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

Annual report 2017/18
Pūrongo ā-tau 2017/18





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FOR THE PERIOD
1 JULY 2017 TO 30 JUNE 2018

Presented to the House of Representatives pursuant to section 44 of the Public Finance Act 1989

Our vision | Tō mātou moemoeā

Aotearoa New Zealand will have a sustainable, world-class, patient-centred health and disability system, which will attract and retain an excellent workforce through its commitment to continually improve health quality and safety and deliver equitable and sustainable care.

In the health and disability sector, the role of the Health Quality & Safety Commission is to 'shine a light' on quality and patient safety to accurately measure and report on health outcomes for New Zealanders.

Our role is also to 'lend a helping hand' to the sector by supporting it to develop improvement programmes and leading the spread of skills to improve quality and safety across the sector and among consumers and their families and whānau.

We engage with consumers and their families and whānau, which evidence links to improved outcomes and experiences of health care.

We seek to make the health system more effective and health outcomes more equitable. Disparities in health outcomes exist between Māori, Pacific and New Zealand European peoples, and between wealthy and poorer New Zealanders.

Māori and Pacific peoples are two to three times more likely to die from conditions that effective and timely care might have prevented. The health of substantial numbers of our young people reflects the impacts of this growing inequity, and child poverty is a leading problem for New Zealand.

We support specific equity improvement programmes to address these concerns. Equity concerns are also part of the decision-making and prioritisation processes in our wider programmes.

Preventing avoidable harm and saving valuable system resources help the system to be more sustainable too. We report regularly on harm prevented and money saved through the improvements health services make in areas we focus on.

Our values | Ō mātou uara

The way we work reflects our role as a national 'leader and coordinator' for health quality and safety and is encapsulated in our values.

It's about people (Mō te iwi) – We are driven by what matters to patients/consumers and their families and whānau, and by what will improve the health of communities and populations.

Open (Ngākau tuwhera) – We have an open, honest, transparent and respectful culture. We value the expertise, knowledge and experience of others and welcome creative approaches and diverse opinions.

Together (Kotahitanga) – We partner with others and learn and share together. We use consumer experience, expert knowledge and current information to come up with new ways of thinking and better ways of doing things.

Energising (Whakahohe) – We are energised and energise others by our passion for improving health and disability support services.

Adding value (Te tāpiri uara) – We focus on adding and demonstrating our value to the health and disability system and to the health of communities.

Whakataukī

Ko te whāinga rangatira hei tūāpapa mō Te Kupu Taurangi Hauora o Aotearoa;

Ko te whakatutuki i te mana taurite hauora mō ngā tāngata puta noa i te motu.

Ko ngā mātāpuna o Te Tiriti o Waitangi hei whāriki e whai ake i tēnei moemoeā.

Pou hihiri	*When your spirits awaken*
Pou rarama	*When your body's alive*
Pou o te whakaaro	*When love is unconditional*
Pou o te tangata	*Enlightenment flows*
Pou o te aroha	*(When your mind and spirit are in tune*
Te pou e here nei i a tātou,	*you can achieve anything).*
Mauri ora	
Ki ngā tāngata katoa!	

Contents

Foreword | Kupu whakataki

We are pleased to present the Health Quality & Safety Commission's annual report for 2017/18.

Highlights for the year include evidence that surgical site infections are declining – patients receiving all three interventions recommended by our safe surgery programme are 40 percent less likely to get a surgical site infection than those who do not.

Deep vein thrombosis and falls rates have also continued on a downward trend.

The Suicide Mortality Review Committee and the mental health and addiction quality improvement programme, initiated in late 2017, are grappling with some of the most critical areas of health care need in New Zealand, particularly for young people and Māori.

We have begun six new projects in our Whakakotahi programme, all featuring a strong focus on equity and consumer engagement. Our Māori advancement framework for staff, Te Whai Oranga, also focuses on promoting more equitable care and health outcomes for New Zealanders.

Our programme of reporting adverse events nationally continues to remind us of the importance of continuous improvement – although by far the majority of patients are successfully treated in our hospitals, too many still experience harm. Statistics apply to groups of people but each adverse event affects an individual and his or her family and whānau, sometimes with devastating consequences. This year we increased our focus on engaging and communicating with consumers adversely impacted by health services to work together to prevent the recurrence of such events.

None of these achievements are attributable to the Commission alone. All reflect the combined efforts of organisations within New Zealand's health and disability system, and of the frontline staff who deliver care to patients and consumers. The coordination of services continues to be a priority if we are to deliver the world-class services New Zealanders rightly expect.

The Commission responds to the Government's priorities expressed each year in our Letter of Expectation. Our letter of June 2018 emphasised four priorities: primary care, mental health, the public delivery of health services, and a strong focus on improving the equity of outcomes.

Our 2017–21 Statement of Intent reflects these priorities, as well our overarching responsibility to continue to improve the safety and quality of health and disability services. Our ongoing work improving consumer, family and whānau experience, improving health equity, reducing harm and mortality, and reducing unwarranted variation in patterns of care all align with these priorities.

The inequitable distribution of health care services and outcomes is one of the most pressing issues affecting New Zealanders. This is particularly apparent among Māori, Pacific peoples and those from disadvantaged socioeconomic environments. Our responsibilities under Te Tiriti o Waitangi require a particular focus on Māori in this regard. We plan to increase our efforts to support the Government's priority of addressing inequity in New Zealand. The Commission will work with the Minister and Ministry of Health and other government organisations to advance this objective through its two main roles of measurement ('shining the light') and projects ('lending a helping hand'). It's important in this endeavour that we recognise Māori as tangata whenua, and partner with organisations reflecting kaupapa Māori approach to health care, if we are to contribute to making serious inroads into improving outcomes for Māori.

We also need to increase the scope of our consumer focus more generally, because evidence indicates that consumers, families and whānau who are informed are more likely to seek information about their care and make choices that are best for them – ultimately leading to better health outcomes.

We have introduced a Consumer Advisory Group, which is promoting consumer co-design across a

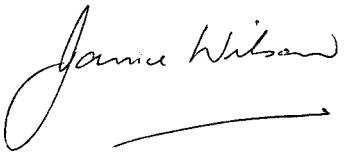
range of our programmes. All our work programmes also include consumer representation. We were pleased to see participation in our primary care patient experience survey accelerate, with 21,800 responses in 2018, up from 5,600 in 2017. We were also busy in the field, with our Partners in Care team in partnership with a district health board successfully delivering six co-design projects. You can read about some of these projects in this report.

Our quality improvement programmes continued to show tangible benefits.

We now plan to include the chairs of the Consumer Advisory Group and Te Rōpū Māori in our normal Board meetings to bring their insights more directly into our strategic thinking.

We welcome the opportunity to share the story of our successful year in 2017/18. We also look forward to continued achievement and successful partnerships in the year ahead as we work with consumers and organisations responsible for delivering health and disability services to continue to improve health outcomes in New Zealand.

Prof Alan Merry ONZM FRSNZ
Chair
15 October 2018



Dr Janice Wilson
Chief Executive
15 October 2018

Highlights 2017/18

These successes are a result of the work and commitment of the whole sector to improve patient safety and save lives

As at **2017/18**, **147**[1] fewer falls resulting in a broken hip since 2013 – almost halved!

Because of our work, hospitals assessed more people for the risk of a fall and more people have an individualised plan of care

$6.9 million[2] saved

112[3] recommendations made by our Child and Youth Mortality Review Committee

85 of them we achieved fully, mostly or in part

As at **2017/18**, **896**[4] fewer deaths of children since 2010

Avoided the **$393 million** loss in value that early deaths would cause

The Commission and other agencies recommended putting babies to bed on their backs. This practice was instrumental in reducing the number of sudden deaths to infants

As at **2017/18**, **351**[5] deep vein thrombosis cases avoided since 2013, the year we worked with DHBs to implement the Safe Surgery NZ programme

$7.3 million saved

As at **2017/18**, **0.9%**[7] infection rate of operations (1.2% in 2015)

72 fewer infections 2015–17

Saving up to **$2.9 million**

*In **2017/18** we have reaped the benefits of implementing New Zealand's first national quality Surgical Site Infection Improvement programme in 2012*

Patient Safety Week, November 2017

300,000[6] views of bilingual awareness videos

250 providers ordered Patient Safety Week resources

1 million pharmacy bags ordered for community pharmacies

78% of those surveyed responded positively to the 'taking your medicines' posters

85%[8] hand hygiene compliance **2017/18** (62% 2011/12)

1. www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers/qsms-january-march-2018/#[FALLS]
2. Health Quality & Safety Commission. 2018. *Open4Results*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3393.
3. Child and Youth Mortality Review Committee. 2017. *Seventh Report on the Activities of the Child and Youth Mortality Review Committee 2011–16*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-programmes/mrc/cymrc/publications-and-resources/publication/2813.
4. Health Quality & Safety Commission 2018, *op. cit.*
5. *Ibid.*
6. www.hqsc.govt.nz/our-programmes/patient-safety-week/news-and-events/news/3123
7. Health Quality & Safety Commission 2018, *op. cit.*
8. Health Quality & Safety Commission. 2018. *National hand hygiene compliance report: 1 November 2017 to 31 March 2018*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/publications-and-resources/publication/3357.

Partners in Care forum

'Let's talk: our communities, our health', 8–9 March 2018

250[9] attendees from across the health sector: 17% clinicians, 13% consumers, 10% government, 20% DHB-funded providers, 13% community-funded providers, 27% other

96% respondents to post-forum survey said forum was valuable (46% response rate):

'Thanks to the Commission. I am so impressed – it has made me see that the Commission is relevant.'

'Putting people back into the health system.'

'It brings the truth in the health system, where the opportunities lie, how we support consumers to redesign these with us in partnership and practical application of how it can be done.'

Primary care patient experience survey 2016–18: Survey participation takes off!

- **August 2017**
  - 314 practices in 24 primary health organisations
  - 5,600 responses
- **May 2018**
  - 713 practices in 27 primary health organisations
  - 21,800 responses

'The biggest health care survey in Aotearoa New Zealand'

Establishing the mental health and addiction quality improvement programme

Programme established in 2017 at the request of sector leaders to support improvement in mental health and addiction services

Launched *Zero seclusion: towards elimination of seclusion by 2020* in March 2018

21[10] participants graduated from eight-month quality improvement facilitator course in March 2018

'This programme has changed how I work for the rest of my life' Participant in quality improvement facilitator course

1 mental health improvement network meeting regionally established with DHBs

9. www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/LetsTalk18/Lets-talk-summary-report-May-2018.pdf
10. www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/programme

Priority one: Your health care experience | Whakaarotau tuatahi: Tō wheako manaaki hauora

Improving consumer, family and whānau experience

Our first priority starts with consumers and their families and whānau. Our focus is on how peoples' health care experience can make a difference to health outcomes and improve the health and disability system. Working with people and communities underpins all of the Commission's work programmes, which have leadership and strategic oversight from the Partners in Care programme.

People are important

How people experience health care in Aotearoa New Zealand is at the heart of our work.

If we want to improve health outcomes, then we need to start with people, and understand their stories and experiences.

Evidence shows that engaging with consumers and their families and whānau is linked with improved outcomes and experiences of health care.

In other words, consumers and their families and whānau who are enabled and knowledgeable are far more likely to seek information about their care and make choices that are best for them. This leads to better health outcomes in the long term.

What is co-design?

Co-design is a method of engaging consumers and providers in service improvement. It involves identifying a challenge or opportunity to improve a service based on experiences of consumers, family and whānau, and staff. Different tools are used to capture and better understand their experiences, generate ideas and organise the learning to try different ways of delivering a service. Importantly consumers and clinicians gain insights and work together to review learning and ideas, plan and implement improvements then, finally, review the difference it made.*

We need to move from a service that does things to and for its consumers to one where the service works with consumers, families and whānau to support them with their health needs.

*adapted from Lynne Maher

Recent evidence has shown that, in hospitals where patients report they received high levels of care, the quality of clinical care is higher across a range of conditions.[11]

Enabled and knowledgeable consumers are far more likely to seek information about their care, participate in the management of that care and make choices that are best for them. Experience has shown that actively involving health consumers at all levels of the health and disability system:

- assists with identifying care that is most likely to be acceptable to consumers
- identifies areas where waste can be reduced or services can be reconfigured so more people use them
- upholds consumer rights and reduces the chance of harm.

A co-design case study resourced by the Commission: Understanding the experience of discharge from hospital as part of the cancer journey

The big C word. A word no one wants to hear. But sadly thousands of Kiwis, their whānau and friends are affected by cancer every year.

As part of a case study to understand consumers' experience of cancer, staff and consumers collected information from 130 people at Bay of Plenty DHB (BOP DHB). This included informal coffee conversations with patients, questionnaires from patients, doctors and nursing staff, and feedback from focus groups.

