CURRENT STATE CRITICAL REVIEW

Review of the National Mortality Review Function

January 2022

Interim 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.

Interim report: January 2022

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1 Executive Summary

The Current State Critical Review details the findings of the Francis Health review team following the stakeholder engagement and information gathering phases of the overarching review of the National Mortality Review Function (NMRF) commissioned by the Health Quality and Safety Commission (HQSC).

The purpose of this review is to deliver a comprehensive 'first principles' review of the NMRF and to explore whether there is a strategic opportunity for system improvement in the reduction of preventable mortality both in health and across government. A key priority for the HQSC when engaging in this process was the desire for a NMRF which reflects Te Tiriti o Waitangi (Te Tiriti) informed practice, processes and outputs. Put simply, a function that is Te Tiriti led and equity focussed. This report documents the process undertaken by Francis Health in partnership with the HQSC, the NMRF and key stakeholders and contains a synthesis of the feedback shared with the Francis Health review team.

The objective of the NMRF is to reduce preventable deaths. The process involves collating and analysing information, review by multi-disciplinary teams of subject matter experts and the development and dissemination of recommendations.

To date, mortality reviews have been considered the responsibility of the health sector. A health lens, while essential, is not sufficient in the context of addressing the impacts of the wider determinants and health on mortality and increasing social complexity. Broader, multi-sector involvement is essential to achieve traction and effect change, particularly in some of the more entrenched issues. It has been noted that the importance of good intersectoral partnerships will only increase as the health system reforms come into effect.

Engagement with stakeholders occurred between August and December 2021 and consisted of 1:1 interviews and focus groups. The Francis Health review team would like to acknowledge and thank the individuals who were able to share their insights as part of the review. Particular acknowledgement is to be made to the members of the Expert Advisory Group who generously provided their expertise and experience in shaping the outcome of the review.

Alongside stakeholder engagement, a literature review was undertaken to examine emerging research and international practice. Findings were considered when critiquing our national approach to the review and efforts to reduce preventable mortality.

The image on the next page, *Figure 1*, outlines the Critical Review Framework (Framework) developed to undertake the current state critical review. This Framework underpins analysis and the development of the first principles which will then feed into recommendations and a future blueprint for the NMRF.

Understanding within Aotearoa of the impacts of inequity experienced by Māori has increased over the last decade. This inequity is evidenced in our mortality statistics with Māori living on average seven years less than non-Māori. Structural factors such as colonisation and institutional racism that advantage non-Māori and disadvantage Māori, are significant drivers of this disparity. The Framework is designed to prioritise the voice of Māori to ensure Te Tiriti and equity for Māori are considered at every stage of the both the review and future recommendations.

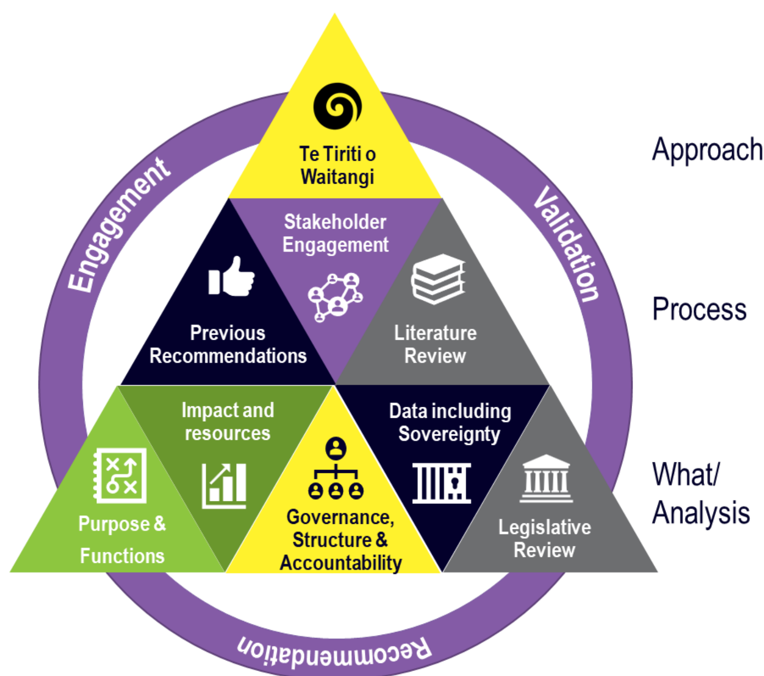

Figure 1: The Critical Review Framework

1.1 Summary of findings

The findings of the Current State Critical Review and engagement conducted to date are summarised below.

- The current NMRF lacks strategies, structure and systems to give effect to Te Tiriti.
- Embedding of the existing Te Tiriti and pro equity guidelines across the NMRF is inconsistent.
- Enabling structures and tools exist (i.e., Te Pou Māori responsiveness rubric) that can be used to strengthen Te Ao Māori perspectives and build a Te Tiriti approach.
- The NMRF's primary purpose is to reduce preventable death through the collection, analysis and review of mortality data. A further function of the NMRF is to make recommendations and disseminate these effectively to contribute to system change.
- Within its current structure and scope, the NMRF reviews specific classes of death (as per the five morality review committees, MRCs) preventing flexibility to investigate new priorities and emerging issues.
- To date the NMRF has been led by and predominantly focused on health. It has insufficient levers to make impact and drive system and service level change, particularly beyond health, where the opportunity for meaningful change is significant.
- Morbidity currently sits within the scope of the NMRF but is neither directly addressed nor actionable within the existing structure and resources.
- There is no systemic approach to setting and aligning priorities across the scopes of the MRCs. Nor for the testing of recommendations and evaluation of implementation.
- Timing is an issue, both in terms of the delay in commencement and time taken to carry

out of the reviews.

- The alignment of publication and reporting cycles of the MRCs do not necessarily align with an annualised system of reporting.
- The five MRCs each have their own approach or methodology for conducting mortality review, contributing to duplication, lack of alignment and coordination as well as inefficiencies across the NMRF.
- There was strong agreement around the value of being able to take an in depth (life course) approach and a strong desire to retain the ability to work in this way as it yields rich insights and improvement opportunities.
- There is a high level of skill and expertise across the MRCs and the work of individual MRCs is generally well regarded and of good quality.
- The impact and traction of recommendations has lessened overtime and under the current structure there is no framework for accountability or action.
- The way each MRC has evolved its own structure and processes overtime has resulted in siloed methodologies, scopes of practice and outputs from the NMRF (committees, secretariat, stakeholder engagement).
- The duplication of effort inherent in the current structure has compounded resource challenges for the current model.
- Relationships with key stakeholders across sector exist within the Secretariat but are not set up to support co-ordinated, systemic engagement. This includes pathways for Iwi partners and community groups to provide input into setting priorities, the review process and agreeing the recommendations.
- The committees have evolved over time, specific to their needs, as determined by their own needs and priorities which has led to complexity, duplication and lack of co-ordination within the current overarching structure creating a significant overhead.
- The operational and governance links between the NMRF and HQSC are structured in a way that impedes clarity in roles, responsibilities and accountabilities impacting the output of the function and the ability to effect change.
- There is a lack of alignment and coordination between the individual committees which contributes to creating missed opportunities for elevating insightful work and harnessing the expertise and value produced at the local and regional level.
- When committees worked together in relation to specific reviews (looking at the same ‘death’), the outcome and experience has been very positive.
- The limited cohesion and collaboration across the committees acts as a barrier to efficiency and effect of their outputs.
- Lack of alignment, consistency, and coordination between the national and local review functions (PMMRC and CYMRC) as well as between local groups (specific to the local CYMRC groups).
- Within local reviews there is considerable value in the collaboration between the local committee and local cross sector agencies (local CYMRC groups).

- The secretariat function is integral to the success and effectiveness of the NMRF.
- Some data collection and analysis is contracted to New Zealand Mortality Review Data Group (NZMRDG) with a history of lack of strategic and technical oversight from HQSC.
- There is variation of data management, caused by segregation of the data results in duplication and limitations around data sharing between the committees, and adds to a difficult relationship with NZMRDG.
- The current structure (siloed scopes and data infrastructures) is limited in its ability to look across the life course of those who have passed and understand emerging patterns of themes.
- Within the data collected there are issues representing Māori and minority groups. There are currently no or limited access to data on Iwi affiliation, outcomes, morbidity or social determinants of health.
- A draft data governance framework was commissioned by the HQSC and provides good guidance for meeting appropriate Māori data governance and sovereignty principles.
- HQSC has minimal independence from the Minister in undertaking the NMRF. The function requires sufficient independence to critique system performance and ensure credible, impactful review and improved outcomes on this critically important, highly sensitive issue.
- Provision of independent expert advice to support the mortality review system is important to help maintain public confidence in the quality of critique.
- Subject to meeting data sovereignty and whānau/community information interests, retaining the ability of the NMRF to request information required for mortality reviews is important.
- Power to require government agencies to report on progress made with implementing recommendations would both clarify accountability and improve impact of the mortality review system.
- It is important that Te Tiriti provisions in the new Pae Ora Bill are fit for purpose to help ensure it is embedded in the mortality review system in the future.
- The purpose of mortality review - commonly accepted as reducing preventable mortality - is not stated in legislation and morbidity is included in the scope of MRCs but not the HQSC mortality role. It would be helpful to address these issues to clarify scope and purpose.

