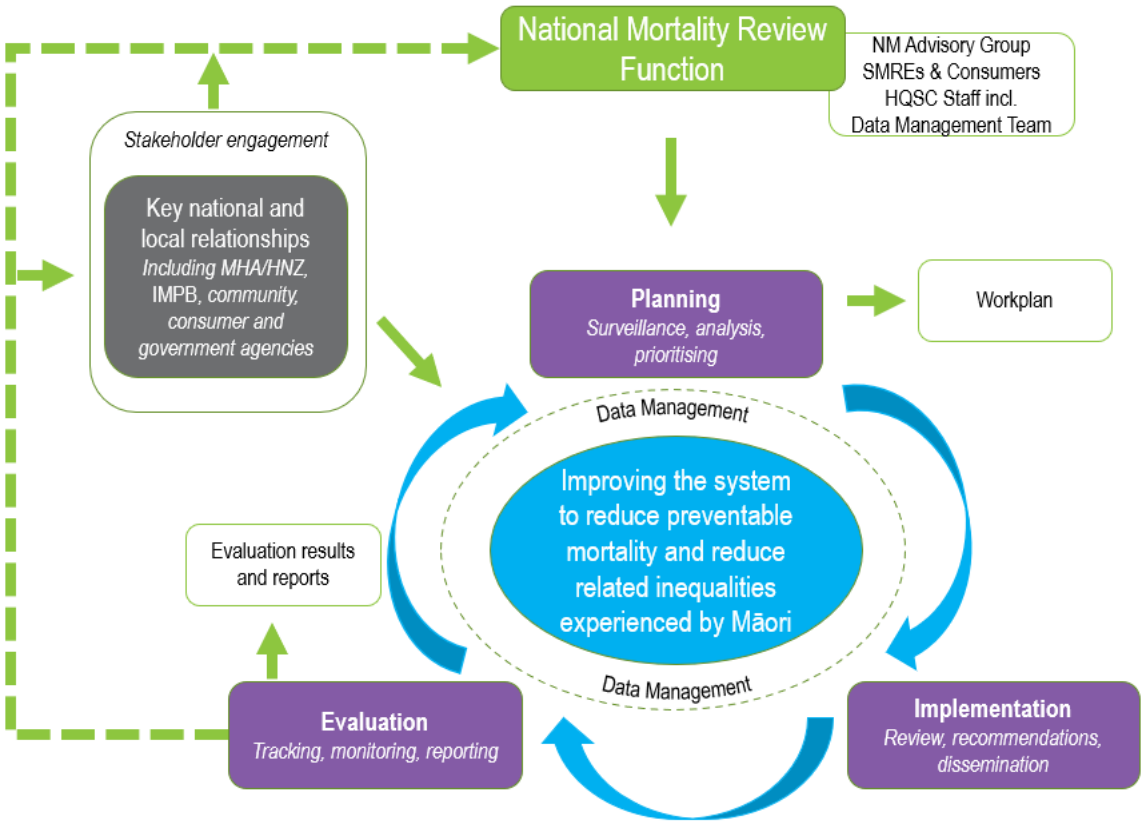


Figure 5: Key activities of the mortality review cycle

Planning: surveillance, analysis and prioritisation

The NMRF will collate and manage data as well as other information relating to preventable mortality. The information gathered will be used to prioritise areas of focus according to need, potential impact or

strategic importance. This differs from the current state where the scope is limited to the specialty areas of the five MRCs. Expanding the scope to consider all preventable mortality will support the NMRF to become more impactful through the ability to respond to changes across sectors as well as to any emerging trends and issues.

It is important to acknowledge that analytical innovations are developing at a rapid pace globally. This presents opportunities for greater insight to inform processes such as mortality review and predictive surveillance. At the same time, public sector policy will need to adapt to ensure that these new capabilities are balanced against key practical and ethical risks such as data sovereignty and privacy implications. This tension between innovation and policy will only increase as the pace of technology advances.

Insights and information on all preventable mortality will feed into each step of the review process and be drawn from a range of sources: engagement with key stakeholders; SMREs; internally from the data analytical team as part of surveillance and scanning; as a result of in-depth reviews or as feedback from ongoing monitoring and tracking of previous NMRF recommendations.

When determining the priorities and the annual workplan of the NMRF, the HQSC will take into account the advice of the NMAG, insights from SMREs and other stakeholders as well as the actions or plans of other relevant organisations. Identification and prioritisation of issues for review is a key activity of the NMRF and integral to the review function. It should be informed by clear and transparent criteria developed as part of the transition process (see section 10.2) and supported by data-driven insights.