Feedback from staff and consumers was positive:

'As a consumer, I have been fortunate to be working with two excellent BOP DHB staff members. We have worked well as a team and collaborated well together throughout the project.'

'As a floor nurse, I feel very privileged to have had the opportunity to engage with consumers out of the hospital setting with no time constraints.'

We identified two key areas of need: the need for consumers to have access to details for contacting a hospital staff member if they have questions; and the need for an early referral to the Cancer Society. (Because of privacy issues, the Cancer Society is unable to contact people within the hospital.)

As a result of the project, we supported the DHB to make the following improvements.

11. Health Quality & Safety Commission. 2018. *A Window on the Quality of New Zealand's Health Care 2018*. Wellington: Health Quality & Safety Commission.

- Its computer system now allows staff to type 'cancer' into the search engine to link to a cancer nurse coordinator page. This page lists those who specialise in each cancer stream and their contact details. It also includes a link to the cancer nurse coordinator's email address, so staff can access it and refer patients quickly and easily.
- We employed a new cancer nurse coordinator team leader who staff can refer patients to if they themselves are unsure of who to refer specific patients to.
- We arranged in-service training sessions for staff.
- We worked with our focus group to develop an information folder for patients with information they identify as helpful in their journey after initial cancer diagnosis and after discharge from hospital. It will include a single point of contact and the name of the senior medical officer providing care. The folder will be trialled initially through Tauranga Hospital.

We supported services to make a difference

Engaging with consumers should take place at all levels of health service delivery: direct level of care, service planning and policy, and governance. We supported services to improve outcomes through undertaking co-design and responding to consumer experience data.

Our Partners in Care programme has a strategic focus on consumer engagement. This year we also formed a Consumer Advisory Group at the Board level, which ensures our Board reflects this consumer outlook in our strategic work. We continued to support our consumer network, complementing the role of the Consumer Advisory Group. We also continue continues to include consumer representation in all our work programmes.

We used expertise in developing six co-design projects in one DHB and focused on providers and consumers working together to identify service delivery improvements.

We built stronger partnerships with consumers and their families and whānau, and spread consumer engagement methods throughout the sector to encourage their involvement. For example, with our mental health and addiction quality improvement programme, we supported all project teams this year to use co-design to develop their initiatives.

Co-design case study in mental health: Te Toki Maurere

'Every client matters. You don't want to let them down' (Inpatient staff member)

In May 2017 the Office of the Auditor-General presented an audit report to the House of Representatives highlighting the pressures on the mental health system when discharging people from inpatient units.

The report recommended that mental health and addiction services urgently work on ways to collaborate more effectively with stakeholders on discharge plans for people about to be discharged from an inpatient unit.

In response to this report, and to national and DHB directives to improve the discharge process, we implemented a co-design project in Te Toki Maurere

(an adult inpatient unit) in Whakatāne. Our aim was to improve the process so that people discharged into community care had a better experience.

In kanohi ki te kanohi (face-to-face) settings, we captured the experiences of 27 stakeholders, including community mental health staff, inpatient staff, non-governmental organisation (NGO) services staff and consumers themselves.

All stakeholders expressed positive feedback about the kindness and caring of the staff and service.

A key finding, however, was that the traditional medical model of health care still seemed to be in play. It was evident in the way NGOs and consumers viewed clinical staff as the people holding the power, and sometimes showed a lack of respect for other roles.

DHB staff tended to focus on problems with the process of discharge, rather than looking at how the different roles people hold may impact on that process. NGO participants sometimes felt like they were spoken down to for being in a support role. Consumers felt unable to speak up in meetings about their care, to ask for written information or to have a support person present. In these situations, they didn't feel comfortable or empowered.

Next steps involve moving to the improvement stage of the co-design project and developing measures to demonstrate improvement. (In the meantime, the clinical lead has already started building more positive relationships with NGOs.) Of course, we'll share the results with the participants and hold a hui with them to decide together what improvements should be made.

Outcome

Following our work with the BOP DHB, its protocol for discharging someone from mental health and addiction services now states that coordination with multidisciplinary services throughout the discharge process is encouraged, and effective communication between staff, the patient and their whānau is needed.

Supporting services to respond to the consumer experience surveys

Evidence and experience tell us that consumer experience is a good indicator of the quality of health services. Better experience, stronger partnerships and consumer- and family-centred care have been linked to improved health outcomes.

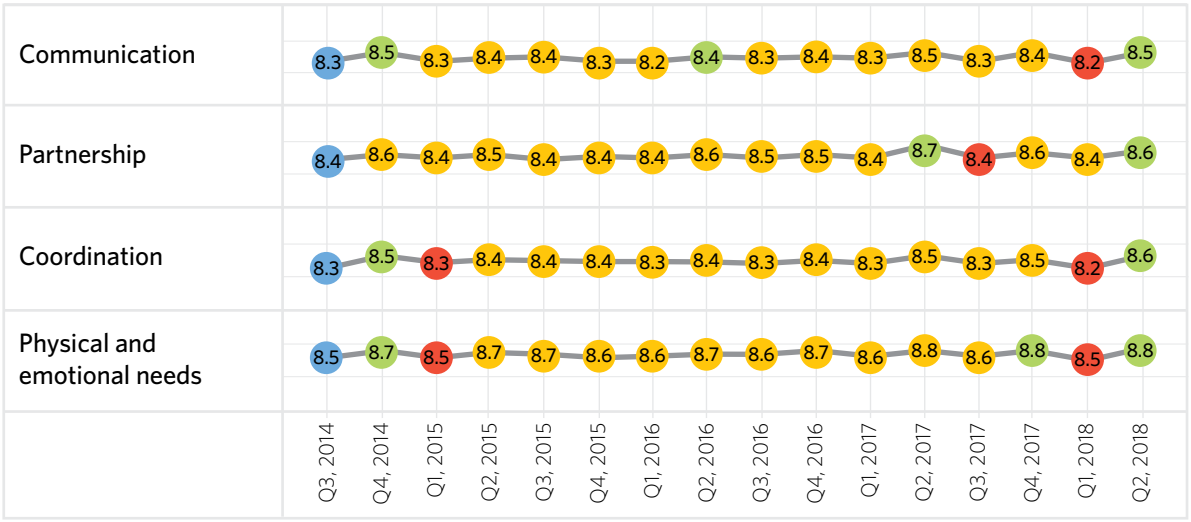
The Commission undertook two types of consumer surveys to capture the range of consumer experience at different points in the health system.

First, each quarter we sent patient experience surveys to selected patients who had spent at least one night in hospital.

Second, we conducted a primary care consumer experience survey on a quarterly basis. Responses revealed what consumers' experience in primary care is like, and how their overall care is managed between their general practice, diagnostic services, specialists and hospital staff.

Both surveys covered four key domains of consumer experience: communication, partnership, coordination and physical and emotional needs.

Survey results



We addressed the lower-scoring questions in our patient experience survey

Since the inpatient experience survey began in August 2014, patients have consistently provided low scores in response to two questions:

- Did a member of staff tell you about medication side effects to watch for when you went home?
- Do you feel you received enough information from the hospital on how to manage your condition after your discharge?

To understand the low scores, and to explore what steps we could take to improve the responses, we collaborated with DHBs.

We developed cost-effective interventions that DHBs could trial and roll out to improve patient ratings on these questions. We promoted nudge interventions and co-design approaches to improve patient experience of care.

Outcomes

In response to information and support we provided to DHBs, they took the following actions.

- Northland DHB made its transfer of care document more consumer-focused by placing the information relevant to patients in a more prominent place.
- Canterbury DHB improved its process of informing hospital staff of who was the point of contact for a patient. Patients now nominate a family or whānau member or another care partner as a point of contact; the contact details for that nominated person are maintained and accurate; and the terms used for the nominated person are consistent and clearly defined.
- Nelson Marlborough DHB followed up with patients following discharge (via a phone call from a hospital pharmacist) to check they had enough information to manage their medication.

Priority two: Equity | Whakaarotau tuarua: Te ōritetanga

Improving health equity

New Zealanders tend to think of equality in health outcomes as a fundamental right for all. However, in reality, there's a lot of work to do to achieve equity in health outcomes, or in the health system, for all New Zealanders.

The Commission has had a focus on equity since its inception in 2010. Equity is one of the three core strands of the New Zealand Triple Aim for quality improvement, which has always underpinned our work. Improving health outcomes for population groups with a focus on, among others, Māori and Pacific peoples, is also the Minister's priority.

We continued this focus in 2017/18 by introducing equity as a strategic priority in our 2017–21 Statement of Intent.

This year we have focused on understanding the extent of equity, so we can then develop strategies that contribute to addressing it.

Shining a light on equity

In *A Window on the Quality of New Zealand's Health Care 2018*, we summarise a range of data and measures that will help us better understand equity across our health system.

Inequities clearly exist across ethnic, age and socioeconomic groups in access to services, treatments, consumer experience and outcomes.

Māori, Pacific peoples and those with greater socioeconomic deprivation are more likely to have greater health needs and are also more likely to have difficulty accessing care. They're less likely to get the best care and, when they do access care, they are less likely to find care a positive experience.

The levels of inequity suggest that New Zealand's health system can perform better at each stage of the consumer journey, as a way of contributing to more equitable health outcomes and a better consumer experience.

Child and Youth Mortality Review Committee's 13th data report

The 13th data report from the Child and Youth Mortality Review Committee (CYMRC)[12] showed striking inequities in mortality for Māori and Pacific children and young people, as well as for children and young people experiencing socioeconomic hardship.

The report notes Māori and Pacific children and young people experienced higher mortality rates than non-Māori, non-Pacific children and young people in all age groups except for children aged five to nine years.

Mortality consistently increased with growing levels of deprivation (as measured by the NZ Deprivation Index). Children and young people living in the most deprived areas (NZ Deprivation decile 10) had mortality rates over three times higher than those living in the least deprived areas (decile 1). That means they were three times more likely to die than those living in the least deprived areas.

Many elements combine to make the Toiora exercise class for people with diabetes an excellent example of the Whakakotahi primary care improvement challenge in action.

Mere Te Paki, Hutt Union and Community Health Services (HUCHS) community health worker, clearly identifies the kaupapa of any further Toiora work: 'It needs to be owned by the community. It's about strengthening relationships.'

HUCHS is a Very Low Cost Access (VLCA) community-owned practice with an enrolled population of 50 percent or more high-needs patients, and the practice agrees to keep its fees at a low level.

One of the Minister's priorities is improving outcomes for those with obesity and diabetes – which aligns with this project. Toiora focused on patients with poorly controlled diabetes; those with HbA1c over 64 mmol/L. Of those, 209 patients had poor glycaemic control.

Of participants, 53 percent were Pacific, 25 percent were Māori and 22 percent were non-Māori and non-Pacific. As HUCHS is a community-owned practice and is managed by a community board, it has always been well connected to its local community.

To strengthen consumer participation the project team set up a consumer group called Te Kete Hauora.

The Commission was able to facilitate an improvement project that was generated and sustained by the high needs, Māori and Pacific diabetes community itself.

12. Child and Youth Mortality Review Committee. 2018. *13th data report: 2012–16*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/assets/CYMRC/Publications/CYMRC-13th-data-report-FINAL-Apr-2018.pdf.

The core element has been the community of people who came together to co-design the class and take part in the project over 12 weeks.

Through the co-design element, the group gave its feedback week by week, class by class, so that the class could change as it progressed. Before classes began, a pre-assessment and interviews also openly addressed personal goals and any concerns.

'Group members really were the masters of their own destiny when it came to our weekly sessions. The regular recording and acknowledgement of feedback and responses gave participants added confidence and trust [in the process] and ensured the class was something they enjoyed,' HUCHS manager Sally Nicholl says.

She also notes that one of the points of difference with Toiora was that no one went into the group as a stranger. 'Everyone knew someone else there, and people would travel together to the class. There were pre-existing relationships to build on... I don't think we would have had the retention that we've had [if we had just advertised].

'Chronic illness exercise classes are not a new thing, but it's the practicalities of the individuals and what they want to do that really helps them to keep going. Those practicalities are just as relevant as the statistics and theories,' says Sally.

In summing up the value of co-design, she says, 'We have the community leisure facilities, we have instructors, we have health care practitioners who share their knowledge, we have community nurses who can monitor progress and have patients who can take part. I believe we just need more cohesion between these public systems, and people with the passion to drive it.'

Sudden unexpected death in infancy

The CYMRC has tracked rates of sudden unexpected death in infancy (SUDI) since the committee was established in 2002.

Overall, mortality due to SUDI has shown a downward trend since 2002. However, inequities are still apparent for Māori and Pacific infants, whose mortality rates remain consistently higher than those for non-Māori, non-Pacific infants. Among Māori post-neonatal infants (aged 28 days to less than one year), mortality from SUDI during 2012–16 was over five times higher than it was among non-Māori, non-Pacific infants.