1.2 First Principles

The first principles have been developed as part of the current state critical review process and will be used as guiding principles for the development of the recommendations and a future blueprint:

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

2 Purpose and Scope of the Current State Critical Review

The Current State Critical Review is a subset of the review of the NMRF commissioned by the HQSC. The purpose of this review is to deliver a comprehensive 'first principles' review of the NMRF to explore whether there is a strategic opportunity for system improvement in health and across government. A particular focus will be given on how the function can give true effect to the Crown's responsibilities to Māori as tangata whenua as affirmed by the TeTiriti.

The health and disability sector environment and priorities have changed significantly since the inception of the mortality review system. The HQSC wishes to assess whether the current mortality review structures and functions are fit-for-purpose and able to facilitate system-level improvements.

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

This review involves a current state assessment of the mortality review function to:

- Revisit the national mortality review at 'first principles' to explore its purpose and relevance and assess whether it is still a required system-level improvement function.
- Review the data and methodologies, including adherence to Māori Data Sovereignty, and privacy and legal considerations.
- Assess achievements across the Mortality Review Committees (MRCs) since their inception.
- Review current legislative provisions in relation to mortality reviews with considerations of any legislative changes.
- Identify the value of the Mortality Review Function to Māori, to Iwi, and hapū.

This report critiques the current state of the NMRF. Once understood, this provides a platform to develop a vision and design of a future national mortality review function. Additionally, the findings have informed a set of first principles that will guide recommendations for any future blueprint addressed in the next phase.

3 Background

The intention of a national mortality review system is to reduce preventable deaths. This is achieved by collating and systematically analysing information, bringing together subject matter experts to conduct the review and develop recommendations, and disseminate learnings to achieve system change and improvement.

Mortality reviews have predominately been led and undertaken by the health sector. Recent announcements of health and disability sector reforms point towards enhanced integration within the sector and externally across the wider social economic environment. An equally strong mandate from the health and disability reform is a heightened focus on ensuring Te Tiriti and health equity are evident in the ways that social and government agencies design and deliver services.

The existing mortality review programme was founded twenty years ago, when the responsibility of mortality review was held by ministerial committees reporting to the Minister of Health. In 2010, the responsibility of mortality reviews was transferred to the newly established HQSC, following the introduction of the New Zealand Public Health and Disability Amendment Act 2010.

Since 2011, the NMRF has reported to the HQSC Board. The HQSC hosts five MRCs that are responsible for independently performing functions within the parameters determined by the New Zealand Public Health and Disability Act 2000 and the budget and scope set by HQSC[1], apart from the budget for the SuMRC which is set by MOH. The HQSC, through the Secretariat, provides the overall support and direction for the MRCs to operate effectively and efficiently. The functions of the five MRCs are to provide advice on specific classes of deaths and on system 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
- Family Violence Death Review Committee (FVDRC) established 2008
- Perioperative Mortality Review Committee (POMRC) established 2010
- Suicide Mortality Review Committee (SuMRC) established 2017.

1. The Ministry of Health, via the Suicide Prevention Office, holds an annual contracting arrangement with the HQSC, to support the SuMRC.

4 Current State Critical Review

Within the critical review section, the current NMRF is assessed against whether it remains relevant and fit-for-purpose in the context of understanding and reducing mortality in Aotearoa New Zealand.

The Critical Review Framework *(Figure 2)* has been used as a diagnostic to critically assess the current NMRF with specific consideration for Te Tiriti and health equity, data sovereignty and legislation. The critical review, informed by the insights gained through the information gathering phase, is fundamental in determining the key recommendations for the proposed future state, to be delivered in the next phase of the broader review.

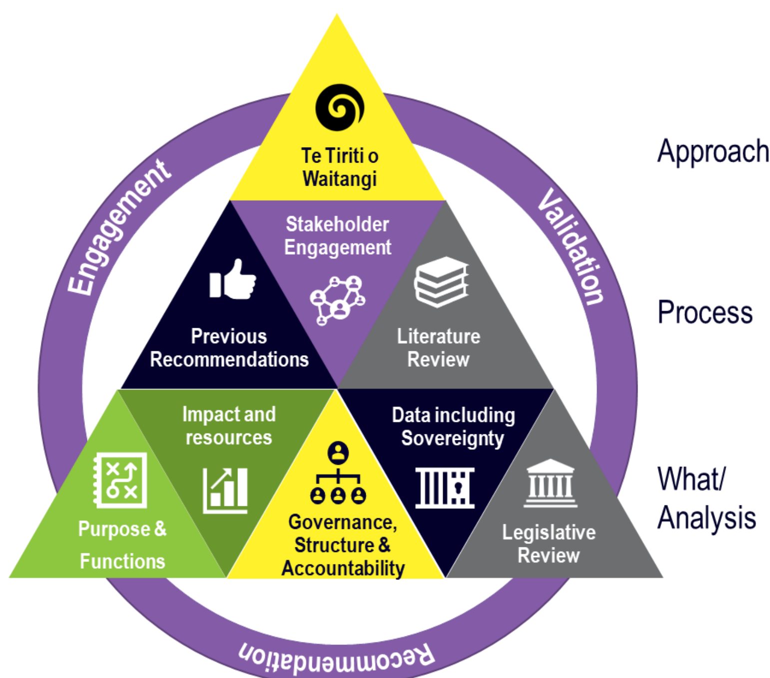

Figure 2: The Critical Review Framework

<u>Approach</u>

Whilst undertaking the critical review, we have adhered to a Māori-centred approach that draws on a range of influences including:

- Historical Māori experiences with, and perceptions about research - keeping participants 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 whānaungatanga 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 Treaty of Waitangi (partnership, protection, and participation) in a genuine and authentic way.

Process

To successfully complete the critical review phase an in-depth understanding of the landscape of mortality reviews was gained through:

- Literature review of current international and best practice evidence
- Extensive engagement with stakeholder groups, who have engaged or are engaging with the NMRF
- Stocktake of previous reviews and summary recommendations

The literature review carried out by Francis Health builds on the findings of the previous literature review undertaken in 2012. It focuses on new topics that have emerged in recent years relevant to the NMRF and prioritises practices relating to indigenous populations internationally with a particular focus on data sovereignty as it relates to the Aotearoa New Zealand context.

The review found consistent messaging around the effectiveness of mortality review entities to develop recommendations. However, although partially successful on local level, 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. Furthermore, countries examined in the literature review for the most part lacked any national entity responsible for conducting or oversight of mortality reviews.

Available literature on approaches to mortality reviews for indigenous populations was limited. It was identified that New Zealand's mortality review programme is at the vanguard of producing literature and studies in this domain as well as in improving indigenous data sovereignty and promoting control over access, collection, and outputs of data[2].

The full report of the Literature Review can be found in Appendix A.

Engagement with key stakeholders was completed in tandem with the literature review. Francis Health requested a register of key stakeholders and stakeholder groups from the HQSC. A list of key stakeholders was developed and in discussion with Francis Health and the HQSC.

The register and subsequent engagement consisted of a combination of one-to-one interviews and focus groups with:

- Internal HQSC staff (governance, committees, Secretariat, agent and local and national working groups) and contracted parties such as the New Zealand Mortality Review Data Group

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[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

- MRC members (past and present) including engagement with the Māori caucus, Ngā Pou Arawhenua and consumer members
- External agencies across the health and wider social organisations, including Māori and Iwi leaders.

An overview of the engagement conducted can be found in *Appendix B.*

The knowledge, expertise, and views on current challenges and opportunities from the engagement were plentiful and provided critical content and context to support the identification of key themes and issues to be addressed.

Engagement with key stakeholders will continue throughout the next phase of the review in which a 'strawman' future state blueprint based on the emerging themes will be tested and refined.

In 2012 the HQSC commissioned a review on the functions of NMRF following it's transfer from the Ministry of Health in 2010 highlighted:

- Lack of a clear strategic direction for the programme as a whole
- Inequitable distribution of resources across the MRCs and a need to fairly and adequately fund resource intensive processes

The objective of the 2012 review was to ensure the NMRF was operating as effectively and efficiently as possible towards a reduction in the number of preventable deaths occurring and improving systems (including health and the wider social sector). The review aimed to build on the successes of the existing programme and sought to:

- Clarify the purpose of the programme
- Optimise programme operation (incorporating structure, resourcing, responsiveness efficiency and effectiveness)
- Recommend options for improving traction and implementation of review findings

Key areas mandated for change by stakeholders at this time were:

- MRC operation: a reduction of the siloed nature of the MRC operational functions. Notably the desire for stronger leadership, more collaborative functions in addition to co-ordinated outputs and advice, including recommendations
- Sustainability and under resourcing: concerns over efficiency of meeting structures, consolidation and streamlining of data processes, increased strategic and analytic support
- Recommendation traction: requirement to increase the coordination, traction, and impact of recommendations
- Increased Māori input: creation of a formalised role to reflect strategic imperative and achieve change.