In line with Te Tiriti responsibilities, areas contributing to impacting on preventable mortality of Māori will be prioritised and the effect of this on the available capacity of the NMRG will need to be considered and addressed.

Once set it is important that priorities are clearly communicated with stakeholders to ensure strategic alignment and coordination of effort working towards the shared objectives. This is a key aspect of the relationship management function described later. Ongoing review of the priorities and engagement will allow the NMRF to respond in an agile fashion and maximise impact against strategic priorities.

Implementation: review, recommendations and dissemination

HQSC may appoint subject matter and representative experts (SMRE) who can contribute either individually or as part of working groups to conduct analysis and in-depth reviews. Working groups may be longstanding, reviewing a specific mortality area or undertake more discrete, time limited reviews.

The NMRF based on advice from the NMAG will identify the skills and the multi-sectoral composition needed for working groups to undertake the review of the priority mortality areas.

The NMRF will build on the existing capability and systems currently in place within the MRCs to complete the in-depth reviews. The methodology and review model developed and applied by the current FVDRC provides a benchmark for taking a holistic and whole of system approach. This model takes a life course approach and allows an intensive and multi sectoral review which yields insights with broad applicability and relevance.

Before recommendations are finalised the NMRF will engage with the key stakeholders directly impacted by those recommendations for their input and sense checking. Once recommendations have been finalised, they will be made accessible to the key stakeholders in writing along with the expectations of implementation, tracking and reporting.

Evaluation: tracking, monitoring and reporting

To measure improvement in outcomes there is a need for monitoring to track and follow up on recommendations. Establishing a framework for the evaluation and monitoring of recommendations would help provide assurance on the overall quality, consistency and ultimately the effectiveness of recommendations to achieve change. It is intended that the ability of HQSC to require other agencies to report back on progress made against recommendations involving them will be strengthened by the proposed legislative changes outlined in section 9.2 of this report.

Before recommendations are finalised the NMRF will engage with the key stakeholders directly impacted by those recommendations for their input and sense checking. Once recommendations have been finalised, they will be made accessible to the key stakeholders in writing along with the expectations of implementation, tracking and reporting.

HQSC will be required to provide an annual report to the Minister of Health which will detail areas of mortality reviewed over the preceding 12-month period including:

- Information from and analysis of the data collated and managed for the purposes of mortality surveillance, including existing datasets from the current MRCs as well as any other prioritised areas or emerging issues and trends
- Information about the dissemination of findings and recommendations made, and updates on progress made against previous recommendations.

Leveraging the existing quality improvement capability within HQSC, the NMRF is well placed to increase its impact through leading and coordinating improvement initiatives where appropriate (in health) and through the hosting and delivery of a regular (annual) conference. The conference would encompass all preventable mortality and be targeted at those involved in conducting mortality reviews, key stakeholders and those with an interest in the elimination of preventable mortality. It focuses on sharing information about the issues and priorities being addressed, learnings and improvement initiatives of local and national activities.

The NMRF data collection, annual report and shared learnings will continue to fulfil a responsibility internationally and contribute to well informed benchmarking

Stakeholder engagement

The future blueprint recognises the importance of external, cross sector engagement and input into the NMRF to discern and address the causes of preventable mortality at a national and systems level. To do this, it is essential for the NMRF to engage with stakeholders on priorities, issues, work programmes, recommendations and follow up. The future blueprint specifically lists Health NZ (HNZ), the Māori Health Authority (MHA), and community and consumers to acknowledge the importance of these relationships and to ensure alignment of priorities and work programmes.

The NMRF has to be intentional and systematic in managing relationships with key agencies and in its engagement with stakeholders, both in terms of having the right input into reviews as well as opportunities to feedback during planning, implementation and evaluation. Specifically, this should be achieved through:

- Sharing and involvement in the analysis and interpretation of data
- Development of the work programme
- Sharing insights from review and analysis as well as information from other agencies (subject to appropriate constraints)

- Discussing and testing recommendations before being finalised
- Closing the loop in which the HQSC staff systematically follow up with stakeholders to report back on implementation and the impact of recommendations.

Systematic engagement will allow for the alignment of priorities and work programmes between stakeholders and agencies and combine resources where appropriate.

Although relationships and cross sector engagement will be naturally stimulated through the membership on the NMAG, working groups and existing NMRF relationships, it will be important to intentionally manage key relationships by way of regular meetings and updates.