Suicide

Marked inequities in suicide are visible between Māori and non-Māori, non-Pacific children and young people from the age of 10 years onwards. Suicide was the leading cause of death in young Māori aged 20–24 years.

The pattern of suicide is also different for Māori children and young people. Deaths due to suicide in Māori tend to begin at a younger age than in non-Māori, non-Pacific. For Māori, the peak age of suicide begins at 16 years and continues until 20 years, whereas for non-Māori, non-Pacific the peak age is 20 years with fewer suicide deaths in children aged 10–14 years.

What we are doing to improve equity

The CYMRC published a report on SUDI with recommendations it had developed in consultation with stakeholders. Recommendations focused on supporting and informing the development of the Ministry of Health's national SUDI Prevention Programme, with a particular focus on improving equity for Māori and Pacific women, and their whānau and families. The CYMRC sought feedback from Ngā Pou Arawhenua (mortality review committees' Māori Caucus) in developing its special topic SUDI report and will work with the Caucus to produce a report on Māori deaths in 2018/19.

To address concerns about inequities in suicide rates for young Māori, the CYMRC is working on a collaborative special report with the Suicide Mortality Review Committee and Ngā Pou Arawhenua. The report looks at data on suicide for Māori children and young people and makes sector recommendations to improve systems that contribute to inequities.

Our patient experience surveys show specific areas where equity improvements can be made, informed by feedback from those experiencing inequity. For example, in our primary care consumer experience survey, Māori respondents reported a worse experience of coordination of their care than other respondents.

The survey is an important indicator of bias in the way the health system treats people. It identifies how well different parts of the system are working together to care for consumers.

We found that cost barriers to accessing primary care affect Māori, younger and more deprived populations disproportionately. Moreover, they have done so consistently for the past five years, despite changes in public health funding to reduce these barriers.

Whakakotahi

We have made equity a core part of all Whakakotahi projects, recognising the crucial role primary care plays in improving the health of all New Zealanders, addressing health inequity and reducing demand for secondary services.

The founding principles of Whakakotahi are equity, consumer engagement and integration. Whakakotahi aims to increase engagement between the Commission and the primary care sector, increase the capability of those involved to improve quality, and contribute towards improved processes leading to improved health outcomes. Co-design with consumers that are receiving services is key.

Three projects undertaken in February 2017 have neared the end of the improvement phase. With Whakakotahi 2018, six projects began in February 2018. For all Whakakotahi projects we provided expert improvement advice from our improvement advisors. Advisors also provided support and specific training. We provided a small amount to offset costs. By working closely with the project teams, we helped the teams to effect change. We provided project advice and experience dealing with health organisations – especially when teams got stuck. An evaluation of Whakakotahi commenced in 2017, with phase one completed in early 2018. Findings will be available once the second phase is completed in 2019 and 2020.

Inequities in mental health outcomes

People living with serious mental health problems are at a greater risk of many chronic health conditions and have a much shorter life expectancy than their counterparts in the general population. These inequities are due to greater exposure to known risk factors, including low socioeconomic status, high rates of smoking, alcohol and other drug use, reduced physical activity and poor nutrition, the side effects of psychotropic medication, and reduced access to physical health care.

In particular, people with serious mental health problems, and addiction service users, are significantly more likely to die of cancer than the general population – even though their rates of cancer are similar.

Tobacco smoking is up to three times higher among mental health and addiction service users, compared with the general population. Between 70 and 98 percent of people in treatment or recovery from substance use disorders are smokers.

Antipsychotics, and to a lesser degree antidepressants and mood stabilisers, are associated with increased risk of obesity, diabetes, cardiovascular disease, and sexual and reproductive and other physical health problems. Psychotropic medication is associated with relatively poor oral health.

A focus on mental health and addiction was also a strong component of the Minister's second strategic priority in 2017/18.

We are also contributing to this important area of health care, by leading a five-year mental health and addiction quality improvement programme, which uses an evidence-based quality improvement approach. It is identifying and testing different ways of improving health services, so people receive high-quality and safe care and support.

While the programme is new, we have adopted five priority areas of focus in mental health: zero seclusion: towards eliminating seclusion by 2020; improving service transitions, connecting care; learning from serious adverse events and consumer experience; maximising physical health; and improving medication management and prescribing.

We propose to eliminate seclusion in mental health and addiction (MHA) services by 2020

On 7 March 2018, in partnership with Te Pou o te Whakaaro Nui, we launched 'Zero seclusion: towards eliminating seclusion by 2020'. This is the first of five MHA quality improvement initiatives. It provides national and international perspectives on eliminating seclusion and uses a quality improvement approach, including co-design and testing change packages of evidence-based interventions. Areas of strong focus are improving equity and involving consumers, families and whānau in supporting long-term change.

What is seclusion?

Seclusion is a harmful practice that occurs in most acute inpatient units in Aotearoa New Zealand. Yet it's been eliminated in some parts of the world. Evidence suggests seclusion causes considerable harm to consumers who receive it and to staff who administer it.

Māori are over-represented in seclusion statistics. Of the people who accessed MHA services in 2015, Māori were nearly five times more likely to be secluded than non-Māori. Younger people, Pacific peoples and males were also more likely to be secluded.

Māori are also over-represented in other restrictive practices. In 2015, Māori were 3.3 times more likely to be subject to an inpatient treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Seclusion contravenes basic human rights. Article 1 of the United Nations Convention on the Rights of Persons with Disabilities calls on governments to remove barriers to enable all people to participate fully in society. The practice is also contrary to the Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment.

Efforts to reduce seclusion in Aotearoa New Zealand over the past eight years, supported by Te Pou o te Whakaaro Nui, have led to a 65 percent reduction in seclusion practice nationwide. However, overall progress has plateaued, and some services find it challenging to sustain gains or reduce seclusion further.

Experts advise that a strong cultural response is needed to meet the needs of Māori. This should include Māori peer support models, cultural advisors and culturally specific interventions.

Our recently formed Māori advisory group is actively working with DHBs to advance a kaupapa Māori model in mental health and to eliminate seclusion.

Inequities in mental health for Māori and Pacific peoples

Māori experience higher levels of mental health disorder than non-Māori. They are also more likely to experience serious disorders and co-morbidities than non-Māori.[13]

Māori make up approximately 16 percent of New Zealand's population, but account for 27 percent of all mental health service users. More Māori accessed mental health services (6.1 percent) than non-Māori (3.1 percent) in 2016.

The nationwide service coverage document requires DHBs to provide kaupapa Māori services. However, because it does not set a particular level of service, DHBs interpret the kaupapa Māori service specifications differently and the service delivered across the country is inconsistent. The quality of these services also varies, which may be due to lack of capability, resources or support.

We recently established an expert Māori advisory group, which is championing kaupapa Māori models to address inequities in mental health among Māori. This group is actively assisting and supporting DHB mental health teams to effect change and reduce inequities.

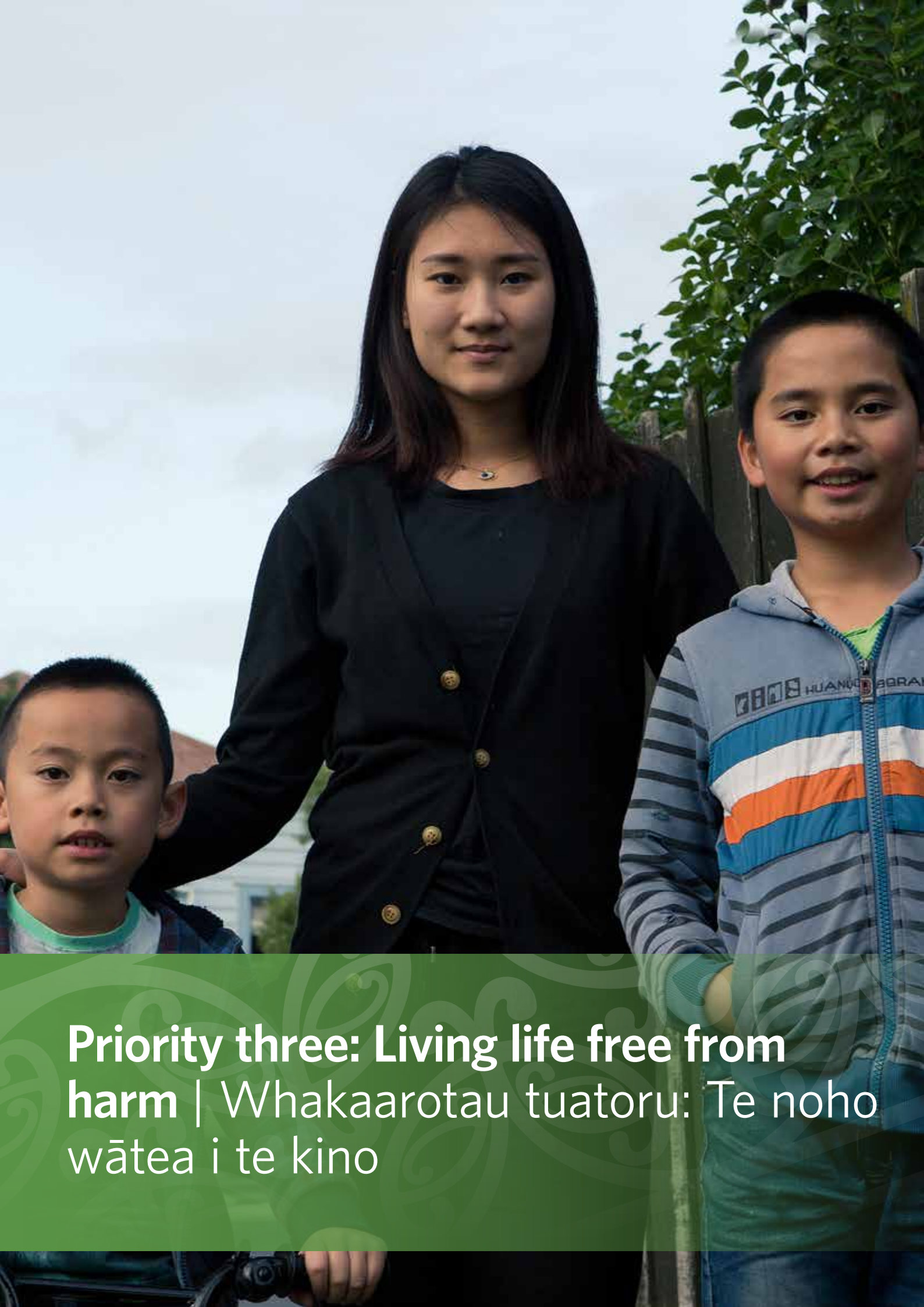
We are also using ethnic indicators to ensure services are collecting data that reflects ethnic issues in the services. Our intention is to co-design services to better meet specific equity needs, such as through ethnic-specific responses, models of care and interventions.

Next steps in our equity challenge

Following feedback, we will engage with internal and external Māori stakeholders and advisors in 2018/19, to explore how our work can better contribute to equity for Māori.

We aim to progress several initiatives to enhance our equity impact. One initiative planned for 2018/19 is a Performance Improvement Framework review that will include a focus on the Commission's responsiveness to Māori health equity. This focus will also acknowledge overlaps in our equity focus for other population groups.

13. Oakley Browne MA, Wells JE, Scott KM. 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey.* Wellington: Ministry of Health.



Priority three: Living life free from harm | Whakaarotau tuatoru: Te noho wātea i te kino

Living life free from harm

We implemented New Zealand's first national quality Surgical Site Infection Improvement (SSII) programme in 2012, in conjunction with district health boards (DHBs).

This initiative was a major reason why surgical site infection (SSI) rates have decreased dramatically from August 2015 to December 2017.

Hospitals do an amazing job of improving New Zealanders' health outcomes. In many cases, they literally save our lives and the lives of our families, whānau and loved ones.

A particular area of focus for the Commission is SSIs. These infections can cause emotional and financial stress, serious illness, longer hospital stays and long-term disabilities. In the worst case, they can result in the loss of life.

Because of their consequences for patients, as well as for health services, preventing SSIs is an extremely important focus for us.

A significant number of SSIs are preventable.

Our SSII programme

To reduce the risk of SSIs, we launched the SSII programme in 2012.

Centred on hip and knee arthroplasties, the programme has increased compliance with best practice across the country.

This year a focus on continued improvement helped to sustain the gains made. In particular, the nationwide median rate of SSIs fell to 0.91 percent in June 2015, from 1.36 percent in the baseline period of April 2013 to March 2014, and this rate was sustained through to 2017.

An evaluation found a patient who receives the three recommended interventions (timing, dose and skin preparation) is ***40 percent*** *less likely to get an SSI than a patient who has not had all three interventions.*

Hospital infection rates now known

'Our staff love the system and the benefits it brings.' Michelle Taylor, ICNet coordinator for Canterbury DHB

Information on infection rates and potential infection issues at Canterbury DHB is now immediately available to the infection prevention and control (IPC) staff. That's because of the introduction of an electronic surveillance system, ICNet.