The final report, published in 2013 included ten recommendations grouped under five themes: strategic operations, governance, expert advice, and leadership; improved efficiency and enhanced operational support; integrated data capture and analysis; local review inputs; monitoring implementation of review recommendations.

Some of the findings and recommendations from the 2013 report are among the priority areas emerging from the engagement carried out in the course of the current review. While the five key

topics are concordant with the key themes identified by the review team, the nature and direction of the changes proposed in 2013 are quite distinct from the priorities emerging from the current review. This is not unexpected given the changes in demographics, public health priorities and the wider transition occurring in the sector. Of greatest significance is the shift within the public and social sectors to focus development that is Te Tiriti led and intersectoral to support the achievement of lasting impactful change.

In the sections below, the critical analysis against the various domains of Critical Review Framework are described.

4.1 Te Tiriti o Waitangi

Francis Health acknowledges HQSC for commissioning the current review and inviting a critical examination whilst being cognisant of the current challenges in terms of delivering for Māori.

Systemic gaps exist and the findings indicate that more needs to be done by the HQSC, the NMRF, and the wider system to achieve a Te Tiriti compliant function.

It is important to note that currently there is no single way to implement or approach the implementation of Te Tiriti within a health, or any other context. For many years, government agencies have, and in some cases still do, build their responses based on applying the three principles of partnership with Māori, participation of Māori and protection of taonga and Māori resources. Other organisations have developed conceptual frameworks specific to their unique strategies, needs and/or programmes. Given that, it also stands to reason that there are multiple ways organisations or programmes can review and assess their capability in relation to Te Tiriti.

With that in mind, it is key that this review defines how Te Tiriti compliance will be analysed and reviewed. For the purposes of this paper, the He Pikinga Waiora Implementation Framework will form the basis of an analytical framework *(see Appendix C).* This framework was bought to the attention of the review team by a member of the Expert Advisory Group. It was considered alongside other methodologies and selected because of its foundation and applicability to both public health and community settings. Also, because as a tool it could potentially be retained by the NMRF beyond the review and used in an ongoing capacity to support the implementation of the HQSC and NMRF's existing frameworks developed to achieve Te Tiriti compliance.

This framework has indigenous self-determination at its core and consists of four elements: cultural-centeredness, community engagement, systems thinking, and integrated knowledge translation.

4.1.1 Embedding Te Tiriti principles and approaches has advanced over recent years – more to be done

There is some evidence of efforts to embed the principles of Te Tiriti into the practice and processes over recent years. Examples include changes in governance, the development of Te Pou Māori responsiveness rubric and guidelines *(see Appendix D).* Overall, the current NMRF structure and systems do not have the clarity and cohesion to give effect to and embed Te Tiriti.

When considering the four elements of the He Pikinga Waiora Implementation Framework, the following characteristics of the NMRF were identified:

- No involvement of Iwi or Māori communities in the problem definition or solutions:
    - There is currently no strategy to engage Iwi or Māori communities to inform or engage in defining the priority areas of mortality review or appropriate solutions

- Recommendations made without community input:
  - Committees make recommendations with no input from Iwi or Māori communities and the information flows one way to health and related sectors, with no specific communication strategy to reach Māori communities
  - Similar to above, there is no strategy to engage Iwi or Māori communities to support the development of recommendations. In addition, once the recommendations are developed, there is no strategy to disseminate this information to Iwi or Māori communities. Equally, there are no systems in place for Māori generally to access Māori data collected in the programme
- The importance of relationships to impact change:
  - Recommendations created by the NMRF have little or no impact due to a lack of consideration given to system level and intersectoral relationships, the steps required for achieving change and the multiple perspectives necessary to support implementation
  - The lack of impact of the recommendations made by the committees could be partly due to the absence of appropriate engagement networks to support Iwi, Māori communities, health and related sectors, to implement change. This includes a lack of opportunities for these groups to provide feedback on the work programme and provide recommendations to the committees or the programme
- Lack of enabling structure and systems to support better outcomes for Māori:
  - Prior to the establishment of the review, there were 12 Māori experts across the MRCs, representing 34 percent of all members. This number is set to increase to 40 percent in 2022. Māori membership is a key agent for change and requires a strategy to support growth and contribution. Ngā Pou Arawhenua and Te Pou rubric are examples of enabling structures, that if optimised, can provide the leadership required and access to te Ao Māori perspectives key to supporting appropriate data interpretation and review.

<u>**Summary:**</u>

- The current NMRF lacks the structure, strategies and systems to give effect to Te Tiriti
- Enabling structures and tools exist (i.e., Te Pou rubric) that can be built on to strengthen te Ao Māori perspectives and a Te Tiriti approach
- There is inconsistency in the embedding of the current measures (tools and guidelines) developed by the HQSC to improve Te Tiriti compliance across the NMRF
- Enabling structures and tools exist (i.e., Te Pou rubric) that can be built on to strengthen Te Ao Māori perspectives and a Te Tiriti approach.

4.2 Purpose and Functions

Within this component of the Critical Review Framework, the purpose and functions of the NMRF are discussed. This includes the relevance of the existing purpose, and whether a revised purpose would enable the NMRF to deliver a more effective review process. One of the key functions, data and information management is discussed in a separate section, 4.4 Data management and Sovereignty.

4.2.1 Clear at a high level about mortality - less clear about morbidity

Feedback from engagement with internal and external stakeholders identified general agreement

on the purpose of the NMRF as being to reduce preventable death through identifying opportunities for system and quality improvements. Considerable value was placed on the non-punitive approach taken by (all of the) review processes in addition to the rich learnings and insights gained.

There was frequent mention of morbidity in that it currently sits within the scope of the NMRF but was felt by many internal stakeholders that it is neither addressed nor actionable within the existing structure of the programme nor the HQSC. It was agreed by stakeholders that morbidity was an area of importance, however, it was considered beyond the reach of the current review function, with true impact requiring a broader cross sector approach.

The strong links between many types of preventable mortality and the socially determined 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 colonisation continues to impact on health outcomes and wellbeing for Māori. This review recognises that the two are linked but that singular responsibility for morbidity under the NMRF is neither appropriate nor practical.

4.2.2 At present and historically, the NMRF has been predominantly led by and focused on health

A health lens, while essential, is inadequate on its own to discern and address the causes of preventable mortality at a national and systemic level. POMRC and PMMRC are strongly linked to clinical information and are a relatively easy fit within health. Whereas mortality reviewed by FVDRC, CYMRC, and SuMRC have strong links to the broader determinants of health and across multiple sectors and as such, are reliant on relationships outside the sector to achieve change.

It is well understood that to achieve meaningful change on cross sector issues, a broad approach encompassing the social determinants of health is required to address underlying inequities and shift outcomes. There is currently insufficient clarity across the NMRF regarding the scope, best levers, and how to impact beyond the health and disability sector.

4.2.3 Areas of review are constrained by the current NMRF structure

The structure of the current MRCs reflects the way in which these areas have emerged as health priorities or areas of interest since the Mortality Review function was installed.

There is considerable loyalty amongst serving committee members to retain the current structure, however, there are questions around whether the current structure allows for optimal impact and best use of the expertise, and values and wisdom within the collective memberships of the committees.

A refreshed commitment to partnering more effectively with and for 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.

An effective and sustainable NMRF needs to have clear processes and key functions (data, review and dissemination) aligned with Māori data sovereignty principles. As well, it needs to be futureproofed by demonstrating agility and responsiveness whilst still capturing opportunities for impact in the reduction of preventable mortalities. Increased collaboration and sharing of intelligence and expertise was highlighted as area for improvement.

Committees were generally unaware of the processes and methods of each other. This internalised, siloed focus and disconnect across opportunities, issues, relationships and impact extends to the relationship between the local and national functions. Again, this was generally observed to be a consequence of how the structure and processes of the MRCs had evolved over time and not a conscious practice of exclusion.

However, the lack of collaboration and cohesion across the function cannot be seen as advantageous for either the function as a whole in terms of efficacy and profile, nor the betterment of outcomes and achieving positive change in preventable mortality. Another further impact of the siloed nature of how the MRCs operate is the variety of approaches taken to identifying areas for focus and review. Whilst there is value in retaining internal drivers for priority setting, this does come at the cost of a unified and potentially a more influential approach to both review and the impact of their findings and recommendations.