Data management

The future design assumes data management and surveillance will be centralised and housed internally within the HQSC (or have full control and access over the data). The data function will be supported by a data management team to be scoped, established and resourced as part of the transition to the future state. It is acknowledged that there will be some additional resource required to establish this function. Key tasks would be:

- Collection and analysis across all review areas
- Reducing complexity and costs of data collection and analysis
- Overall mortality monitoring and reporting including analysis of mortality trends, benchmarking and dashboard reporting
- Maintenance and continuation of the current data sets, including collection (provided these practices align with appropriate data management guidelines and data sovereignty principles)
- Providing advice and input into the analysis, reviews and reporting through dedicated expertise
- Enabling anonymised data to be available to a wider audience for analysis and research supported by best practice data sharing agreements.

9.5 Case for change summary

In this section the key changes between the current state and the future blueprint NMRF are summarised. The implementation and transition are discussed in the following chapter.

The key findings, first principles, and recommendations for a future blueprint outline a compelling case for change. The recommendations, when addressed, will improve both the effectiveness and efficiency of the national mortality function, one that considers all preventable mortality when setting priorities and is Te Tiriti compliant.

The key changes of the future state compared to the current state can be categorised into the following areas:

- Improved Te Tiriti compliance
- Expansion of scope to include consideration of all preventable mortality
- Increased attention to cross sector engagement approach
- Focussed attention on increasing the impact of recommendations
- Improved capacity to adapt and respond to both changes across sectors and emerging health priorities
- Better coordination and alignment of review and data related activities at an operational level

- Strengthened independence of the entity responsible for the national mortality function, and clarity of roles and accountabilities related to that function
- Modernised legislation giving effect to these changes and incorporating a clear statement of the purpose of the NMRF

Table 1 below summarises the case for change and contrasts the key areas of change noted above between the current function and the recommended future state.

Table 1: Case for change

Current	Future
Inconsistent embedding of Te Tiriti	Achieve Te Tiriti compliance
Only considers five specific areas	Consider **all** preventable mortality (then prioritises)
Predominant focus on health	Broader than health – systematic cross sector approach
Limited collaboration on developing recommendations and following up on actions	Increased interagency collaboration and impact of recommendations
Static focus on specific areas	Greater capacity to adapt and respond
Independence is not uniformly understood or applied	Strengthened independence and clarity of role
Siloed data and support functions	Integrated data and coordinated support functions
Objectives of the system mentioned obliquely in legislation	Overarching statement of purpose to guide performance of mortality review functions

Te Tiriti compliance

Enacting and embedding the tools and recommendations discussed in this report will be key to the success of the NMRFs commitment to eliminating inequities for Māori. Central to this will be resourcing, relationships, valuing and nurturing of capability. For the vision of the HQSC to be realised, all three need to be available and maintained. For Te Tiriti compliance to be achieved, mana whakahaere, mana motuhake, mana tangata and mana Māori must all be able to be realised and tikanga upheld.

The NMRF and the HQSC must ensure that Māori voices are enhanced, enabled and activated through partnership that involves Māori at all levels of decision making. The recommendations contained in this report create an enhanced platform for Te Tiriti compliance within the NMRF supporting it to achieve one of its key objectives – the elimination of inequities for Māori in preventable mortality.

In practice, what this looks like is Māori having greater influence, increased Māori membership and by supporting the NMRF to apply Te Tiriti frameworks consistently. This requires non-Māori members to also have improved knowledge and understanding of tikanga and capability in applying Māori and Te Tirit-based frameworks. The NMRF will also need to foster close relationships with the MHA and HNZ to ensure strategic alignment. Through these approaches there will be an increased understanding of what is important to Māori communities and ultimately and greater opportunity for the key drivers of preventable Māori mortality to be addressed.

Consider all mortality

A key recommendation resulting from the review is the move away from the current fixed five MRC structure to an overarching review of mortality that would support the flexibility to adapt, and for review topics to be changed in response to new and emerging priorities or other areas of strategic importance.

Supported by the strengthened data management function (based on tier one data collected for all death), the new NMRF will monitor and analyse mortality trends and issues that are focussed on areas of need, strategic impact and priority based on advice from the NMAG.

Broader than health – a cross-sector approach

The review identified a pressing need for a coordinated, multi-sector approach to engagement, review and dissemination in order to successfully address the drivers of preventable mortality. The review process used by FVDRC provides an example of taking an in-depth multi agency approach. The suggested changes within the future state, as listed below, will ensure a systematic cross-sector approach that enables the highest impact and system change across preventable mortality:

- Cross-sector membership on the NMAG as noted in section 9.1
- Cross-sector, multi-disciplinary membership when establishing and/or formalising the working groups to conduct reviews
- Regular opportunities for external stakeholders to provide input to various activities of the mortality review cycle (Planning, Implementation and Evaluation)
- Engaging closely with external stakeholders linked to the priority areas, to ensure they have the opportunity to contribute to the workplan and development of recommendations
- A structured and intentional approach to relationship management with key stakeholders and external agencies
- Reflecting the cross-sector approach in legislation, with specific obligations to collaborate in addition to the general duties set out in the Public Service Act and the Crown Entities Act
- Compliance with the HQSC Code of Expectations for consumer and whānau engagement (once the Code is finalised).