Canterbury was the first DHB in New Zealand to begin using the electronic surveillance system in 2012. ICNet is now also used at West Coast and Taranaki DHBs.

Michelle Taylor says that, until the introduction of ICNet, IPC surveillance was a manual process.

'Surveying rates of methicillin-resistant *Staphylococcus aureus* and other micro-organisms was done manually. It involved multiple spreadsheets and took a huge amount of time, time that could be better spent on clinical care and advice, and education to medical and nursing staff,' she says.

Using ICNet means staff can monitor where the patients with the infections are within the hospital.

Michelle says that hundreds of microbiology samples are taken daily to detect micro-organisms that cause disease – too many to investigate manually. ICNet allows alerts to be set up so staff can be automatically notified if an infection is detected in a sample, rather than relying on verbal notification, which can be much slower.

With real-time data available, the IPC staff can immediately advise teams on the ward about what actions to take to prevent the spread of the infectious agent.

'The system can also alert us to whether an infection was acquired in hospital or was present on admission.' Michelle adds.

We continue to encourage DHBs to implement ICNet as an effective tool for achieving the aims of the SSII programme.

Reducing harm from falls

As a result of our work in falls prevention, more people in hospital were assessed for the risk of a fall and more people have an individualised plan of care to reduce the risk of falling. Since 2012 the rate of falls has significantly reduced.[14]

The Commission led the reducing harm from falls national programme in partnership with a wide range of stakeholders and service providers from 2012/13 to 2017/18. Our aim was to reduce the harm people can suffer if they fall and hurt themselves – especially older people receiving care, whether in hospital, residential care or their own home.

We developed tools and resources for frontline staff, consumers, families and whānau to help them better understand and assess a person's risk of falling and then develop a personalised plan of care to address these risks. These are summarised in a suite of evidence-informed 'Falls 10 Topics', which were widely used across the sector and internationally recognised.[15]

The rate of in-hospital falls causing a fractured hip per 100,000 admissions to hospital was 12.6 in the baseline period of July 2010 to June 2012. Since September 2014, that rate has decreased significantly to 8.4 per 100,000 admissions.[16] This reduction means fewer people in hospital are falling and fracturing their hip, which saves costs for hospitals and reduces the number of people admitted to aged residential care earlier than necessary.

While our core focus has been on the inpatient setting, we have partnered with the Accident Compensation Corporation (ACC) and the Ministry of Health to accelerate a whole-of-system approach to preventing falls and fractures. The result has been the development of a unifying brand, 'Live stronger for longer', and a falls and fracture outcome framework that sets a vision for the sector to promote prevention initiatives addressing frailty among an ageing population.

'A fall can be devastating for older people. It can make them fearful of falling again, which stops them doing the things they used to do. This can lead to social isolation and even depression. Every year, one in three people over 65 will fall. For people aged 80 and over, the risk increases to one in two.' Sandy Blake, the Commission's clinical lead, reducing harm from falls programme

April Falls 2018: The theme of our annual falls prevention awareness month was 'Live stronger for longer'.

We updated our 'Ask, assess, act' pocketcards and sent 200 copies to hospital falls leads.

Aged residential care

As part of our expanding work across the health sector, we continued to develop an improvement programme in aged residential care. In late 2017 and early 2018, we hosted regional workshops for those working in the sector to contribute to quality improvement in aged residential care in the future, and to give their ideas on how we can add value.

The workshops included an education session on care planning and the use of interRAI,[17] picking up on the key themes of communication and leadership facilitation for improvement.

We also shared with participants the latest clinical research on assessing frailty, high-risk indicators, and the development of frailty care guides.

At the workshops, we called for consumer stories and examples of best practice in improving care, with the aim of sharing these with the sector.

We identified key themes to help structure our programme of work. These focus on: leadership; using data for improvement; strengthening the voice of residents, families and whānau; building quality improvement capability; improving the safety culture; and providing a platform for shared learning. We have established a leadership group, led by seconded national clinical lead Dr Michal Boyd, to inform and guide this work as we partner with the aged residential care sector in our improvement efforts.

14. S Appleton-Dyer, N Edirisuriya, A Boswell. 2016. *Reducing harm from falls programme evaluation*. Wellington: Synergia for the Health Quality & Safety Commission.
15. *Ibid.*
16. www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers/qsms-january-march-2018/#[FALLS]
17. interRAI is a a suite of comprehensive clinical assessment tools, developed by an international collaborative to improve health outcomes for New Zealanders.

Adverse events

Aotearoa New Zealand has an excellent health system that provides safe and efficient care to the vast majority of Kiwis. However, about 12 percent of people using health care are harmed due to failures in the system – most of these adverse events are preventable.[18]

At the centre of every adverse event are a consumer and their family and whānau. We have a responsibility to these people to review and learn from each event, and to make effective changes to the system.

In 2017/18, the Commission published the following adverse event resources:

- an always report and review list
- a quality check for adverse event analysis for DHBs
- an eight-step guide to partnering with consumers, families and whānau following an adverse event.

We developed these resources according to international and national best practice, and in partnership with consumers, families and whānau.

An adverse event is an incident that results in harm to patients who use health and disability services. Adverse events involve negative reactions or results that are unintended, unexpected or unplanned. For instance, if a patient is accidentally given the wrong medication, which worsens their condition or leads to death, that is an adverse event.

National reporting of adverse events enables us to take a system-level view of the opportunities to improve patient safety. A key focus is sharing learnings across New Zealand.

We have increasingly focused on consumer, family and whānau engagement and have supported open communication with consumers who are adversely impacted by health services. This ensures people have information about what happened, the contributing factors, and actions people can take to prevent similar events occurring again.

We worked with providers to encourage an open culture of reporting, where people can learn from what happened and put in place systems to reduce the risk of similar events occurring in the future.

The revised National Adverse Events Reporting Policy was released in June 2017 and the focus for 2017/18 has been supporting its implementation.[19] There is an increased focus on the Policy applying to all health and disability providers.

Following feedback, we clarified roles at local and national levels, and made it easier for organisations to report adverse events, by streamlining the process. It's important the Policy demonstrates public accountability and transparency. The 2017 changes also strengthen the expectation that providers will include ethnicity data in adverse event reports as part of initial event notifications, so we can consider equity in future adverse event reporting.

Progress

At the end of 2017, we released the annual *Learning from adverse events* report, which includes a stronger focus on consumers as partners in learning from adverse events. We also published *How to engage with consumers following an adverse event* as a resource on our website.[20]

Targeting health professionals, we delivered four learning from adverse events training workshops, attended by over 200 health professionals, to improve the quality of reviews and engagement with consumers. We presented four Open Book reports that share learnings from specific events with other providers.

We produced data and commentary for mental health-related adverse events, which were provided in the *Office of the Director of Mental Health Annual Report 2016*.

The Commission also worked with HealthCERT on the reporting of pressure injuries from aged residential care facilities. We continued work with ACC and St John New Zealand on reporting adverse events, with a common purpose of learning and improving consumer safety. Forty staff from the ambulance sector participated in our learning from adverse events training workshops.

18. Health Quality & Safety Commission. 2017. *Learning from adverse events: Adverse events reported to the Health Quality & Safety Commission 1 July 2016 to 30 June 2017*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/3111.
19. *Ibid.*
20. www.hqsc.govt.nz/our-programmes/adverse-events/projects/engaging-with-consumers

Priority four: Getting the same care | Whakaarotau tuawhā: Te whiwhi i te manaaki hauora ōrite

Getting the same care

Variation across geographical areas

Across Aotearoa New Zealand, health care outcomes vary a lot. It helps to first get a picture of the extent of this variation, before we can help the sector to address the socioeconomic, geographical and systematic issues at play.

To gain this overview, we introduced the Atlas of Healthcare Variation. This tool displays easy-to-use maps, graphs, tables and commentary, which highlight variations across geographic areas in the way specific health services are provided and used, as well as variations in health outcomes.

The Atlas helps us to identify need in health care, and is designed to prompt dialogue and debate among clinicians, users and providers of health services about health service use and provision and why differences exist. We hope the dialogue and debate in turn stimulate improvement focused on overcoming those differences.

Addressing variation in Nelson Marlborough

It takes a village to look after a patient following an acute coronary event (heart attack) and that's what Nelson Marlborough DHB's cardiology services and its extended community team are aiming to achieve.

It all started when project lead and Nelson general practitioner (GP) Dr Elizabeth Wood saw our Atlas of Healthcare Variation.

'We found that only 62 percent of post-stent patients in our region were taking life-saving triple therapy in the year after their heart attack,' she says. So she decided to rally health services to close this gap, and put together a proposal for our Whakakotahi primary care quality improvement challenge.

'*Living longer and feeling better following a heart attack* is one of the three successful initiatives supported by the Whakakotahi programme,' says Dr John Wellingham, chair of the Commission's primary care expert advisory group. 'We provide advisors, support, training and $6,000 to offset costs, and the project teams provide the local knowledge and expertise, the can-do enthusiasm, and the drive to improve care.'

The team's aspirational aim was to help patients keep to their medication regime 100 percent at 3 and 12 months post-stent across the three general practices by December 2017. Although the team did not meet this ambitious goal in the timeframe it set, it has already made a difference and continues to make advances.

Dr Wood says the team is just at the beginning of trying to fully understand where the problems lie. 'Cardiology does an amazing job. However, when it comes to discharge from the service, things can unravel – starting with the transfer of information to the patient, the GP and community care.'

With support from our quality improvement advisors, the team has conducted a thorough analysis of the issue – an essential step before making changes.

'We identified a whole raft of factors,' says Fran Mitchell, quality improvement coordinator at Nelson Marlborough Health. 'These include that there was no standard process in the year post-discharge, poor integration between professional groups, and IT barriers. An "ah-ha" moment was when the hospital proudly said it never discharged a cardiac patient without the discharge summary, and the GPs replied that they don't always see it.

'From a patient, family [and] whānau perspective, there was often a lack of understanding about how to get back to wellness after a stent, what was needed for self-care and making positive choices.'

Using these insights, the team has come up with four key areas to work on: improving the discharge process; establishing a post-stent health pathway; reducing barriers to follow-up; and improving patient education. Putting together a set of measures to gauge success, they are embarking on testing a series of change ideas using a plan–do–study–act cycle.

Patient deterioration

The Commission's goal in the area of patient deterioration is to reduce harm from failures, and to recognise or respond to physical deterioration nationally for all adult inpatients, excluding maternity, by July 2021.

Because New Zealand's recognition and response systems have evolved locally, regions vary considerably in the vital-sign triggers they use to prompt escalation of care, their models of clinical

response and their organisational approaches to managing the care of deteriorating patients.

Taking a nationally consistent approach to recognising and responding to acute deterioration is beneficial to patients, clinicians and the system as a whole. An effective and sustainable system includes a standardised national vital signs chart with early warning score, and localised clinical escalation and response processes.

In a survey we undertook in late 2017, DHB staff said they liked the national patient deterioration recognition and response system, because it enabled and empowered them to escalate their concerns to senior staff.

Their feedback indicated that, when they can draw on the nationally and locally mandated recognition and response system, staff find it easier to address issues such as a sense of lack of support, and a fear of being blamed or reprimanded. Similarly, how much a responder trusts and respects their colleagues influences how they respond to escalation.

Having a standardised system increases confidence among staff because guidelines are clear. The more confident a recogniser is, the less likely they will be to hesitate in escalating care or to seek a second opinion about escalating care when escalation trigger points are reached. We also heard that some recognisers might not escalate care, or might hesitate to do so, because they were afraid of how responders might react.

During 2017/18, the patient deterioration programme supported all DHBs to prepare and implement improvements to their recognition and response systems across all their hospitals. At the end of June 2018, eleven DHBs had implemented improvements across all their hospitals. An additional five had implemented improvements at their main hospital and were preparing to implement in their other hospitals. Four were continuing their preparations to implement improvements during 2018/19.

Kōrero mai – patient, family and whānau escalation of care

Patients, families and whānau often recognise subtle signs of patient deterioration even when vital signs are normal, but may not have immediate access to health care. Communication problems are common in health services and this can delay treatment.