4.2.4 Five separate methodologies to review mortality

Currently, there are five committees, each with their own approach to conducting mortality reviews and executing this function.

On an individual basis it makes sense that each committee has evolved its own process and methodology specific to its own area of focus. Overall, this contributes to inefficiencies and a lack of cohesion across the five domains. Some of which, it can be argued, have large areas of overlap in scope and potential impact.

Feedback from across the committees identified that in-depth reviews with access to quality and meaningful data (quantitative and qualitative) are the preferred approach to identifying systemic, cross sector issues. Committee members reflect a strong desire to retain such an approach as it yields rich returns in both insights and improvement opportunities and provides an opportunity to give voice to the wealth of experience and expertise within the committee membership.

The methodology used by FVDRC presents a good example of a life course approach where cross sector engagement is applied to reviews. The FVDRC applies a regional review process on a subset of FVDRC deaths to identify changes or enhancements to systems, policy and services that may contribute to the prevention of family violence and family violence deaths.

4.2.5 There is no systemic approach to dissemination and implementation of recommendations, follow up, and monitoring

There is no discernible process for tracking progress or measuring action taken in response to recommendations arising from the reviews. To improve outcomes as well as systems and practices for impact, the Secretariat recognises the need for monitoring to track and follow up on recommendations made by the committees be added to the workplan.

Across the engagement conducted as part of this review, the single greatest point of frustration lies with a perceived overall lack of action and accountability for following up on and measuring the impact of recommendations made by the committees.

Issues were expressed at both a local and national level relating to a perceived lack of process and visibility around feedback, recommendations, and the end point of reports. Committee members reported not having a line of sight or feedback loops.

Concerns around timeliness and co-ordination were raised in relation to the delay and length of time taken to complete reviews and subsequently for any insights and recommendations to be made. Also, regarding how the outputs of committees lacked alignment or coordination with reporting cycles and how these relate to the broader activity of government and across the

sector. A consequence of this being that opportunities for uptake and change are not able to be incorporated into the planning and work programmes of related agencies.

Each committee manages different volumes of cases and interfaces with a range of distinct external agencies. As such, they have separate streams of reporting which do not necessarily align with an annualised system of reporting. Whilst there is always going to be a requirement for centralised reporting, the current framework does not align with the cadence or complexity of the material being managed by the committees.

Summary:

- The NMRF's primary purpose is to reduce preventable death through collecting, analysing, and reviewing information pertinent to mortality. An additional function of the NMRF is to make recommendations and disseminate these effectively to contribute to system change
- Within its current scope, the NMRF reviews specific classes of death, preventing the flexibility needed to provide oversight and investigate of all preventable mortality, or the inclusion of new and emerging priorities
- The NMRF has been predominantly led by and focused on health. There is insufficient scope and leverage to impact beyond health, the role of which in achieving meaningful change is well understood
- Morbidity currently sits within the scope of the NMRF but is neither directly addressed nor actionable within the existing structure and resources
- There is no systemic approach to setting and aligning priorities, testing recommendations, and assessing the impact of implementation
- Timing is an issue, both in terms of the delay and duration of the reviews themselves but also regarding reporting cycles which don't necessarily align with an annualised system of reporting
- The five MRC's each have their own approach to conducting review, contributing to in-efficiencies. There is a strong desire to retain an in-depth (life course) approach as it yields rich returns in both insights and improvement opportunities.

4.3 Impact and Resources

In this section, the impact of the NMRF is explored. This includes the ability to effect change on preventable mortality, the effectiveness of recommendations, and the adequacy of resources to manage any future expectations. A further consideration was whether the current processes are as effective and efficient as they could be.

4.3.1 Impact across the system to reduce preventable death hampered

Under the current structure, there is no clear or recognised framework for accountability or action in relation to the process that follows from when reports are written and recommendations are made. The result being lost opportunities for creating positive change in health services and in the reduction of preventable mortality. A second aspect being that the NMRF is seen to 'lack teeth' due to the absence of power to ensure uptake or change arising from review recommendations. This aspect also links to the inconsistent nature of formal relationships with strategic partners outside of the HQSC.

The review found high levels of agreement around the lack of certainty and assuredness of the

'journey' of recommendations once they had been made by the committees. There was confidence in the quality and potential value of the recommendations, however, much less so about whether these were targeted, implemented, tracked or evaluated.

It was reported by stakeholders that the perceived impact and traction of recommendations had lessened over time. Reasons given for the reduction of impact included the breadth of engagement required to achieve change across issues grounded in the broader social determinants.

Additionally, the absence of a clear, cohesive process for managing, tracking and monitoring recommendations lends itself to potential duplication as well as dilution of purpose and effect. Overall, the opportunity to gain and build traction both within health and importantly with cross sector partners and agencies requires a clear organised process with clear accountabilities and adequate resourcing.

It is acknowledged that there is genuine difficulty in capturing the impact of a NMRF (supported by the Francis Health Literature Review and the 2013 report). However, neither the complex nature of the health system nor the problems it seeks to address should be accepted as justification for not being held accountable for creating measurable impact.

The acknowledged complexity of many of the drivers of preventable mortality in Aotearoa New Zealand require a joined up multisector, community-based approach to effect change. While these relationships exist in places, there is no agreed process either across the MRCs nor within the NMRF in place to implement or monitor any change resulting from the reports published by the committees or recommendations made. Further to this, the types of change required to improve outcomes over the life course often require not only extensive collaboration, but also sustained effort. Both factors add to the necessity of networked relationships and a robust monitoring/evaluation function.

4.3.2 Aspects done well – Strengths

Among the key areas of strength communicated during the engagement process, there was admiration for the dedication and depth of expertise of committee members and their contribution to the reviews. The high calibre of input was evident in both the reviews themselves and in the quality of the reports produced.

The outputs of the NMRF are widely valued across the broad range of stakeholder groups, both internal and external to the HQSC.

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

Examples provided of (cross sector) success include:

- Road safety and reduction in driveway death following the release of a report of the CYMRC examining deaths from low-speed run overs and ways of preventing them
- The CYMRC reviewing preventable death from drowning in home pools resulting in legislation requiring fencing of domestic pools
- Strangulation, where insights and evidence reviewed by the FVDRC directly informed a revision of criminal law intended to proactively manage risk in family violence
- 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.

4.3.3 Duplication in processes

Feedback revealed numerous concerns about duplication, although there are a range of views about the degree to which this impacted on the efficacy and efficiency of the NMRF. Areas of duplication highlighted include: resourcing; missed opportunities for collaboration and greater impact; difficulties with measuring, comparing, and reporting on the findings of the reviews; and the risk of missing or not fully capturing the true nature of issues due to poor or low information sharing and collaboration.

As referenced elsewhere in this report, siloes exist throughout the NMRF. For the most part this is a consequence of the way in which the function and the committees have been set up and evolved over time.

The key impact of this being inefficiencies due to duplication of effort e.g., data is not shared and learnings not being shared in the most timely and useful way. The separate and isolated way in which the scopes of review are set and undertaken can mean that some deaths are reviewed by multiple committees. It was noted that a single case could conceivably be reviewed multiple times at both a local and national level and that these processes were not well coordinated with investigations or reviews carried out by other agencies.

4.3.4 Resource challenges for current model

Resources have recently been pulled in line with budget constraints. During the 20/21 financial year, the Secretariat undertook a consultation and subsequent change process to review the organisational structure to align with reduced budget. As a result, the Secretariat became smaller, the impact of this reduction was evident and felt across the MRCs.

The individualised approaches to data processes, identifying areas for review, and ensuing review methodology creates a lack of consistency across the committees and encourages needless duplication. In addition to not making the best use of valuable resources, this feature makes collaboration across review functions difficult, meaning that opportunities to capitalise on synergies across committees and achieve increased traction for change are lost.

The current structure supports the five MRCs completely independently and in isolation of each other. Whilst it is understood how this came to be, continuation is difficult to justify under the current financial constraints. Maintaining five discrete functions also prevents flexibility with regard to supporting the investigation of new and emerging issues and priorities.

Advances in the data space in terms of access, collation, the use of cloud-based information storage, subsequent enhanced opportunities for collaboration and advanced analysis are not evident across all areas. Increased resourcing and capability to support fuller utilisation of available technology would support better use and application of the capability within the MRC’s.

4.3.5 Relationship management not formalised

Effective relationships are an essential aspect and a key enabler in the work of the committees.

It is acknowledged that the role and importance associated with these relationships has likely developed over time. The complexity of health system challenges has increased, but there is an overwhelming need for stakeholder relationship management provided by the Secretariat to be formalised structurally as well as adequately and appropriately resourced to enable the NMRF to fulfil its purpose.

The review emphasised the value of relationships and how this supported high quality outputs, particularly at a local level. Stakeholder engagement highlighted that whilst both strong and effective, these links were not in any way systemic or formalised, nor were they adequately

supported to be so.