Impact of recommendations

Stronger and more closely managed relationships with key agencies will position the NMRF to more effectively influence their work programmes and escalate issues as they relate to preventable mortality.

While strong relationships are key to influencing change, the legislative changes proposed will enable the NMRF to compel agencies to feedback on their actions in response to recommendations which will improve transparency and strengthen accountability across agencies.

Additional accountability will be achieved by the requirement for the NMRF to report back annually to the Minister on the advice from the NMAG and the traction and impact of previous recommendations.

Capacity to adapt and respond

Feedback received during engagement noted that current performance had plateaued and that there was a sense of recommendations being repeated year after year. The proposed changes mean the NMRF will be able to adapt more effectively to changing demands rather than focus only on the existing MRC topics. Supported by the NMAG, who maintains oversight of all mortality, the changes will enable the NMRF to drive areas of high priority and/or significant opportunity.

Integrated data and coordinated operations

As an integrated function, activity can be aligned and coordinated with external reporting and/or policy cycles.

This would be supported by having an internal data management function that is owned and directed by the HQSC. The benefit will be a modern infrastructure allowing the NMRF easier and more appropriate

access to data which in turn will support surveillance and creation of mortality evidence and insights that strengthen the impact of recommendations. Having improved access to data will allow the NMRF the opportunity to advance their analytics over time. This will need to comply with data sovereignty and privacy requirements.

It should be acknowledged that achieving the outlined future state will require an investment of both time and financial resource. Once established, efficiency and sustainability will be favourable when compared to managing five separate MRC data sets. The proposed simplified structures, supported by standardised protocols and processes, will reduce the level of management and effort from the NMRF business unit.

Strengthened independence, clarity of roles and statement of purpose

The proposed blueprint, legislative changes and recommendations aim to address the current challenges relating to roles and responsibilities, independence and purpose.

The proposed changes address the ambiguity of the independence of the MRCs and their recommendations with respect to the HQSC. This is largely historic and results from the way the current legislation has been interpreted. Having independent expertise in undertaking mortality reviews and developing recommendations is essential. However, a NMRF that enables recommendations to be made that are not supported by the HQSC, as the accountable organisation for the NMRF is unhelpful, frustrating to all parties involved, and ultimately confusing to the wider sector. The proposed changes clarify that the NMRF is the responsibility of the HQSC. The legislation itself will require HQSC to establish, the NMAG (even if HQSC has already established it under the existing Act). The NMAG will provide expert and independent advice to inform the NMRF decision making, prioritisation and application of resourcing. It will also have to seek additional expertise based on the topic and need required.

This proposed change clarifies the roles and responsibilities (i.e., the HQSC is responsible for the NMRF), while providing clarity on the role and importance of independent expertise. Transparency that independent advice is fully considered by the HQSC is structurally embedded by virtue of proposed legislation requiring the HQSC to report to the Minister of Health on the actions taken in response to the NMAG advice.

The second form of independence clarified in the blueprint and recommendations is the importance of the NMRF being statutorily independent (irrespective of any strengthening of HQSC's Crown entity status). Being independent of Ministerial direction or influence by other government agencies will ensure HQSC is fully able to critique aspects of our systems that are not delivering to the level required reduce preventable mortality and eliminate inequities for Māori.

Legislative change is proposed to address these issues however, as noted in section 9.2 some changes can be achieved through existing legislation. These changes will ensure the NMRF has the credibility, skills and trust to enhance its influence to affect positive social impact.

10 Phased implementation

The key steps for a phased implementation are summarised in Table 2 and discussed in detail below. The future column in the table reflects key changes as discussed in 6.3.

The transition is anticipated to take 12-18 months to complete. It is recommended that as a first step a readiness assessment will be completed to identify the capacity, skills and expertise required to ensure a successful transition.

Any changes will need to be carefully considered with respect to known challenges to change management and against any risks associated with the planned change. It will be important to consult, confirm and articulate the vision for the future state thoughtfully and clearly. A considered, coordinated approach will be required to support a successful transition. Leadership and the current secretariat will be key in informing and operationalising the changes.