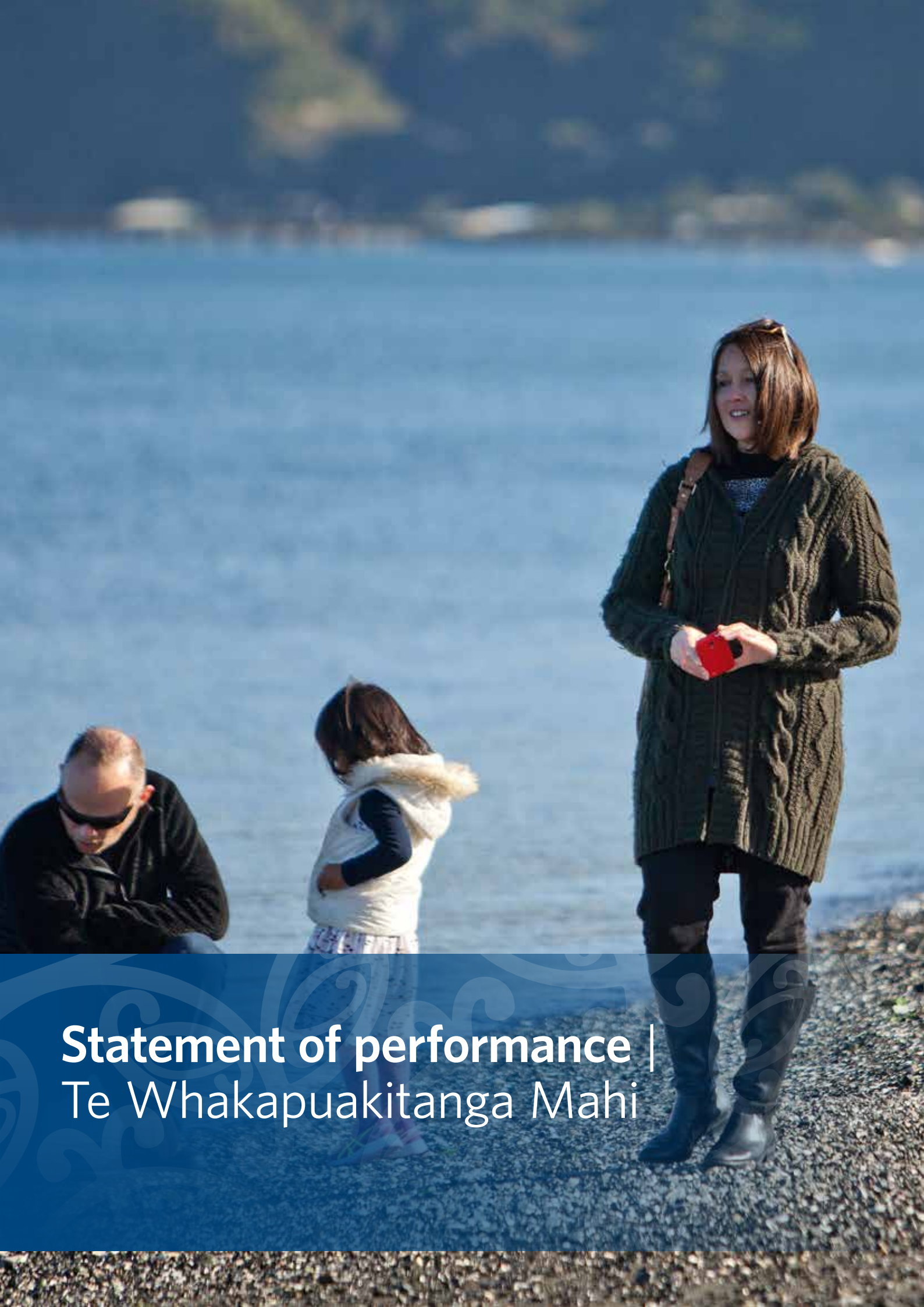
Patient, family and whānau escalation of care processes are a part of the patient deterioration recognition and response system. These processes allow patients, families and whānau to call for help when they are concerned about the patient's clinical condition and feel unable to get the help they need through engaging with the immediate care team. Escalation is intended to complement the work that staff do to recognise patient deterioration early.

We surveyed DHB staff in late 2017, and their feedback was that patients, families and whānau sometimes help recognise clinical deterioration early, but they are usually given the opportunity to communicate their concerns.

The survey indicated that DHBs need to consider raising awareness about the role of patients, families and whānau in recognising patient deterioration early. Staff also noted that DHBs should provide staff with training on communicating about deterioration, including towards the end of life.

Health care institutions internationally and throughout New Zealand are introducing these family-led escalation processes.

During 2017/18, the patient deterioration programme worked with four Kōrero mai lead sites to co-design and test patient, family and whānau escalation of care processes. Following further testing, these lead sites will be implementing their developed escalation processes across their hospitals and have linked this work to their clinical governance of recognition and response systems.



Statement of performance | Te Whakapuakitanga Mahi

Statement of performance

The Commission provided the Ministry of Health and the Minister of Health with information to enable monitoring of our performance. This included:

- quarterly statements of financial performance, financial position and contingent liabilities
- quarterly reporting on progress against our performance measures
- quarterly reporting on emerging quality and safety risks as part of the no surprises expectation
- an annual report in accordance with the Crown Entities Act 2004 and the Public Finance Act 1989.

Section 50D(3b) of the New Zealand Public Health and Disability Act 2000 requires the Commission to, at least annually, provide the Minister of Health with a report on the progress of mortality review committees. It must also include each such report in the next year's annual report.

Report against the Statement of Performance Expectations

The Commission's 2017/18 Statement of Performance Expectations was prepared in line with generally accepted accounting practice. It describes progress on our two output classes during 2017/18. For each class of outputs, it includes:

- the standards of delivery performance we achieved, as compared with the forecast standards included in our statement of forecast performance for 2017/18
- the actual revenue earned, and output expenses incurred, as compared with the expected revenues and proposed output expenses included in our statement of forecast performance for 2017/18.

The following sections report on our output performance measures in their respective output classes.

Output class 1: The intelligence hub

Our intelligence hub reflects the way our work is structured as our first output class.

International literature shows that measuring the quality and safety of health care and publishing the findings stimulates improvement. Used wisely, measuring and reporting on quality and safety engages clinicians, managers and consumers, generates informed discussion and improves the efficiency of the sector.

Measurement and evaluation allow us to identify problems and key opportunities to improve, as well as to provide, assess and share examples of good practice. Without good measurement and evaluation, we cannot identify the places where waste is happening due to poor quality, or whether interventions to reduce waste have worked.

Our performance measures

A = Achieved SA = Substantially Achieved

Report against the full set of national and international measures of quality and safety

		16/17	17/18
Publish one *Window on Quality* report by 30 May 2018[21]	Peer reviewed	SA	SA
Publish four integrated quality dashboards from July 2017 to April 2018[22]			

Patient experience indicators

		16/17	17/18
Publish four reports on patients' experience of hospital services, August 2017 to May 2018	Peer reviewed	A	A
Publish four reports on patients' experience of primary care, August 2017 to May 2018[23]			

Atlas of Healthcare Variation

		16/17	17/18
Update at least six domains of the Atlas of Healthcare Variation by 30 June 2018	Peer reviewed	A	A
Implement key recommendations of the Atlas evaluation to increase the sector's use of the Atlas by 30 June 2018			

21. The *Windows* publication was peer reviewed by the Ministry of Health, Central Region Technical Advisory Services (TAS) and academics.
22. The quality dashboards are reviewed by DHBs upon release.
23. Patients experience reports were peer reviewed by the patient experience survey governance group.

Adverse events

Publicly report on adverse events by 30 March 2018

Peer reviewed | 16/17: A | 17/18: A

Quality and safety markers

Publish four integrated quality dashboards from July 2017 to April 2018

Peer reviewed | 16/17: A | 17/18: A

Mortality review committee reports

Publish at least two mortality review committee reports by 30 June 2018

Evaluated | 16/17: A | 17/18: A

Informing the sector

Publish at least four articles or opinion pieces by 30 June 2018

Evaluated | 16/17: A | 17/18: A

Output class 2: The improvement hub

Our second output class flows on from our first output class of the intelligence hub. The improvement hub provides expert advice and commentary on quality and safety, to make improvements to health and safety outcomes for New Zealanders.

Our performance measures

A = Achieved

Expert advice, tools and guidance

Implementing teamwork and communication in DHB operating theatres

Reducing SSIs for people having hip, knee or cardiac surgery

Implementing a patient deterioration recognition and response system

Implementing the National Adverse Events Reporting Policy

All by June 2018

16/17: A | 17/18: A

Primary care improvement

Implement chosen primary care improvement programmes by 30 June 2018

Identify and select the next set of primary care improvement initiatives to implement in 2018/19, by 30 June 2018

Evaluated | 16/17: A | 17/18: A

Aged residential care improvement

Scope a potential improvement programme in aged residential care by 31 March 2018

Peer reviewed | 16/17: A | 17/18: A

Mental health and addiction improvement

Scope a potential improvement programme in mental health and addiction to begin in July 2018, by 30 June 2018

Establish four regional networks to support the potential programme by June 2018

Peer reviewed | 16/17: A | 17/18: A

Workshops featuring international speakers

Deliver at least two workshops featuring international speakers, including one scientific symposium, by 30 June 2018

Evaluated

16/17 A

17/18 A

Mortality review committees

Deliver at least two mortality review national conferences to share results and recommendations by 30 June 2018

Evaluated

16/17 A

17/18 A

Partners in Care

Deliver a co-design programme for consumer–provider teams focused on key providers by 30 June 2018

Peer reviewed

16/17 A

17/18 A

Support at least two DHBs to respond to the lower-scoring areas of the national adult inpatient experience survey by understanding the context of the scores and testin small-scale interventions in response

Build sector capability

Review the outcomes and sustainable improvement that our quality improvement advisor courses achieved by 30 June 2018

16/17 A

17/18 A

Review the implementation and outcomes of the Commission's *From knowledge to action* quality and safety framework

Build sector knowledge

Annual conferences, workshops and events to share good practice and innovation included:

16/17 A

17/18 A

- national workshops for infection prevention
- strengthening and maintaining regional networks to support clinical leadership for medication safety
- four regional workshops to support sector capability in learning from adverse events
- safe surgery regional workshops
- supporting the primary care improvement network
- deteriorating patient regional and national workshops.

All were completed by 30 June 2018.

Who we are | Ko wai mātou

Governance

The Board

The Commission is governed by a board of eight members who are appointed by the Minister of Health and led by Chair Professor Alan Merry. Two Board committees supported the Board's work in 2017/18.

The Audit Committee, including independent member Andrew Boyd from St John, provided assurance and assistance to the Board on our financial statements and internal control systems.

Te Rōpū Māori and Te Whai Oranga: Advancing the Commission's responsiveness to, and partnership with, Māori

As a Crown entity, we recognise our responsibilities to uphold our obligations under the Treaty of Waitangi. We refer to the Treaty of Waitangi principles as described in the Ministry of Health's Māori Health Strategy He Korowai Oranga and the Royal Commission on Social Policy's interpretation of Te Tiriti.[24] The principles of this strategy are:

- **partnership** – working together with Māori groups and communities to develop strategies for Māori health gain and appropriate health and disability services
- **participation** – involving Māori at all levels, including decision-making, planning, development and delivery of health services
- **protection** – working to ensure Māori have at least the same level of health as non-Māori, while safeguarding Māori cultural concepts, values and practices.

Māori advancement is a vital component of high-quality health care. The Commission works to improve the quality and outcomes of care for Māori, and address systemic inequity, through all the work we do. We have formed broad networks of Māori advice to and through our work programmes. We are proactively seeking more Māori staff to work for us, and we are building the capability of our current staff to understand and apply Treaty principles and an equity lens to all of the work they are involved in.

Te Rōpū Māori is an external advisory group that advises our Board and our chief executive on strategic issues, priorities and frameworks. The group also advises on our work programme and campaigns. Membership consists of up to six Māori health sector experts whose peers across the health and disability sector recognise them for their skills and knowledge.

In addition to Te Rōpū Maori, a network of clinical and expert advisors works with us across all that we do. Included in this network are Māori advisors that help us to identify key quality and safety issues for Māori consumers and their whānau. Te Rōpū Māori helps us to broaden this network and extend our collaboration.

The Māori members of our mortality review committees formed a 'Māori Caucus' (Ngā Pou Arawhenua) and have helped to make each committee's reviews more responsive to Māori. They have assisted the committees' processes, and, with their input, our analysis and recommendations have become more culturally valid and appropriate.

Te Rōpū Māori provides ongoing leadership in the development of Te Whai Oranga – our Māori advancement framework – and oversees its implementation. This framework supports and enhances the Commission's strategic direction, in working with the sector to achieve the best possible health outcomes for Māori and eliminate health inequities. Te Whai Oranga is a practical resource, linking strategic elements with practical examples and achievable goals, so it can guide Board members, advisors and staff members.

The proverb 'He ora te whakapiri, he mate te whakatakiri' is an expression of the concepts, and the sharing of ideas that have contributed to the development of Te Whai Oranga. It represents the whāriki (woven mat) of ideas woven together to form a framework of the cultural factors that will guide us to enhance the quality and safety outcomes for Māori in the health and disability sector.