There are no clear pathways for Iwi partners and stakeholders to provide feedback on the recommendations to the committees or the programme. This also applies to access to feedback and contributes to other critical points including priority setting, input into the reviews, formalising and agreeing the recommendations, as well as follow up.

Well networked, developed, and adequately resourced stakeholder relationships are needed to support the NMRF and its work in a complex and unfolding environment of change.

Summary:

- There is a high level of skill and expertise across the committees and the work of individual committees are generally well regarded and of good quality
- Impact and traction of recommendation has lessened overtime and under the current structure, there is no framework for accountability or action
- The way each MRC has evolved its own structure and process overtime has resulted in a siloed NMRF (committees, secretariat, stakeholder engagement) adding to duplication and reduced efficiencies
- The duplication in effort by the Secretariat under current financial constraints and reduced budget has resource challenges for the current model
- The structure of the NMRF, and resource capacity, limit the ability of the secretariat to formalise and further build and develop strategic relationships across the health and social sector with key stakeholders to support system and service level change. This includes clear pathways and appropriate resourcing for Iwi partners and community to provide input into setting priorities, the review, and agreeing on the recommendations.

4.4 Governance, Structure and Accountability

The NMRF structures including governance, the relationship with HQSC, and local review functions have been reviewed to determine if accountabilities are clear to deliver on the core processes and ultimately on the overarching objectives to reduce preventable mortality and improve the quality and safety of the health and disability system and other systems.

4.4.1 Current design and governance structures are complex

The NMRF is comprised of multiple committees and working groups established to respond to specific needs at the time of inception which have evolved organically over time. They are now operating as divergent silos; each having their own distinct processes and methodologies including data management (see data section). The complexity and duplication within the current structure creates an additional administrative burden for the Secretariat. Each committee requires a high level of support, coordination, and oversight from the Secretariat which is effectively the engine keeping the function going.

Retention of independence and autonomy is vital to the integrity of the work of the committees as well as maintaining public and sector confidence. Independence and appropriate authority (to request information and enforce recommendations) is essential to hold influence and leverage for change. Questions were raised by stakeholders throughout the engagement as to whether the current NMRF has sufficient independence such that it can offer and be seen to offer free and frank advice on issues *(see also 4.6 Legislative Review).*

Alignment and coordination between the management of the NMRF and the MRC’s is unclear in

relation to the overall strategic direction, work programmes, management of recommendations and stakeholder engagement. This adds to the difficulty to collaborate effectively and reduces opportunities for impact on reducing preventable mortality.

Operational and governance links between the NMRF and HQSC are structured in a way that does not serve either party well. The roles and relationships of the NMRF and HQSC could be adjusted better to serve both and ultimately the public good through increased support of the work and outputs of the committees. This would need to include clarification of roles, responsibilities, and accountabilities.

4.4.2 Accountability for setting the strategic direction for the NMRF is unclear

There is a lack of alignment and coordination between the individual committees that currently comprise the national programme resulting in missed opportunities for sharing insightful work and harnessing the expertise and value produced at the local and regional level. Currently, the process for setting priorities or themes is unique to each function and follows a different process across each of the MRCs.

The lack of alignment across the review functions is largely the result of the way the working groups and committees having emerged over time. Each function evolving processes that reflect their subject area, purpose, and membership.

It is not clear who is responsible for setting priority areas for reviews nor how this process should occur. Most groups reported being happy with how their function carried out its work and having confidence in their processes. There was support for a continuation of autonomous direction setting, but also wide recognition that a more cohesive approach would be beneficial in terms of efficiency and impact. Whilst this was not regarded as a weakness, it does introduce risk/inefficiency in terms of alignment, efficiency, and impact.

4.4.3 Equitable Outcomes

The priority at this time is to identify and address systemic failings and the unacceptable health disparities experienced by Māori as a direct result of colonisation and subsequent institutional racism/failings of the health system. This does not negate the responsibility of the NMRF and the sector to respond to preventable mortality and health needs within other population groups.

Equity for Māori as tangata whenua is sought on a rights basis and is distinct from other groups traditionally underserved by health services where it is approached on a needs basis. Populations impacted in this way include people descended from Pacific Island nations, those with a disability, migrant populations, Rainbow or gender diverse people, and those with mental ill-health, who all currently have poorer health outcomes and reduced life expectancy. The ability to respond to the disparities experienced by these and other groups currently less well served by our health system and services is vital to reducing preventable deaths. Currently, the NMRF is not able to review and/or respond to new priorities due to a fixed structure.

Stronger and better maintained stakeholder relationships, as discussed in 3.4.5, will support diversity and representation across the membership of committees and the HQSC. This will also support appropriate attention to other vulnerable or frequently marginalised groups such as migrant and ethnic minority groups, rainbow, rural or regionally isolated populations, older people, disabled, women, and the socially isolated/those in unstable housing.

4.4.4 A strengthening culture of collaboration continues to struggle

Feedback received identified some success in MRC's working together in relation to specific reviews, looking at the same 'deaths'. However, there is no formal approach to this, and it only occurs sporadically.

Committee members who worked together on these reviews recognised the benefits and considered this as an opportunity to reduce overlap and increase efficiencies and impact. There is an increasing need for collaboration to achieve the desired progress in mortality issues spanning multiple disciplines and sectors. An ad hoc approach is no longer adequate in the face of a growing population of increasing diversity and increased multiagency collaboration externally and across the social sector. This point also speaks to the value of strong and embedded, systematic relationships at both a local and national level, supporting effective flow of information and insights internally, as well as the impact and profile of recommendations outside of the NMRF and HQSC.

Across the mortality data currently collected separately by the MRC's, there is the possibility of overlapping cases of death and duplication in review. Currently, there is no clear coordination or intent to collaborate when reviewing such cases, which is a poor use of resources and wasteful of people's time and effort. This occurs specifically between SuMRC, FVDRC, and CYMRC and is evidence of the siloed ways of working and duplication referenced elsewhere in this report.

Generally, the feedback received from committee members was strongly related to their specific area rather than exploring the purpose and opportunities of a national programme. Specialised knowledge and experience are vital to the quality and integrity of the review process, and it would be detrimental were it to be lost.

4.4.5 Linkages between national and local function are not clearly defined

Engagement with the local committees confirmed that the mortality review function, both nationally and locally, was highly valued. The benefit and contribution at local level was attributed to the expertise and dedication of committee members and close links with the community. There was a strong sense of the need to retain the functions, if not increase the focus on the work and activity of the local committees.

The CYMRC and PMMRC are established and networked locally in DHB's and have developed their own local processes, systems, and structures. The strength of the relationships held and maintained by the local committees supports cross sector collaboration, meaningful reviews and effective mobilisation for change within their area.

Links between local committees and with the national function are weak and inconsistent, providing little opportunity for meaningful collaboration or sharing of insights. Issues were expressed with a lack of process and visibility around feedback, recommendations, and the end point of reports. Local committee members reported not having a line of sight or feedback loops, creating a sense of dislocation from the activity of the national function, although they are united in purpose.

Between the different local committees, there is little evidence of consistency in approach to identifying issues or methodology in the execution of local reviews including which stakeholders are engaged.

The roles and responsibilities of the local versus national committees are somewhat unclear. This was observed in the areas of setting strategic priorities, feedback between the two levels, and clarity of accountabilities.

The pending transition of responsibility for the funding of local child and youth mortality reviews to DHB's may impact on the continuity and quality of ongoing data collation. As a driver and enabler of the NMRF, this change could have a significant impact.

4.4.6 Secretariat as key enabler of the function

The Secretariat holds and carries out a broad range of functions. These include data collection and management, report and recommendations production, stakeholder engagement and recommendation monitoring, communications, and committee management administration (appointments, meetings, logistics, coordination, and accountability reporting) essential to the work of the committees.

The Secretariat performs more strongly in some areas over others but overall, its contribution is integral to the operation of the review function and its success and effectiveness. This is largely due to the fact that the committee members are subject matter experts and community/consumer representatives who are participate in an MRC in addition to of other roles.

The effectiveness of the Secretariat is constrained by the siloes which permeate the NMRF and also by a lack of resources.

Areas of strength include:

- The secretariat provides vital support for the committees, without which their effectiveness would be severely compromised. On an operational level, this includes coordination, report writing, and drafting recommendations
- In terms of expertise, the Secretariat holds a wealth of subject matter expertise and knowledge of their own functional area which extends to data quality.

Areas identified as needing development or additional resource include:

- Relationship management - MRC's have an extensive range of parties with an interest or investment in its processes. The absence of a structured approach to engagement means there is a risk of oversight and/or missed opportunities. Furthermore, strong and well managed relationships with external agencies are essential to achieve progress on actions arising from recommendations
- Knowledge sharing - there is little sharing of knowledge, process, or insights across the secretariat function, with each operating completely separately
- Tracking progress - there is no discernible process for tracking progress or measuring action taken in response to recommendations; nor any requirement for recommendations to be implemented.