The MRCs and working group members are passionate about their specific areas and, in many cases, their contributions to the work of the NMRF represent decades of knowledge, skill and experience. There is a risk that any changes, proposed or actual, will impact on how people perceive their contribution to be valued and how they may contribute to the NMRF in the future. It is important to retain the current commitment, expertise and experience within the NMRF. That is why the transition summary below proposes the current MRCs continue their work during the transition and advise the new NMAG about future priorities and issues and how they may best be addressed. It also proposes the existing data collections are continued and reviewed by relevant SMEs and others. These proposals will help ensure the NMRF continues to have the ability to deliver its surveillance and review functions whilst undergoing transition to the future state.

Table 2: Summary phased implementation

Function/Structure	Transition (12-18 months)	Future (18 months +)
Te Tiriti compliance	Ngā Pou Arawhenua continues and provide input into: – Implementing the principles of Māori data sovereignty as developed by Te Mana Raraunga – Critical analysis and development of processes and outputs that enact the articles of Te Tiriti o Waitangi	Te Tiriti o Waitangi Hauora Framework adopted including: – Ngā Pou Arawhenua – Increased Māori membership in NMAG and working groups – Māori chair appointed to NMAG – Key relationships established (e.g., IMPB & MHA)
Independence and advice	– Legislation enacted to increase independence and strengthen the function of the NMRF (or confirm its statutory status if established under existing legislation) – Establish a NMAG	– Continuous strengthening of the independence of HQSC's mortality review function leading to increased credibility across agencies – NMAG providing independent advice across mortality, to support prioritisation and the development of the work programme
Prioritising	Develop a decision making and prioritisation framework including clear principles and criteria to set annual priorities	Mortality review focus areas are prioritised based on clear criteria and a transparent process with weighting given towards mortality affecting Māori
Expertise	– Existing MRCs continue to perform existing functions as well as contribute to identifying future	HQSC establishes the work programme based on advice from NMAG, which will include:

	priorities for consideration by the new NMAG – NMAG provide advice to inform the development of the future work programme	- Analysis and advice from subject matter and representative experts (SMRE) - Establishing working groups for specific areas of reviews which may be longstanding and/or time limited reviews
Secretariat support	Redesign and manage the transition for the secretariat support to become an integrated function for the NMRF	NMRF working across mortality review based on priority analysis supported by: – SME advice and support – Integrated data management and analysis – Systematic stakeholder engagement – Reporting, information sharing, monitoring and follow up – Regular mortality review conference/s
Data management	– Integrate mortality review data management and analysis within HQSC – Broaden mortality review surveillance – Implement integrated data governance and management, including Māori data governance	– Centralised data management and surveillance within HQSC – Overall mortality monitoring and reporting including benchmarking and dashboard reporting – Continue current data collection and increase when necessary to meet the requirements of working groups
Local mortality review	Maintain local input	– Develop broader local mortality input – Coordinate with HNZ and MHA and IMPB

10.1 Independence and advice

It is recommended that during the transition phase two key legislative changes need to be progressed:

1. Changes to achieve greater independence of the HQSC, and
2. The establishment of the NMAG to provide independent expert advice.

There are considerations regarding how to achieve these two changes. Changing the status of the HQSC from that of a Crown agent to an autonomous Crown entity would impact all HQSC's functions, not just the NMRF, but would also be a key factor in increasing the level of independence in relation to the NMRF. As recommended, the NMRF functions should in any event be classified as statutory independent functions for the purpose of the Crown Entities Act (i.e., irrespective of any change in the status of HQSC itself). Either or both of these steps would require legislative change.

While legislation should also provide for the NMAG, establishment of the NMAG is not necessarily dependent on legislative change and could be established under the existing Act.

The legislative reform process is the responsibility of the Ministry of Health, requiring the necessary policy changes to be submitted to Cabinet following the required steps such as regulatory impact analysis, with drafting instructions for the Parliamentary Counsel Office likewise the responsibility of the Ministry. The HQSC, as a Crown entity, should however seek to be actively involved in each step of this process with the agreement of the Minister and the Ministry. As with any Crown entity seeking involvement in the Crown's update of its governing legislation, this necessitates a Board-driven

engagement plan (including through communications with the Minister and the Ministry) and sufficient staff resources. This strategy should include taking what steps are possible under existing legislative settings but, in turn, highlighting the benefits of a strengthened legislative framework. The establishment of the NMAG is a key first step to signal the change for the new NMRF.

In establishing the NMAG, considered selection and recruitment into positions is needed, as described previously in section 9.1. A key task of the NMAG will be to advise on the prioritisation of areas for review and on the overarching workplan. The NMAG will also provide advice on the SMRE input required to support the reviews and determine the activity involved, i.e., whether the work is conducted by an individual, a task focussed group or a standing group.

A decision needs to be made as to whether the SuMRC remains as part of the NMRF. Noting that the current funding for SuMRC is direct from the Ministry of Health, rather than via the HQSC which funds the other MRCs.