In our mental health and addiction programme, the programme kaumatua/cultural advisor and members of the programme's Māori advisory group provided advice and Māori participation and actively supported project teams to improve equity.

Consumer Advisory Group

The Commission's Board established the Consumer Advisory Group to advise the Board and Chief Executive on strategic issues, priorities and frameworks. This includes advice from a consumer perspective, and a consumer view on health quality and safety.

The group also identifies key issues for consumers and organisations, including responsiveness to patients, consumers, families and whānau, the strategic direction of the Commission's programmes, and measuring and examining quality and safety.

24. Royal Commission on Social Policy. 1988. *The April Report.* Wellington: Royal Commission on Social Policy.

Staff

Staff wellness

Our staff are our number one resource. Many of our staff are passionate about their work and invest a lot of their energy and time working for the Commission. We see immense value in supporting our staff, so they are able to carry out their work, and still have time for their families and whānau, and out-of-work interests, and also are supported in dealing with work-related stress at work.

Rainbow Connection group

We formed our Rainbow Connection group in early 2018. The group comprise staff identifying as LGBTQ and supporters. We aim to lead by example to ensure gender and sexual orientation diversity is visible in our staff, our relationships and our outputs. Our Rainbow Connection group aligns with our second strategic priority of equitable health outcomes for all New Zealanders.

In 2018/19 the Commission will seek 'rainbow tick' certification, which shows employees, prospective employees, stakeholders and the wider world that we are a progressive, inclusive and dynamic organisation. A range of government agencies are considering or are in the process of getting the rainbow tick, and the State Services Commission is advocating for all government departments to seek certification.

Flexible working

We realise staff have families and whānau, and other commitments outside of work, and value supporting flexible work arrangements for employees who have carer responsibilities. We provided flexible working arrangements under the provisions of Part 6AA of the Employment Relations Act 2000. We also supported employees who require flexible work opportunities for a variety of other reasons, including further study and career development. Flexible work arrangements included:

- changes to hours of work
- part-time work (for example, to accommodate partial retirement or further study)
- working from remote locations and regional office space.

Some staff worked shorter days to accommodate school hours, while other staff worked from home to support this. Being flexible in these ways helped us maintain the skills we needed from our staff – it encouraged a working environment adaptable to the needs of our employees.

Health and fitness

Working in the health sector, we supported the fundamental difference good health makes to peoples' lives by promoting good health to our staff. We supported healthy lifestyles by providing readily available drinking and carbonated water, and free fruit for staff. We also have business-house sports teams, showers and changing rooms, a regular yoga group, and an active staff participation in various social events. In 2018/19 we will develop a gym for staff at our Wellington office.

Wellness and safety support

We have a safety and wellness committee that oversees these areas for staff. We provided staff with discreet access to the Employee Assistance Programme, should they require it. We also offered staff free life and terminal illness insurance up to $100,000, and free trauma benefits up to $20,000.

Staff also attended resilience workshops, and we provided clinical supervision for staff in the mortality review committees, due to the often-distressing nature of their work.

We fulfilled our obligations under the Health and Safety at Work Act 2015, and trained staff in the responsibilities set out in the Act. We provided emergency preparedness training to staff.

Supporting career and personal development through training

Our core expertise is in the science of consumer safety and quality improvement, clinical leadership, programme management, stakeholder engagement, the collection and use of information, and evaluation.

We have a dedicated staff training budget and encourage staff to identify future education and training needs and undertake relevant programmes. We arranged regular education and training opportunities for staff in 2017/18.

Training in cultural responsiveness

We provided te reo and Treaty training for all staff, and it's compulsory for staff to attend the Commission's annual visit to a marae. This is part of staff capability building towards gaining an understanding of Māori health care perspectives. In 2018/19 we are planning further initiatives in this area.

Equal employment opportunity policies

Our policy on equality and diversity included a firm commitment to equal employment opportunity principles. This ensured no discriminatory policies or practices, including harassment and bullying, existed in any aspect of employment.

Treating people fairly and with respect is at the heart of the way we work. Understanding, appreciating and realising the benefits of individual differences not only enhances the quality of our work environment but also helps us to better reflect the diversity of the community we serve.

Equal employment opportunity and diversity practices include hiring on merit, fairness at work, flexible working options and promotion based on talent. These opportunities relate to all aspects of employment including recruitment, pay and other rewards, career development and work conditions.

All staff involved in recruiting and managing staff were made aware of the requirements of our equal employment opportunity policy. We actively sought and targeted diversity as we recruited for vacancies. We are broadening our reach with Māori recruiters to actively look to increase our potential pool of Māori applicants for vacancies.

Staff profile

As at 30 June 2018 the Commission had 68 staff members (63 full-time equivalents, FTEs). Fifty staff were full time (52 in 2017) and 18 part time (14 in 2017). Sixty-five percent had more than two years of service with the Commission (59 percent in 2017). Fifteen percent of staff were fixed term.

	2018	2017
Female	72%	71%
Male	28%	29%
Māori	6%	7%
Pacific peoples	1%	0%
Asian	3%	4%
NZ European	79%	81%
Other ethnicity	10%	8%
Not declared	0%	0%
Age 20–29 years	7	7
Age 30–39 years	17	14
Age 40–49 years	17	22
Age 50–59 years	19	16
60+	8	7
People with disabilities (injury, illness or disability)	7.5%	7.5%

Remuneration

We worked closely with the Ministry of Health as our monitoring agency to reach agreement around annual remuneration levels.

Statistics New Zealand provides measures of gender equity for employers. Our gender pay gap for 2017/18 is calculated at 7.6 percent. This remains lower than the last reported public service average pay gap,[25] which was 12.5 percent in 2017 but is higher than the previous year (4 percent in 2017). If the calculation takes median hourly earnings into account, the gap is 12.9 percent (7 percent in 2017). We are unable to calculate a 'motherhood penalty' total because we do not collect this level of personal detail from staff.

In 2017/18 we provided regular update reports to the Minister with delegated responsibility for the Commission and provided quarterly update reports on performance against our Statement of Performance Expectations. We met regularly with the Minister and Associate Minister with delegated responsibility for the Commission and kept the Minister, Associate Minister and Ministry of Health informed of any potentially contentious events or issues in a timely manner.

25. www.ssc.govt.nz/2017-public-service-workforce-data-published

Collaboration and partnerships with stakeholders

Partners are vital to a small agency like the Commission. We tapped into the considerable expertise in the sector and internationally, and identified and learnt from existing innovative quality and safety practices. Of particular importance were our partnerships with DHBs, the Ministry of Health, the Health and Disability Commissioner, ACC, professional colleges and associations, clinical leaders, consumers and consumer groups, and our developing partnership with Māori. We also continued to develop strong international links, so we are well connected to innovation, evidence and advice from our colleagues overseas.

We developed partnerships for work in priority areas where our investment will be supplemented by investments other agencies have made. For example, for our work on SSIs, reducing harm from falls, neonatal encephalopathy and pressure injuries. ACC provided additional resources.

In 2017/18 we routinely engaged with the Ministry of Health in strategic planning and cooperation on joint work programmes. The Commission, the Ministry of Health, the Health and Disability Commissioner and ACC met to support collaboration and joint planning. The four agencies worked collaboratively and shared the different information each agency received.

Strategic advice to Government

The Commission's legislative responsibilities, as set out in section 59C(1) of the New Zealand Public Health and Disability Act 2000, included several aspects with a strategic advice function. In particular, we are responsible for advising the Minister of Health on:

- how quality and safety in health and disability services may be improved
- any matters relating to 1) health epidemiology and quality assurance and 2) mortality.

Improving internal efficiency

The Commission used the all-of-government procurement processes and contracting, unless there was a compelling reason not to. All-of-government processes are used for most of our office and information technology purchases, data storage, communications, print services and travel. We continue to tender for services on the Government Electronic Tender Service (GETS). We have implemented the ComplyWith legislative compliance information, monitoring and reporting programme, which is used by over 60 Crown-owned or funded entities, departments and companies, and by the Office of the Auditor-General. Financial services remain in-house.

Meeting our legal responsibilities

Through our governance, operational and business rules, we ensured we met our good employer requirements and our obligations under the Public Finance Act 1989, the Public Records Act 2005, the State Sector Act 1988, the Crown Entities Act 2004 and other applicable Crown entity legislation.

In 2017/18 we undertook two ComplyWith surveys for staff and one survey for Board members. These continued to show a high level of overall legislative compliance with no material breaches.

In line with the whole-of-government approach agreed by Cabinet, we are required to report on our progress with implementing the New Zealand Business Number (NZBN). In 2017/18 we received our NZBN (9429041905340); using it will help customers and suppliers get consistent information in our business interactions with them.

Risk management

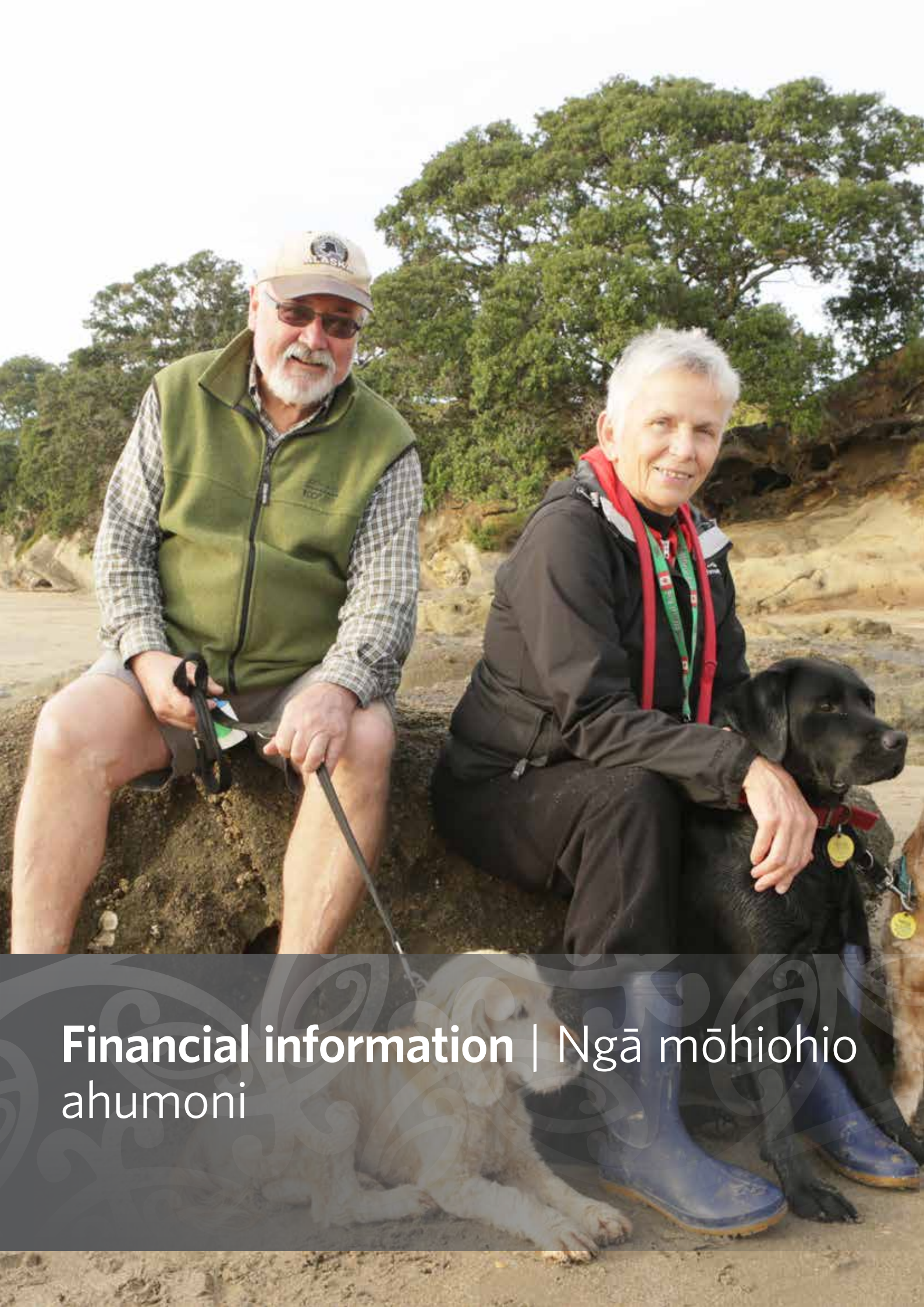
The Commission maintained a risk management register in 2017/18. Risk and health and safety are regular agenda items at Board meetings.

Permission to act despite being interested in a matter

For the period covered by this report, no instances occurred where permission was given to act despite being interested in a matter.