Summary:

- The multiple committees have evolved over time, specific to their needs, which has led to complexity and duplication within the current structure creating a significant overhead
- The operational and governance links between the NMRF and HQSC are structured in a way that impedes clarity in roles, responsibilities, and accountabilities. Impacting the output of the function and the ability to effect change
- There is a lack of alignment and coordination between the individual committees which contributes to missed opportunities for elevating and harnessing the expertise and value produced at the local and regional level
- Where committees worked together in relation to specific reviews, looking at the same 'death' to outcome and experience has been positive
- Current priority on addressing inequity– important to respond to preventable mortality and health needs within other population groups

- The low cohesion and collaboration across the committees acts as a barrier to efficiency and effect of their outputs
- There is a lack of alignment, consistency, and coordination between the national and local functions as well as between local committees
- Within local reviews, there is great value in the collaboration between the local committee and local cross sector agencies
- A properly resourced and linked up Secretariat function is imperative to carry out the NMRF and drive improved outcomes.

4.5 Data management and Māori data sovereignty

A key enabler underpinning the NMRF is the data component. A current state assessment regarding the use of data, governance frameworks, methodologies, and reporting has been completed as part of the review. Key findings are summarised in this section.

4.5.1 Variation in data management practices

Currently, the MRCs for the most part work separately to develop a range of reports. As already outlined, data collection processes are kept separate to each committee with varying degrees of data collection oversight and methods. There is limited data sharing between committees which can lead to duplication of efforts and limits the ability for committees to access a wider range of data sources to derive insights.

The current technical structure reinforces the segregation of the committees through the strictly enforced separation of data. Issues caused by the segregation of data were a recurring theme in stakeholder interviews, highlighting limitations around data sharing between the committees. There were also comments that the relationship with NZMRDG could be approached differently so as to optimise efficiency and access without the creation of unnecessary friction. Regardless of future structural changes to the mortality review process, the overlap across all mortality causes points to considerable benefits in looking at the data as a whole.

4.5.2 Consensus that Te Pou is a valuable rubric, but not applied consistently across committees

Te Pou is widely seen as a valuable tool in checking Māori responsiveness within the work of the NMRF. The rubric is primarily used as a checkpoint for peer review once MRC reports are ready to be published. In some cases, this checkpoint is used earlier in the overall process. However, it varies between MRCs and according to local practice, time constraints and resources. In general, it does not appear that it is embedded throughout the whole lifecycle of a review or in MRC reports. It is a valuable tool but needs to be part of a much stronger governance framework which reflects te Ao Māori.

4.5.3 Relationship with New Zealand Mortality Review Data Group

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 taken the opportunity to direct the management and use of MRC data and analytical resource at a predominantly academic, or researcher audience.

Whilst the reputation of the mortality data collection and research conducted by NZMRDG was perceived by stakeholders as 'world-leading', this should not be at the expense of providing a high-quality, agile, and flexible service to the HQSC that helps to more directly achieve their goals.

4.5.4 Interpretation of legislation

There appears to be very constrained access to the data, even within HQSC, which is perhaps a risk-averse interpretation of the Privacy Act and the NZPHD Act, pertaining to the data collected by the committees. This is also a symptom of the variation noted in 4.2.4 which is itself caused by a lack of cohesion and common understanding across committees.

Additionally, there are very few analysts enabled to access the data, creating the potential for a limited skill base and succession; if an analyst leaves, this creates a significant gap in the knowledge of the analyst team. It may be that a wider analyst group can provide wider expertise on analytical approaches and support improved data management processes.

4.5.5 Approach to data analysis

The current structure - both in the configuration of the committees, variation between data infrastructures and the range of stakeholders involved - limits the ability of the MRC specialists and analysts look for patterns in response to review and specific research questions. Feedback from the business intelligence team reflected a sense of being “kept at arm’s length” by the requirements around data requests to NZMRDG and expressed a preference for being able to look for trends and patterns without the restrictions of these requirements.

The NZMRDG note the requests they get from PMMRC and CYMRC are based on issues that are already known, rather than investigative.

Compared to PMMRC and CYMRC whose data is managed by NZMRDG, the data from the other MRCs is more readily accessible to the commission. This internal access allows an approach to data use in which evolving analytical processes can be applied to survey and analyse trends in preventable mortality.

Having improved access to data will allow the NMRF overtime to advance their analytics. This will need to ensure it complies with data sovereignty and privacy requirements. An example was shared in which POMRC tools under development support decision making to provide a risk analysis for patients prior to surgery. This is taking a more prospective view on the role of the NMRF, rather than retrospective reporting. Essentially, this is predictive analytics.

Different MRCs use different types of data to support the individual review methodologies developed for their own areas of specialty. For example, POMRC draw on quantitative analysis, whereas FVDRC use qualitative analysis more which supports providing a relatively small number of very in-depth reviews each year.

4.5.6 Approach to data collection

MRCs suffer from a data collection issue, whereby the Tier 1 data relied on is often delayed but also problematic in that it does not allow for the collection of good quality ethnicity data. Consequently, there is currently no or very limited access to data on Iwi affiliation and outcomes, morbidity, or the social determinants of health.

As a consequence of this some committees (FVDRC) rely heavily on collated qualitative data, which introduces issues with regard to data management and kaitiakitanga. There is also a view that too much data is collected, possibly raising Privacy Act 2020 implications. There are no standardised processes to determine which data to collect.

In addition, the FVDRC review of regional data is time-consuming and complex to compile, with limited ability to systematically interrogate.

4.5.7 Māori Data Sovereignty

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.

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 has been reviewed by the Data Iwi Leaders Group as requested by the developers of the framework who have confirmed it meets their expectations.

The framework remains in draft and significant changes in the structure and processes of the NMRF would be required before it could be fully implemented.

Summary:

- Some data collection and analysis are contracted to NZMRDG with a history of lack of strategic and technical oversight from HQSC
- There is variation of data management, caused by segregation of the data, resulting in duplication and limitations around data sharing between the committees
- The current structure - in configuration of the committees variation in data infrastructure, and the range of stakeholders involved - limits the ability to look for patterns and trends in the data in response to review and research questions
- Within the data collected there are issues properly representing ethnicity. There is currently no or limited access to data on Iwi affiliation, outcomes, morbidity or social determinants of health
- A draft data governance framework has been developed and provides very good guidance for meeting appropriate Māori data governance and sovereignty.

4.6 Legislative Review

As part of the current state review the suitability and adequacy of the legislation that sets out the functions and powers of the NMRF and HQSC, conferred in the NZ Public Health and Disability Act ss.59C and 59E, has been assessed.

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 MRC 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 of Health on the progress of its MRCs and subsequently, in its annual report. Schedule 5 of the Act requires the provision of information to MRCs and the protection of confidentiality of the information (and the Act includes fines for breaches of these requirements).

The following issues have been identified in relation to the current legislation:

- HQSC has minimal independence from the Minister of Health in undertaking the NMRF. To fulfil its purpose, the NMRF requires sufficient independence to critique system performance and ensure credible, impactful review, and improved outcomes on this critically important, highly sensitive issue
- Provision of independent expert advice to support the mortality review system is important to help maintain public credibility in the quality of critique
- 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)

- Power to require government agencies to provide that information and report back on recommendations made during mortality reviews and the impact of the recommendations would clarify the accountability of agencies and improve the impact of the mortality review system
- The purpose of mortality review - commonly accepted as reducing preventable mortality - is not stated in legislation and morbidity is included in the scope of MRCs but not the HQSC mortality role. It would be helpful to address these issues to clarify scope and purpose.

Summary:

The issues identified above would need to be considered in the legislative design for the future state.

5 Summary of Findings

The conclusion of the initial engagement phase, literature review and critical review has identified the key findings to be addressed within a future state design. The consolidated list of key findings has been summarised below.