10.2 Prioritisation

As noted in section 9.4 the HQSC will be required to work closely with the NMAG to develop a framework for prioritisation that involves the explicit identification of principles and criteria, and agreed processes that ensure evidence and data informed approaches to decision making. Input from members of the existing MRCs will be helpful for this work too.

Within the framework:

- A weighting should be given towards mortality disproportionately impacting Māori
- Prioritisation should also take into account the relative impact and resource capacity of the NMRF, as well as whether other agencies are better placed to address some issues or collaborate with the HQSC
- The capacity to adapt to the context and needs of the time
- The prioritisation process draws on the expertise of a broad range of stakeholders.

10.3 Expertise

It is expected that the current MRCs and Ngā Pou Arahenua will continue during the transition, until such time that future priorities and the work programme have been set by the NMAG and the HQSC. It is recommended that the focus of the activity of the MRCs will need to support and inform the NMAG and the HQSC and to ensure existing knowledge and insights within the specific area are maintained. The MRCs ought to:

- determine surveillance data and advance the development of dashboards
- identify priorities within their specific area
- develop a proposed workplan to be considered by the NMAG and the HQSC.

The NMRF, with advice from the NMAG, will determine how the prioritised topic areas will be managed in the workplan.

SMRE's who are well respected and connected across the various sectors are key to the success of the NMRF and needed to conduct the review processes. Where possible the existing expertise may be retained as part of working groups completing in-depth reviews or as part of ongoing surveillance of existing mortality topic areas.

10.4 NMRF business unit support

The support function will be key supporting the overall transition to the new state. The major tasks during the transition period will be focussed on the developing and operationalising the new processes and functions of the new national mortality review function:

- Supporting the establishment of the NMAG including ToR, recruitment and induction
- Developing and integrating a decision-making framework to support prioritisation by the NMAG and the HQSC
- Working closely with the data management team, analysts and Ngā Pou Arewhenua to develop the surveillance function
- Formalising partnerships with external stakeholders and developing a structured and systematic engagement strategy
- Designing the protocols that support the various function including review processes, and local mortality review engagement and coordination
- Developing new structures and ways of working that will eliminate silos
- Developing a new annual reporting format that consists of a summary of measures as a proxy for outcomes with an explanatory narrative that will be used to report on preventable mortality and related inequalities experienced by Māori
- Develop an accountability framework to help monitor and assess whether recommendations are implemented and achieving the intended results and outcomes
- Together with input from Ngā Pou Arawhenua, setting up a plan for an ongoing Māori cultural capability development programme for the NMRF
- Developing a preventable mortality improvement programme which includes an annual conference.

10.5 Data Management

There is considerable change required regarding data management to achieve the recommended centralised data management function and to effectively implement the principles of Māori Data Sovereignty as developed by Te Mana Raraunga.

The data currently gathered, and crucial to the mortality review function, is taonga to New Zealanders and it is important that any changes safeguard and ensure existing data sets are maintained and the data collection continues. This data should be migrated to the new data environment and integrated with new data collections.

To integrate data management into the HQSC the key activities and considerations are:

- Ensuring Ngā Pou Arawhenua members provide advice throughout the implementation programme to embed the ethos of the framework in all data management practices and that any analysis and dashboards reflect Māori aspirations
- Development of new processes including data collection processes that support an integrated data management function
- Disestablishment of the NZMRDG under the HQSC centralised data management model which poses a risk to retaining knowledge

- Development of solution in a new cloud platform to manage the various artifacts supporting data management and sharing
- Development of the data warehouse (which together with the operational administration can be outsourced). Note that the data management function cannot be outsourced as it is very context specific.
- Establishment of an operational data management team within the HQSC, that includes Māori data expertise, led by a manager that is knowledgeable in Data Management Body of Knowledge (DM-BOK) practices
- Supporting the migration of existing data during the transition and ensuring effective integration, documentation and development of data management processes
- Implementation of an effective data management tool that will reduce workload and support automation of processes
- Development of dashboards utilising existing datasets and incorporating new dashboards to the suite based on working group outcomes. The ongoing development and maintenance of dashboards will require analysts.
- Securing access to an epidemiologist to support the analytical team and increase their health surveillance knowledge. This could be an employed or a retainer type role.
- Governance will dictate the availability of dashboards to a wider group of stakeholders to ensure the data is accessible while being used appropriately.