Revenue/expenses for output classes

	OUTPUT CLASS 1 Intelligence $000		OUTPUT CLASS 2 Improvement $000		TOTAL $000	
	Actual	Budget	Actual	Budget	Actual	Budget
Revenue						
Crown revenue	6,277	6,469	8,618	7,271	14,895	13,740
Interest revenue	25	16	38	24	63	40
Other revenue	217	52	3,460	2,265	3,677	2,317
Total revenue	**6,519**	**6,537**	**12,116**	**9,560**	**18,635**	**16,097**
Expenditure						
Operational and internal programme costs	4,728	4,078	7,129	7,065	11,857	11,143
External programme cost	2,107	2,459	3,501	2,585	5,608	5,044
Total expenditure	**6,835**	**6,537**	**10,630**	**9,650**	**17,465**	**16,187**
Surplus/(deficit)	(317)	0	1,487	(90)	1,170	(90)



Financial information | Ngā mōhiohio ahumoni

Financial statements

Statement of comprehensive revenue and expenses for the year ended 30 June 2018

Actual 2017 $000		Notes	Actual 2018 $000	Budget 2018 $000
	Revenue			
14,239	Revenue from Crown	2	14,895	13,740
18	Interest revenue		63	40
2,536	Other revenue	3	3,677	2,317
16,793	**Total revenue**		**18,635**	**16,097**
	Expenditure			
7,856	Personnel costs	4	8,709	8,446
147	Depreciation and amortisation	12,13	143	150
2,643	Other expenses	6	3,004	2,547
4,493	External quality and safety programmes		3,935	3,310
1,770	External mortality programmes		1,673	1,734
16,909	Total expenditure		**17,465**	**16,187**
(116)	**Surplus/(deficit)**		**1,170**	**(90)**
0	Other comprehensive revenue		0	0
(116)	**Total comprehensive revenue**		**1,170**	**(90)**

Explanations of major variances against budget are provided in note 27.
The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2018

Actual 2017 $000		Notes	Actual 2018 $000	Budget 2018 $000
	Assets			
	Current assets			
1,789	Cash and cash equivalents	7	2,699	1,715
205	GST receivable		226	290
220	Debtors and other receivables	8	540	354
109	Prepayments		71	52
2,323	**Total current assets**		**3,536**	**2,411**
	Non-current assets			
250	Property, plant and equipment	12	408	198
43	Intangible assets	13	21	64
293	**Total non-current assets**		**429**	**262**
2,616	**Total assets**		**3,965**	**2,673**
	Liabilities			
	Current liabilities			
1,087	Creditors and other payables	14	1,277	1,066
430	Employee entitlements	16	398	487
1,517	**Total current liabilities**		**1,675**	**1,553**
	Non-current liabilities			
45	Employee entitlements	16	66	0
45	**Total non-current liabilities**		**66**	**0**
1,562	**Total liabilities**		**1,741**	**1,553**
1,054	**Net assets**		**2,224**	**1,120**
	Equity			
1,170	General funds July		1,054	1,210
	Contributed capital	17	0	0
(116)	Surplus/(deficit)		1,170	(90)
1,054	**Total equity**		**2,224**	**1,120**

Explanations of major variances against budget are provided in note 27.
The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2018

Actual 2017 $000		Notes	Actual 2018 $000	Budget 2018 $000
1,170	Balance at 1 July		1,054	1,210
	Comprehensive revenue and expenses for the year			
(116)	Surplus/(deficit)		1,170	(90)
	Owner transactions		0	0
	Capital contribution		0	0
1,054	**Balance at 30 June**	**17**	**2,224**	**1,120**

Explanations of major variances against budget are provided in note 27.
The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2018

Actual 2017 $000		Notes	Actual 2018 $000	Budget 2018 $000
	Cash flows from operating activities			
14,239	Receipts from Crown		14,895	13,740
2,622	Other revenue		3,328	2,552
18	Interest received		63	40
(8,933)	Payments to suppliers		(9,134)	(7,698)
(7,753)	Payments to employees		(7,942)	(8,311)
10	Goods and services tax (net)		(21)	37
203	Net cash flow from operating activities	18	1,189	360
	Cash flows from investing activities			
(87)	Purchase of property, plant and equipment		(279)	(150)
(4)	Purchase of intangible assets		0	0
(91)	Net cash flow from investing activities		(279)	(150)
	Cash flows from financing activities			
0	Capital contribution		0	0
0	Net cash flow from financing activities	17	0	0
112	**Net (decrease)/increase in cash and cash equivalents**		**910**	**210**
1,677	Cash and cash equivalents at the beginning of the year		1,789	1,505
1,789	**Cash and cash equivalents at the end of the year**	**7**	**2,699**	**1,715**

Explanations of major variances against budget are provided in note 27.
The accompanying notes form part of these financial statements.

Notes to the financial statements

Note 1: Statement of accounting policies

REPORTING ENTITY

The Health Quality & Safety Commission (the Commission) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. The Commission's ultimate parent is the New Zealand Crown.

The Commission's primary objective is to provide services to the New Zealand public. It does not operate to make a financial return. Accordingly, the Commission has designated itself as a public benefit entity for financial reporting purposes.

The financial statements for the Commission are for the year ended 30 June 2018 and were approved by the Board on 15 October 2018.

BASIS OF PREPARATION

The financial statements of the Commission have been prepared on a going concern basis. The accounting policies have been applied consistently throughout the period.

Statement of compliance

The Commission's financial statements have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

These financial statements have been prepared in accordance with and comply with Tier 2 public benefit entities (PBE) accounting standards.

Measurement base

The financial statements have been prepared on an historical cost basis, except where modified by the revaluation of certain items of property, plant and equipment, and the measurement of equity investments and derivative financial instruments at fair value.

Functional and presentation currency

The functional currency of the Commission is New Zealand dollars (NZ$). The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

Changes in accounting policies

There have been no changes in accounting policies.

Financial instruments

In January 2017, the External Reporting Board issued PBE IFRS 9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with earlier application permitted. The main changes under the standard are:

- new financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost
- a new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses
- revised hedge accounting requirements to better reflect the management of risks.

The timing of the Commission adopting PBE IFRS 9 will be guided by the Treasury's decision on when the Financial Statements of Government will adopt PBE IFRS 9. The Commission has not yet assessed the effects of the new standard.

Critical accounting estimates and assumptions

In preparing these financial statements, the Commission has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are:

- Retirement and long service leave – refer to Note 16.

SIGNIFICANT ACCOUNTING POLICIES

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Revenue from the Crown

The Commission is primarily funded through revenue received from the Crown, which is restricted in its use for the purpose of meeting our objectives as specified in the Statement of Intent. The Commission considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement. The fair value of revenue from the Crown revenue has been determined to be equivalent to the amounts due in the funding arrangements.

Grants received

Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Interest

Interest income is recognised using the effective interest method.

Foreign currency transactions

Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into NZ$ (the functional currency) using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

Operating leases

Leases that do not transfer substantially all the risks and rewards incidental to ownership of an asset to the Commission are classified as operating leases. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the term of the lease and its useful life.

Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held at call with banks and other short-term, highly liquid investments, with original maturities of three months or less.

Debtors and other receivables

Debtors and other receivables are measured at face value less any provision for impairment. There are no provisions for impairment in 2017/18.

Bank deposits

Investments in bank deposits are initially measured at fair value plus transaction costs. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

Inventories

Inventories held for sale are measured at the lower of cost (calculated using the first-in, first-out basis) and net realisable value. There are no inventories held for sale in 2017/18.

Property, plant and equipment

Property, plant and equipment asset classes consist of building fit-out, computers, furniture and fittings, and office equipment.

Property, plant and equipment are measured at cost, less any accumulated depreciation and impairment losses.

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the Commission and the cost of the item can be measured reliably.

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported in the surplus or deficit.

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the Commission and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided using the straight-line (SL) basis at rates that will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Building fit-out	10 years	10% SL
Computers	3 years	33% SL
Office equipment	5 years	20% SL
Furniture and fittings	5 years	20% SL

Intangibles

Software acquisition

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs associated with maintaining computer software are recognised as an expense when incurred. Costs associated with the development and maintenance of the Commission's website are recognised as an expense when incurred. Costs associated with staff training are recognised as an expense when incurred.

Amortisation

Amortisation begins when the asset is available for use and ceases at the date the asset is de-recognised. The amortisation charge for each period is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Acquired computer software	3 years	33% SL

Impairment of property, plant and equipment, and intangible assets

The Commission does not hold any cash-generating assets. Assets are considered cash generating where their primary objective is to generate a commercial return.

Non-cash-generating assets

Property, plant and equipment, and intangible assets that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Goods and services tax

All items in the financial statements are presented exclusive of goods and services tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, New Zealand Inland Revenue is included as part of receivables or payables in the statement of financial position. The net GST paid to or received from Inland Revenue, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

The Commission is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

Creditors and other payables

Short-term creditors and other payables are recorded at their fair value.

Employee entitlements

Short-term employee entitlements

Employee benefits due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, and sick leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

A liability and an expense are recognised for bonuses where there is a contractual obligation or where there is a past practice that has created a constructive obligation.

Presentation of employee entitlements

Sick leave, annual leave and vested long-service leave are classified as a current liability. Non-vested long-service leave and retirement gratuities expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

Defined contribution schemes

Obligations for contributions to KiwiSaver, the Government Superannuation Fund and the State Sector Retirement Savings Scheme are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Note 2: Revenue from the Crown

The Commission has been provided with funding from the Crown for specific purposes as set out in the New Zealand Public Health and Disability Act 2000 and the scope of the 'National Contracted Services – Other' appropriation.

Apart from these general restrictions, no unfulfilled conditions or contingencies are attached to government funding.

An additional $1.125 million was received, consisting of:

- $0.750 million from the Ministry of Health for suicide review
- $0.200 million towards continuation of the joint Ministry of Health and Commission eMedicine programme for 2017/18
- $0.175 million from the Ministry of Health for bowel screening review.

Note 3: Other income

Other income was $3.677 million ($2.536m 2017) was received, consisting of:

- $1.500 million (2017 $nil) from DHBs for mental health quality improvement
- $0.956 million ($1.36m 2017) from DHBs for a contribution towards advance care planning
- $0.621 million ($0.738m 2017) from ACC and DHBs towards infection prevention
- $0.142 million ($0.044m 2017) from additional workshop and event revenue
- $0.108 million ($0.094m 2017) from adverse event training workshops
- $0.104 million (2017 $nil) from ACC for development of a falls dashboard
- $0.080 million ($0.025m 2017) from ACC and PHARMAC for Patient Safety Week events
- $0.048 million ($0.053m 2017) from DHBs for patient experience question set licencing
- $0.046 million ($0.051m 2017) towards continuation of the joint Ministry of Health and Commission eMedicine programme for 2017/18
- $0.032 million ($0.063m 2017) from ACC towards neonatal encephalopathy
- $0.040 million other.

Note 4: Personnel costs

	Actual 2017 $000	Actual 2018 $000
Salaries and wages	7,125	7,931
Recruitment	144	68
Temporary personnel	242	411
Membership, professional fees and staff training and development	122	155
Defined contribution plan employer contributions	148	158
Increase/(decrease) in employee entitlements	75	(13)
Total personnel costs	**7,856**	**8,709**

Employer contributions to defined contribution plans include KiwiSaver, the Government Superannuation Fund and the National Provident Fund.

Note 5: Capital charge

The Commission is not subject to a capital charge as its net assets are below the capital charge threshold.

Note 6: Other expenses

	Actual 2017 $000	Actual 2018 $000
Audit fees to Audit NZ for financial audit	32	30
Staff travel and accommodation	459	423
Printing/communications	260	220
Consultants and contractors	350	410
Board costs/mortality review committees*	557	802
Lease rental	394	400
Outsourced corporate services and overhead	582	713
Loss on property, plant and equipment	4	2
Other expenses	5	4
Total other expenses	**2,643**	**3,004**

*Mortality review committee costs increased in 2018 due to two new committees being established/implemented.

Note 7: Cash and equivalents

	Actual 2017 $000	Actual 2018 $000
Cash at bank and on hand	1,789	2,699
Total cash and cash equivalents	**1,789**	**2,699**

The carrying value of cash at bank and short-term deposits with maturities less than three months approximates their fair value.

Note 8: Debtors and other receivables

	Actual 2017 $000	Actual 2018 $000
Debtors and other receivables	220	540
Less: provision for impairment	0	0
Total debtors and other receivables	**220**	**540**

Fair value

The carrying value of receivables approximates their fair value.

Impairment

All receivables greater than 30 days in age are considered to be past due.

Note 9: Investments

The Commission has no term deposit or equity investments at balance date.

Note 10: Inventories

The Commission has no inventories for sale in 2017/18.

Note 11: Non-current assets held for sale

The Commission has no current or non-current assets held for sale in 2017/18.

Note 12: Property, plant and equipment

Movements for each class of property, plant and equipment are as follows.