- The current NMRF lacks strategies, structure and systems to give effect to Te Tiriti.
- Embedding of the existing Te Tiriti and pro equity guidelines across the NMRF is inconsistent.
- Enabling structures and tools exist (i.e., Te Pou Māori responsiveness rubric) that can be used to strengthen Te Ao Māori perspectives and build a Te Tiriti approach.
- The NMRF's primary purpose is to reduce preventable death through the collection, analysis and review of mortality data. A further function of the NMRF is to make recommendations and disseminate these effectively to contribute to system change.
- Within its current structure and scope, the NMRF reviews specific classes of death (as per the five morality review committees, MRCs) preventing flexibility to investigate new priorities and emerging issues.
- To date the NMRF has been led by and predominantly focused on health. It has insufficient levers to make impact and drive system and service level change, particularly beyond health, where the opportunity for meaningful change is significant.
- Morbidity currently sits within the scope of the NMRF but is neither directly addressed nor actionable within the existing structure and resources.
- There is no systemic approach to setting and aligning priorities across the scopes of the MRCs. Nor for the testing of recommendations and evaluation of implementation.
- Timing is an issue, both in terms of the delay in commencement and time taken to carry out of the reviews.
- The alignment of publication and reporting cycles of the MRCs do not necessarily align with an annualised system of reporting.
- The five MRCs each have their own approach or methodology for conducting mortality review, contributing to duplication, lack of alignment and coordination as well as inefficiencies across the NMRF.
- There was strong agreement around the value of being able to take an in depth (life course) approach and a strong desire to retain the ability to work in this way as it yields rich insights and improvement opportunities.
- There is a high level of skill and expertise across the MRCs and the work of individual MRCs is generally well regarded and of good quality.
- The impact and traction of recommendations has lessened overtime and under the current structure there is no framework for accountability or action.
- The way each MRC has evolved its own structure and processes overtime has resulted in siloed methodologies, scopes of practice and outputs from the NMRF (committees, secretariat, stakeholder engagement).

- The duplication of effort inherent in the current structure has compounded resource challenges for the current model.
- Relationships with key stakeholders across sector exist within the Secretariat but are not set up to support co-ordinated, systemic engagement. This includes pathways for Iwi partners and community groups to provide input into setting priorities, the review process and agreeing the recommendations.
- The committees have evolved over time, specific to their needs, as determined by their own needs and priorities which has led to complexity, duplication and lack of co-ordination within the current overarching structure creating a significant overhead.
- The operational and governance links between the NMRF and HQSC are structured in a way that impedes clarity in roles, responsibilities and accountabilities impacting the output of the function and the ability to effect change.
- There is a lack of alignment and coordination between the individual committees which contributes to creating missed opportunities for elevating insightful work and harnessing the expertise and value produced at the local and regional level.
- When committees worked together in relation to specific reviews (looking at the same 'death'), the outcome and experience has been very positive.
- The limited cohesion and collaboration across the committees acts as a barrier to efficiency and effect of their outputs.
- Lack of alignment, consistency, and coordination between the national and local review functions (PMMRC and CYMRC) as well as between local groups (specific to the local CYMRC groups).
- Within local reviews there is considerable value in the collaboration between the local committee and local cross sector agencies (local CYMRC groups).
- The secretariat function is integral to the success and effectiveness of the NMRF.
- Some data collection and analysis is contracted to New Zealand Mortality Review Data Group (NZMRDG) with a history of lack of strategic and technical oversight from HQSC.
- There is variation of data management, caused by segregation of the data results in duplication and limitations around data sharing between the committees, and adds to a difficult relationship with NZMRDG.
- The current structure (siloed scopes and data infrastructures) is limited in its ability to look across the life course of those who have passed and understand emerging patterns of themes.
- Within the data collected there are issues representing Māori and minority groups. There are currently no or limited access to data on Iwi affiliation, outcomes, morbidity or social determinants of health.
- A draft data governance framework was commissioned by the HQSC and provides good guidance for meeting appropriate Māori data governance and sovereignty principles.
- HQSC has minimal independence from the Minister in undertaking the NMRF. The function requires sufficient independence to critique system performance and ensure credible, impactful review and improved outcomes on this critically important, highly

sensitive issue.

- Provision of independent expert advice to support the mortality review system is important to help maintain public confidence in the quality of critique.
- Subject to meeting data sovereignty and whānau/community information interests, retaining the ability of the NMRF to request information required for mortality reviews is important.
- Power to require government agencies to report on progress made with implementing recommendations would both clarify accountability and improve impact of the mortality review system.
- It is important that Te Tiriti provisions in the new Pae Ora Bill are fit for purpose to help ensure it is embedded in the mortality review system in the future.
- The purpose of mortality review - commonly accepted as reducing preventable mortality - is not stated in legislation and morbidity is included in the scope of MRCs but not the HQSC mortality role. It would be helpful to address these issues to clarify scope and purpose.

6 First Principles

The findings of this report have been used to develop first principles that will be used as guiding principles for recommendations and a future blueprint. These have been developed collaboratively with the members of the Expert Advisory Group and are listed below:

- In order to eliminate inequities across mortality, particularly in Māori mortality, a prioritised Te Tiriti compliant approach is required
- 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
- Any review of mortality needs to consider that preventable death is broader than the health system and impacted by a range of social drivers
- The mortality review system needs to take an intentional multi-sector and community approach, with significant Māori influence, to succeed
- An effective mortality review system requires sufficient independence and influence to critique system performance and ensure credible, impactful review and improved outcomes
- A national mortality system needs to include broad surveillance and robust prioritisation for best impact
- 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
- 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
- The national mortality review system needs to be credible, enduring, and flexible to enable it to respond to changing and emerging priorities

7 Conclusion

The content of this report reflects the process undertaken by Francis Health in partnership with the HQSC, and key identified stakeholders, to engage, collate, and evaluate the national mortality review function in its current state against the Terms of Reference for the review commissioned by the HQSC and the Francis Health Critical Review Framework.

Top of mind for this process was the desire for a NMRF which reflects Te Tiriti in its practice, processes, and outputs. Put simply, a function that is Te Tiriti led and equity focussed.

The themes identified in stakeholder feedback led to the decision to adapt the domains within the Critical Review Framework to better reflect the aspirations for the future state. The adaptations include placing Te Tiriti and equity as the priority and rearranging the domains to reflect the methodology followed by the review team: Process followed by Analysis.

The key themes (incorporating strengths, gaps and weaknesses) fed back through the engagement and information gathering phase were synthesised into the domains within the Analysis tier. The outputs of this process informed the revision of the First Principles *(detailed in Section 6) and* the issues to be addressed which have been discussed in this report and are summarised below:

- A lack of consistency between the existing Te Tiriti and pro equity guidelines and the range of approaches to applying these is evident across the committee functions. This applies to data sovereignty which is also addressed separately in the review *(Section 4.1)*
- Scope:
    - The NMRF currently reviews specific causes of mortality and does not extend across all mortality
    - A health lens, while essential, is not adequate to identify, understand, and 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 importance of this will only increase as the Health system reforms come into effect
    - Morbidity is currently in the Act and has a major impact on the scope of the NMRF and yet it receives limited attention. Whilst there is agreement about the importance of addressing morbidity, there is some support for it come out from under the remit of the mortality review function
- Several issues relating to the impact of the NMRF and its outputs were raised:
    - Roles, lines of accountability, and responsibilities are not clearly defined
    - The mortality review function has minimal independence from the Minister in undertaking this function limiting credible, impactful review and improved outcomes
    - The lack of a systemic approach or shared process were considered to impede the efficacy and impact of the excellent work behind the recommendations made by the committees. This includes but may not be limited to: setting and aligning priorities, making and testing recommendations, as well as monitoring and evaluation
    - Relationships across the sector with key stakeholders aren't set up to support

partnership or the collaborative effort required to achieve meaningful for change

    - Significant resource challenges exist for the current model, raising concerns for any changes arising from future health reforms
    - Reduced efficiency: pervasive silos in committees, secretariats, data management and access. Stakeholder engagement constitutes a barrier to the best use of expertise and resource within the NMRF

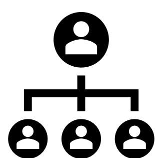
- Alignment: there is considerable disconnect between the national and local functions. Namely in feedback, transparency of process, consistency, and coordination
- Several key gaps or issues in the current function and structure of the NMRF were identified during consultation with the Expert Advisory Group, EAG. There was a request that system adaptability, workforce sustainability and capability, evaluation (including monitoring of the function and its outputs) and future proofing be noted as needing to be incorporated or at least considered as part of the future state.

The design and configuration of the present NMRF has evolved over time as a consequence of its place within the system and also in the face of emerging 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 ability to influence is adequate to drive the level of change required to address preventable mortality in Aotearoa New Zealand. The outputs of the investigative phase (literature review, stakeholder engagement, and critical review) clearly identify the key issues to be addressed and inform the first principles. Together, these clearly indicate the nature and shape of the blueprint for the future structure of an equitable, sustainable, and impactful future NMRF.