10.6 Local mortality review

With the transition of the funding for Child and Youth local mortality review to district health boards at the end of 2021 there is a real risk local connections disintegrate, and the continuity and quality of ongoing data collection will be negatively impacted. To ensure the maximum value from local functions is achieved the transition period should be used to:

- Reconnect with local review functions and unite in purpose
- Provide clarity on accountabilities and integrate local review processes with the NMRF processes including sharing of data, priorities and learnings as well as dissemination of recommendations and feedback loops
- Work closely with HNZ and MHA to ensure alignment of:
    - Quality initiatives and priorities
    - Quality and adverse event systems with the new NMRG processes
- Develop protocols and guidance for a general local review process
- Secure funding for local reviews and data collection through contracts with localities
- Consider the benefits of changes in legislation to clarify the accountability of the local mortality review.

10.7 Costing considerations

The transition to the future state will require redesign of processes, functions and structures and will require additional resources given the broader focus proposed. It may also require reallocation of

funding currently used to support the various MRCs depending on the outcome of wider surveillance of preventable mortality and subsequent decisions on future priorities.

Following the successful transition, it is expected that:

- The national prioritisation and review functions managed by the NMAG will be able to be funded within a similar budget as FY21/22.
- Additional ongoing costs will be incurred for the increased scope of the NMRF including:
    - broader surveillance, assessment of priorities, systematic engagement and follow up of recommendations
    - the reestablishment and development of the local engagement and support, similar to the budget prior to the disestablishment of this activity
- The centralised data management will be funded from the current operational costs which includes the current NZMRDG contract costs, data warehouse set up and operational costs, ad hoc improvements to existing systems, ad hoc data request costs, and existing data analyst roles.

High-level costings for the various components are summarised in the tables below. The first table (Table 3) shows the mortality review programme budget over the last four financial years excluding SuMRC, the second table (Table 4) shows a breakdown of the budget FY21/22 and the third table (Table 5) shows the estimated costs for components during the transition and future budget considerations.

Table 3: Mortality review programme budget last four years

Combined (ex SuMRC)	2018/19	2019/20	2020/21	2021/22
Committee Costs *(Incl: staffing, travel, board & committee and overheads)*	1,499,190	1,588,640	1,615,002	1,413,102
Service & Programme costs *(Incl: programme coordination, Ngā Pou Arawhenua and local coordination)*	1,734,000	1,579,000	1,579,000	1,293,000
Total	**3,233,190**	**3,167,640**	**3,194,002**	**2,706,102**

Table 4: Budget FY 2021/22 breakdown

Item	Costs	Comments
Committee Costs	1,413,102	
Service and Programme costs	650,000	Service and programme costs vary from $25k to $410k per committee. This Includes $410K for local coordination Note: Funding of local coordination discontinued in December 2021 - previous years approximately $650k allocated to this activity

Data collection MRCs	643,000	Contract with Otago Data Group and one-off data requests
SuMRC	500,000	Budget set by MOH
SuMRC carry forward	120,000	Funds carried over from previous FY
Total budget (excl SuMRC)	**2,706,102**	
Total Budget (incl SuMRC)	**3,326,102**	

Table 5: Transition costs and future considerations

Item	Estimated transition Costs (12-18 months)	Future Considerations
Committee Costs	**$--** Cost as-is during transition	Assume move to NMAG and more one off or periodic working groups, plus SMREs continue to monitor info/trends from data in specific areas (See also NMAG and Future SMRE)
Service and Programme costs	**$-** Cost as-is during transition	Assume current service and programme cost to support future NMAG and SMREs and additional work (See also Future SMRE)
Data collection MRCs	**$725,000** Transition funding to set up the centralised data management function incl: – Data transfer, data Management team, data integration and initial reporting and dashboards, project management, data warehouse implementation	Ongoing management of data and analytics for mortality reviews – Data Management Team (Manager/ Data Managers /Analysts) – Licensing – Hosting Assume cost neutral but with productivity gains and increase in quality and security
SuMRC	**$- (to be negotiated with MOH)** To be negotiated with MOH (390k allocated in 2022/23 as per contract for database and support only)	To be confirmed If this funding ceases it may impact overhead costs for the future NMRF programme.
National Mortality Advisory Group	See one-off transition costs	Assume funded from current Committee and Service and Programme budget