	Computer $000	Furniture and office equipment $000	Leasehold improvements $000	Total $000
Cost or valuation				
Balance at 1 July 2016	258	308	37	603
Additions	48	26	16	90
Disposals	(49)	0	0	(49)
Balance at 30 June 2017/1 July 2017	257	334	53	644
Additions	268	11	0	279
Disposals	0	(4)	0	(4)
Balance at 30 June 2018	525	341	53	919
Accumulated depreciation and impairment losses				
Balance at 1 July 2016	146	170	4	320
Depreciation expense	71	43	8	122
Elimination on disposal	(48)	0	0	(48)
Balance at 30 June 2017/1 July 2017	169	213	12	394
Depreciation expense	68	41	12	121
Elimination on disposal	0	(4)	0	(4)
Balance at 30 June 2018	237	250	24	511
Carrying amounts				
At 1 July 2016	112	138	33	283
At 30 June and 1 July 2017	88	121	41	250
At 30 June 2018	288	91	29	408

The Commission does not own any buildings or motor vehicles.

There are no restrictions over the title of the Commission's assets nor any assets pledged as security for liabilities.

Note 13: Intangible assets

Movements for the Commission's single class of intangible asset are as follows:

	Acquired software $000
Cost	
Balance at 1 July 2016	208
Additions	4
Disposals	(74)
Balance at 30 June 2017/1 July 2017	138
Additions	0
Disposals	(19)
Balance at 30 June 2018	119
Accumulated amortisation and impairment losses	
Balance at 1 July 2016	142
Amortisation expenses	25
Elimination on disposal	(72)
Balance at 30 June 2017/1 July 2017	95
Amortisation expenses	22
Elimination on disposal	(19)
Balance at 30 June 2018	98
Carrying amounts	
At 1 July 2016	66
At 30 June and 1 July 2017	43
At 30 June 2018	21

Software is the only intangible asset owned by the Commission. There are no restrictions over the title of the Commission's intangible assets nor are any intangible assets pledged as security for liabilities.

Note 14: Creditors and other payables

	Actual 2017 $000	Actual 2018 $000
Creditors	452	610
Accrued expenses	630	663
Other payables	5	4
Total creditors and other payables	**1,087**	**1,277**

Creditors are non-interest bearing and are normally settled on 30-day terms. Therefore, the carrying value of creditors and other payables approximates their fair value.

Note 15: Borrowings (NZ IAS 1.77)

The Commission does not have any borrowings.

Note 16: Employee entitlements

	Actual 2017 $000	Actual 2018 $000
Current portion		
Accrued salaries and wages	86	88
Annual leave and long-service leave	344	310
Total current portion	430	398
Non-current portion long-service leave	45	66
Total employee entitlements	**475**	**464**

No provision for sick leave or retirement leave has been made in 2017/18. Provision for long-service leave has been made in 2017/18.

Note 17: Equity

	Actual 2017 $000	Actual 2018 $000
General funds		
Balance at 1 July 2017	1,170	1,054
Surplus/(deficit) for the year	(116)	1,170
Capital contributions	0	0
Balance at 30 June 2018	**1,054**	**2,224**

There are no property revaluation reserves as the Commission does not own property.

Note 18: Reconciliation of net surplus/(deficit) to net cash flow from operating activities

	Actual 2017 $000	Actual 2018 $000
Net surplus/(deficit)	(116)	1,170
Add/(less) movements in statement of financial position items		
Debtors and other receivables	96	(370)
Creditors and other payables	29	219
Depreciation	147	143
Prepayments	(56)	38
Employee entitlements	103	(11)
Net movements in working capital		
Net cash flow from operating activities	203	1,189

Note 19: Capital commitments and operating leases

Capital commitments

There were no capital commitments at balance date (2017 $nil).

Operating leases as lessee

The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:

	Actual 2017 $000	Actual 2018 $000
Not later than one year	353	334
Later than one year and not later than five years	255	549
Later than five years	0	0
Total non-cancellable operating leases	**608**	**883**

At balance date the Commission leases a property (from 1 March 2014) at Levels 8 and 9, 17 Whitmore Street, Wellington. The lease expires in March 2021 with a one-year right of renewal. The value of the lease to March 2021 is $0.863 million.

The Commission does not have the option to purchase the asset at the end of the lease term.

The Commission sub-leases an office space at 650 Great South Road, Penrose, Auckland, from the Ministry of Health for up to 10 staff. The sub-lease expires in December 2018.

There are no restrictions placed on the Commission by its leasing arrangement.

Note 20: Contingencies

Contingent liabilities

The Commission has no contingent liabilities (2017 $nil).

Contingent assets

The Commission has no contingent assets (2017 $nil).

Note 21: Related party transactions

All related party transactions have been entered into on an arm's length basis.

The Commission is a whole-owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the Commission would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management personnel

Salaries and other short-term employee benefits to key management personnel[26] totalled $1.13 million ($1.12m 2017).

26. Key management personnel for 2017/18 include the chief executive; director, learning & improvement and deputy chief executive; director, health quality intelligence; and chief financial officer. Board members have been reported separately.

Note 22: Board member remuneration and committee member remuneration (where committee members are not Board members)

The total value of remuneration paid or payable to each Board member (or their employing organisation*) during the full 2017/18 year was as follows:

	Actual 2017 $000	Actual 2018 $000
Prof Alan Merry* (Chair)	29	29
Shelley Frost (Deputy Chair)	18	18
Dr Bev O'Keefe*	15	15
Dame Alison Paterson	15	15
Dr Dale Bramley*	15	15
Robert Henderson*	16	15
Heather Shotter	15	0
Gwendoline Tepania-Palmer	15	15
Gloria Johnson*	0	15
Total Board member remuneration	**138**	**137**

Fees were in accordance with the Cabinet Fees Framework.

The Commission has provided a deed of indemnity to Board members for certain activities undertaken in the performance of the Commission's functions.

The Commission has taken Directors' and Officers' Liability and Professional Indemnity Insurance cover during the financial year in respect of the liability or costs of Board members and employees.

No Board members received compensation or other benefits in relation to cessation.

Members of other committees and advisory groups established by the Commission are paid according to the fees framework where they are eligible for payment. Generally, daily rates are $450 per day for chairs and $320 per day for committee members.

Note 23: Employee remuneration

Total remuneration paid or payable was as follows:

	Employees 2017	Employees 2018
$100,000–$109,999	8	6
$110,000–$119,999	7	6
$120,000–$129,999	9	8
$130,000–$139,999	1	1
$140,000–$149,999	1	0
$150,000–$159,999	0	1
$160,000–$169,999	3	3
$170,000–$179,999	1	2
$200,000–$209,999	0	0
$210,000–$219,999	2	2
$220,000–$229,999	0	0
$230,000–$239,999	0	0
$240,000–$249,999	1	1
$250,000–$259,999	2	1
$300,000–$309,999	0	1
$400,000–$409,999	0	1
$410,000–$419,999	1	0
Total employees	**36**	**33**

During the year ended 30 June 2018 no employees received compensation or other benefits in relation to cessation.

Note 24: Events after the balance date

There were no material events after the balance date.

Note 25: Financial instruments

The carrying amounts of financial assets and liabilities are shown in the statement of financial position.

Note 26: Capital management

The Commission's capital is its equity, which comprises accumulated funds. Equity is represented by net assets.

The Commission is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowing, acquisition of securities, issues guarantees and indemnities, and the use of derivatives.

The Commission manages its equity as a by-product of prudently managing revenue, expenses, assets, liabilities, investments and general financial dealings to ensure the Commission effectively achieves its objectives and purpose, while remaining a going concern.

Note 27: Explanation of major variances against budget

Explanations for major variances from the Commission's budgeted figures in the 2017/18 Statement of Service Expectations follow.

Statement of comprehensive revenue and expenses

The year-end result for the year to 30 June 2018 is a $1.170 million surplus against a planned Statement of Performance Expectations deficit of $0.090 million.

Of the $1.170 million surplus, $0.972 million relates to the receipt and recognition of third-party revenue in 2017/18 where revenue has been received yet associated expenses will occur in 2018/19. Specific areas are:

$0.450 million, suicide mortality review
$0.213 million, maternal morbidity review
$0.170 million, advance care planning training programme
$0.124 million, mental health and addiction quality improvement programme
$0.015 million, Patient Safety Week.

The balance of the surplus relates to the timing of the replacement of staff vacancies throughout the year and the programme timing of some 'non' Statement of Performance Expectation deliverables.

Additional expenditure on personnel, other expenses, and external quality and safety programmes are offset by additional revenue.

External mortality review expenditure was less than budgeted as work was delivered by the use of additional internal staffing and contractors rather than third-party providers.

Increases in other expenses are associated with travel, printing, communications, contractors, advisory groups, leasing costs, information technology (IT) support and software licensing for the additional staff required to deliver on the additional revenue during 2017/18.

Statement of financial position

Cash and cash equivalents were higher than budgeted due to the additional revenue received in 2017/18 where the expenditure against this revenue will occur in 2018/19.

Property, plant and equipment are higher than planned because the Commission purchased an additional laptop fleet at the end of the financial year. The Commission's existing laptop fleet is fully depreciated and will be retired in early 2018/19.

Statement of changes in cash flow

Because the Commission received an additional $2.5 million in revenue during the period, both revenue received and 'payment to suppliers and employees' are higher than budgeted figures.

Note 28: Acquisition of shares

Before the Commission subscribes for purchase or otherwise acquires shares in any company or other organisation, it will first obtain the written consent of the Minister of Health. The Commission did not acquire any such shares, nor are there any current plans to do so.

Note 29: Responsibilities under the Public Finance Act

To comply with our responsibilities under the Public Finance Act 1989, here we report the activities funded through the Crown Vote Health and how performance is measured against the forecast information contained in the Estimates of Appropriations 2017/18 and of those as amended by the Supplementary Estimates.

Monitoring and Protecting Health and Disability Consumer Interests (M36)

This appropriation is intended to achieve the following: Provision of services to monitor and protect health consumer interests by the Health and Disability Commissioner, District Mental Health Inspectors and Review Tribunals, and the Mental Health Commission.

Output class financials	Actual 2017/18 $000	Budget 2017/18 $000	Location of end-of-year performance information
Crown Funding (Vote Health – Monitoring and Protecting Health and Disability Consumer Interests (M36))	13,476	13,476	The end-of-year performance information for this appropriation is reported in the statement of performance as given on page 27.

The Commission also received Crown funding of:

- $0.750 million from Vote Health – Mental Health
- $0.390 million from Vote Health – National Personal Health Services
- $0.200 million from Vote Health – Health Workforce and Training
- $0.072 million from Vote Health – National Health Information Services.

Statement of responsibility | Te whakapuakitanga kawenga

The Board is responsible for the preparation of the Commission's financial statements and statement of performance, and for the judgements made in them.

The Board of the Commission is responsible for any end-of-year performance information provided under section 19A of the Public Finance Act 1989.

The Commission is responsible for establishing and maintaining a system of internal controls designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the Board's opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Commission for the year ended 30 June 2018.

Signed on behalf of the Board:

Prof Alan Merry ONZM FRSNZ
Chair
15 October 2018

Shelley Frost
Deputy Chair
15 October 2018

Auditor's report | Te pūrongo a te kaiarotake

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of the Health Quality & Safety Commission's financial statements and performance information for the year ended 30 June 2018

The Auditor-General is the auditor of Health Quality & Safety Commission (the Commission). The Auditor-General has appointed me, John Whittal, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, of the Commission on his behalf.

Opinion

We have audited:

- the financial statements of the Commission on pages 36 to 52, that comprise the statement of financial position as at 30 June 2018, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements including a summary of significant accounting policies and other explanatory information; and
- the performance information of the Commission on pages 9 to 25, 26 to 29.

In our opinion:

- the financial statements of the Commission on pages 36 to 52:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2018; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Standards Reduced Disclosure Regime; and
- the performance information on pages 9 to 25, 26 to 29:
  - presents fairly, in all material respects, the Commission's performance for the year ended 30 June 2018, including:
    - for each class of reportable outputs:
      - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
      - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 15 October 2018. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the Commission for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The Board is responsible for such internal control as they determine is necessary to enable them to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Commission for assessing the Commission's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to merge or to terminate the activities of the Commission, or there is no realistic alternative but to do so.

The Board's responsibilities arise from the Crown Entities Act 2004 and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Commission's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Commission's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Commission's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Commission's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the

financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Commission to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 8, and 30–35 and 53 but does not include the financial statements and the performance information, and our auditor's report thereon.

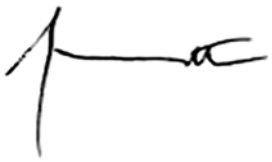
Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Commission in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1 (Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

In addition to the audit we have carried out a review on the engagement of consultants, which is compatible with those independence requirements. Other than the audit and this assignment, we have no relationship with, or interests in, the Commission.



John Whittal
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

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