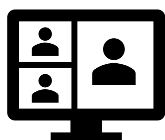
Appendix A – Literature Review

HQSC Literature Review _Final January

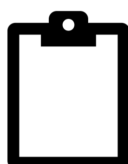
Appendix B – Stakeholder Engagement Overview



51 Organisations involved.



52 Interviews and Focus Groups conducted.

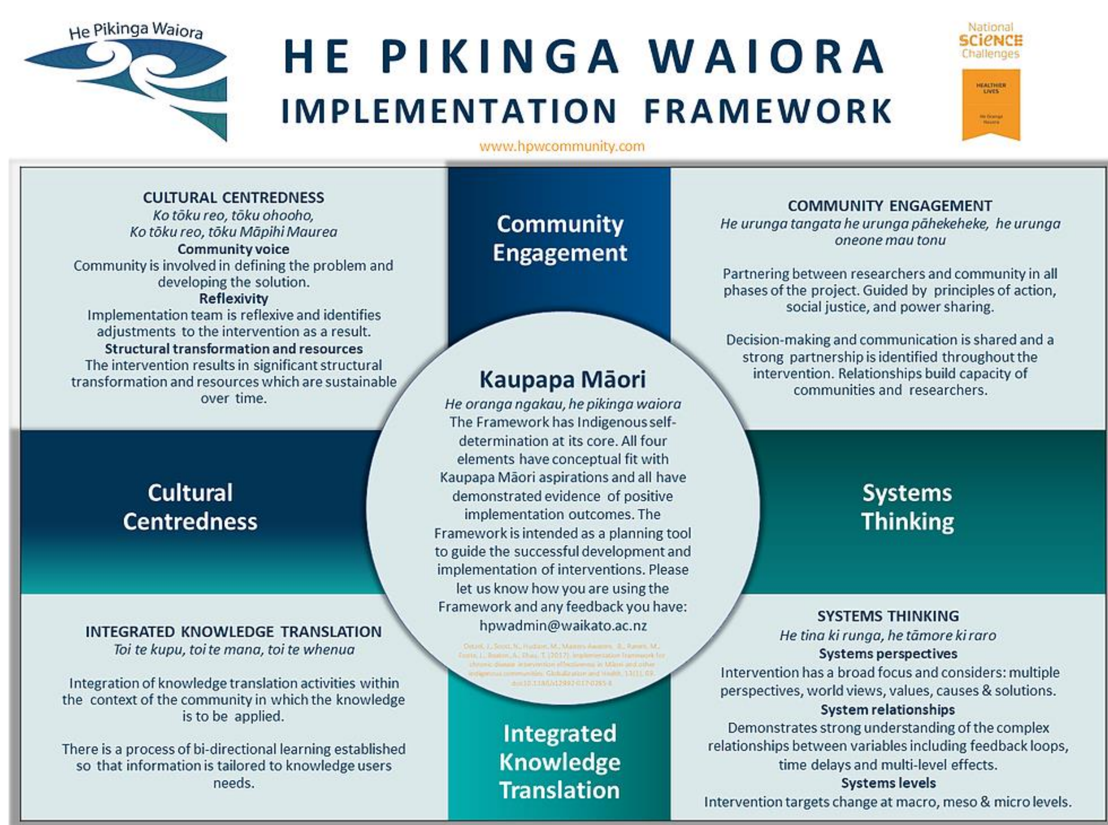


11 Survey's conducted.

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

Appendix C – He Pikinga Waiora Implementation Framework



HE PIKINGA WAIORA
IMPLEMENTATION FRAMEWORK

www.hpwcommunity.com

		High	Medium	Low	Negative
Cultural centredness	Community voice	Community involved in defining the problem and developing the solution.	Community involved in either defining the problem or developing the solution.	Community only informed but has no direct involvement in the definition of problem or solution development.	Intervention implemented in the face of significant community opposition.
	Reflexivity	Explicit statements regarding reflexivity and identification of adjustments to the intervention as a result.	Methods to engage in reflexivity or state they were aware of it; adjustments to the intervention are unclear.	No evidence that the team was reflexive about its processes or no changes made in response to team learnings.	Victim blaming, unintended bias or overt racism in intervention design, implementation or evaluation.
	Structural transformation and resource	Significant structural transformation and resources which are sustainable over time.	Intervention receives significant resources but has a limited focus on structural transformation.	Intervention receives minimal resources and is only sustainable over a short term.	Less resources available or lower quality resources as a result of the intervention compared with no intervention.
Community engagement	Community engagement	Strong community leadership. Decision-making and communication is shared and strong partnership is identified throughout the intervention.	Communication is two-way and there is co-operation to implement the intervention with a partnership becoming apparent.	The intervention team has ultimate control over the intervention and communication, which flows one-way to the community.	Intervention is placed in the community with no consultation with community.
IKT	Integrated knowledge translation	There is a process of mutual learning established so that information is tailored to knowledge users needs.	Medium level support for knowledge user by intervention team for implementing the intervention.	Minimal or no support for implementing intervention or outsiders implement the intervention for the knowledge users.	Knowledge users have major concerns which they are not able to discuss with the intervention team.
Systems Thinking	System perspectives	Intervention includes the following: 1)multiple causes, 2)broad focus/multiple solutions; and 3)multiple perspectives/world views, values of multiple actors.	Intervention includes 2 of the 3 factors in the high category.	Intervention includes 1 or none of the 3 factors in the high category.	Intervention has a negative impact due to a lack of consideration of multiple perspectives necessary to support implementation.
	System relationships	Demonstrates a strong understanding of the complex relationships between variables including feedback loops, time delays and multi-level effects.	Moderate understanding of the complex relationships between variables including feedback loops, time delays and multi-level effects.	Limited understanding of the complex relationships between variables including feedback loops, time delays and multi-level effects.	Intervention has a negative impact due to lack of consideration of system relationships important for implementation.
	System Levels	The intervention targets change at the macro, meso and micro levels, and provides sufficient rationale and context for each level.	The intervention targets change at 2 levels with some rationale and context for each level.	The intervention targets change at 2 levels or less without providing rationale and context.	Intervention has a negative impact due to lack of consideration of systems levels necessary to support implementation.

Appendix D – Te Pou Māori responsive rubric

Te-PouRUBRIC.Visual
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*Te Pou – Māori responsive rubric

to provide guidance to MRCs for interpreting and reporting on **Māori mortality**

	Tika Getting the story and the interpretation right	**Manaakitanga** Being culturally and socially responsible	**Mana** Advancing equity, self-determination, and social justice	**Mahi tahi** Establishing relationships for positive change
Good practice	• Provides a clear detailed analysis of Māori mortality • Uses appropriate in-depth reviews methods to analyse inequities and access to high-quality health and social services and in equity of outcomes • Appropriate analysis of data using ethnicity data protocols and appropriate techniques such as Māori responsive methodologies,[2] and utilising Māori expertise to inform the analysis	• The expertise, wisdom and input of Māori Caucus members are prioritised • MRC members are health literate[3] regarding, and provide a comprehensive understanding of, Māori mortality • Uses a Māori health and equity lens to inform the interpretation of data	• Recommendations are informed by the contextual analysis of Māori mortality • Makes specific recommendations that focus on improving access to high-quality health and social services[1] and equity of outcomes • Makes system-level and culturally responsive recommendations that will benefit Māori whānau, hapū, iwi and communities	• MRCs involve the Māori Caucus members in the planning process for the focus, data collection and analysis, and its interpretation and recommendations in a timely manner • Establishes ongoing and meaningful relationships with relevant agencies and services to promote and guide practice changes
Needs development	• Reports Māori mortality data • Analysis of data by ethnicity but quality may be inconsistent or insufficient • Identifies and describes some inequities for Māori	• The expertise, wisdom and input of Māori Caucus members are sought but no action is taken • Interpretation of Māori data is limited to descriptive epidemiological reporting without a Māori health and equity lens	• Provides information that agencies and services could act on that will benefit Māori whānau, hapū, iwi and communities	• Māori Caucus members' input is sought, but the MRC actioned response to advice is variable • Consults with relevant agencies and services
Unacceptable	• Does not report on Māori mortality, or there is inconsistent or insufficient reporting by ethnicity	• Simplistic description with no Māori health and equity considerations	• Makes no recommendations for Māori or makes deficit-based or blaming recommendations	• Does not involve the Māori Caucus members • Does not establish relationships with agencies or services

[1] Ministry of Health. 2004. Ethnicity data protocols for the health and disability sector. Retrieved from **www.health.govt.nz/system/files/documents/publications/ethnicitydataprotocols.pdf**; Robson B, Purdie G, Cram F, et al. 2007. Age standardisation – an Indigenous standard? *Emerging Themes in Epidemiology* 4(3). doi:10.1186/1742-7622-4-3.

[2] Te Rōpū Rangahau o Eru Pōmare. 2002. Mana Whakamārama - Equal explanatory power: Māori and non-Māori sample size in national health surveys. Retrieved from **https://www.fmhs.auckland.ac.nz/assets/fmhs/Te%20Kupenga%20Hauora%20M%C4%81ori/docs/Equal_explanatory_power.pdf**.

[3] Ministry of Health. 2014. *Equity for health care for Māori: A framework.* Retrieved from **www.health.govt.nz/system/files/documents/publications/equity-of-health-care-for-maori-a-framework-jun14.pdf**.

* This framework uses the three (of the four) tikanga-based principles in the Māori Ethical Framework published in *Te Ara Tika* by the Health Research Council of New Zealand.

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