Future SMRE advice and input	**$200,000** Some transition funding for additional advice, meetings etc. over 12 months to enable new work to be developed and both maintain and broaden SME group.	Assume work funded from current Committee, and Service and Programme budgets plus funds for additional work including broader surveillance, assessment of priorities, systematic engagement, recommendations follow up etc. Annual conference re findings, priorities, recs and follow up requires additional funding
Integrated support function, data management and engagement	**$-** No savings during transition – continuing existing committees, establishing NMRF, implementing transition plan.	Assume gain in productivity rather than savings
Strengthen and broaden local engagement	**$TBD** To be phased in, occurring additional costs	Assume additional budget to re-establish and develop local engagement and support
One-off transition activities and costs	**$75,000** − Prepare transition plan (Internally resourced or contract in some capacity) − NMRG establishment − Develop new support function (Establish formal relationships with MHA, HNZ (national, localities), iwi leaders (national, local) − Some T&D including cultural safety/competence − Costs depend on mix of internal and external capability and capacity required.	
Total estimated one-off / additional transition costs	**$1m** additional costs for strengthening local engagement	

11 Conclusion

The content of this report reflects the process undertaken by Francis Health, the NMRF and key identified stakeholders to engage, collate and evaluate the NMRF in its current state against the ToR for the review commissioned by the HQSC. Top of mind for this process was the desire for a NMRF which reflects Te Tiriti o Waitangi informed practice, processes and outputs. Put simply, a function that is Te Tiriti compliant and delivers for Māori.

The design and configuration of the present NMRF has evolved over time as a consequence of its place within the system and also of shifting health priorities. This has inadvertently resulted in a NMRF that is fragmented, lacking in cohesion and unsustainable in terms of resourcing. These factors have contributed to a state where neither the structure of the NMRF nor its position within the wider social sector is able to ensure its recommendations and outputs have maximum impact. The NMRF lacks the authority and influence to drive the changes necessary to impact the key drivers of preventable mortality in the current environment nor in the context of significant sector change. The outputs of the investigative phase (literature review, stakeholder engagement and critical review) clearly identified the key issues to be addressed and informed the development of the first principles. Together these create the case for change and signal the nature and shape of the blueprint for the future state of an equitable, sustainable and impactful NMRF. The recommendations contained in this report highlight key areas for change as well as provide guidance as to the phasing and steps to be followed to achieve them.

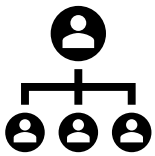
Appendix A – Current State Critical Review

NMRF Current State Critical Review_Final J

Appendix B – Literature Review

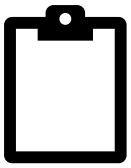
NMRF Literature Review Final_Jan2022

Appendix C – Stakeholder Engagement Overview



51 Organisations involved.

52 Interviews and Focus Groups conducted.



11 Survey's conducted.

Stakeholder Function	Organisation
HQSC	NMRF Review Expert Advisory Group
	Chief Executive
	Group Manager Mortality Review
	Director of Health Quality Intelligence
Committees	Ngā Pou Arawhenua
	Child and Youth Mortality Review Committee (CYMRC)
	Family Violence Death Review Committee (FVDRC)
	Perinatal and Maternal Mortality Review Committee (PMMRC)
	Perioperative Mortality Review Committee (POMRC)
	Suicide Mortality Review Committee (SuMRC)
	Ex-POMRC Members
Specialists and Working Groups	Child and Youth Mortality Review Committee (CYMRC)
	Family Violence Death Review Committee (FVDRC)
	Perinatal and Maternal Mortality Review Committee
	Perioperative Mortality Review Committee (POMRC)
	Suicide Mortality Committee (SuMRC)
	Neonatal Encephalopathy Working Group (NEWG) of the PMMRC
	Maternal Mortality Review Working Group (MMRWG) of the PMMRC
District Health Boards	DHB CYMRG Chairs - CYMRC
	Small DHB Local co-ordinators – CYMRC and PMMRC
	Large DHB Local co-ordinators – CYMRC and PMMRC

Data Groups	NZ Mortality Review Data Group (NZMRDG)
	HQSC Health Quality Intelligence
Māori Partners	Māori Health Authority
	Te Tumu Whakarae – DHB Māori General Managers
Consumer Networks and Representatives	Child and Youth Mortality Review Committee
	Family Violence Death Review Committee
	Perinatal and Maternal Mortality Review Committee
	Perioperative Mortality Review Committee
	Consumer Advisory Group (HQSC)
	Stillbirth and Neonatal Death Society (Sands)
Ministry of Health	Ministry of Health - Clinical Advisors ELT
	Health NZ
Wider Health Sector	NZ Medical Council
	Chief Coroner's Office
	Suicide Prevention Office
	Health and Disability Commission
	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
	NZ College of Midwives
	Council of Medical Colleges
Wider Government Agencies	Ministry of Justice
	Ministry of Social Development
	Department of Corrections
	Oranga Tamariki
	DPMC Policy Advisory Group Health Advisor
	Office of the Children's Commissioner
	Mental Health Wellbeing Commission
	NZ Police
	Ministry of Education
	Kainga Ora
	Pasifika Medical Association