Pūrongo ā-tau 2019/20

ANNUAL REPORT 2019/20

Kupu Taurangi Hauora o Aotearoa | Health Quality & Safety Commission

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Tā mātau matakitenga: Our vision

Hauora kounga mō te katoa

Quality health for all

Tā mātau uaratanga: Our mission

Whakauru | Whakamōhio | Whakaawe | Whakapai Ake

Involve | Inform | Influence | Improve

Ā mātau kaupapa matua pūmau, i ahu mai i Te Tiriti o Waitangi: Our enduring priorities, based on Te Tiriti o Waitangi

Kāwanatanga
Partnering and shared decision making

→

Tino rangatiratanga
Recognising Māori authority

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'Mā te whakātu, ka mōhio, mā te mōhio ka mārama, ma te mārama ka matau, ma te matau ka ora.'[1]

'With discussion comes knowledge, with knowledge comes light and understanding, with light and understanding comes wisdom, with wisdom comes wellness.'

We are pleased to present the Health Quality & Safety Commission's (the Commission's) Annual Report for the 2019/20 fiscal year.

As a Crown entity mandated under the New Zealand Public Health and Disability Act 2000 we are categorised as a Crown agent for the purposes of the Crown Entities Act 2004.[2] We drive and coordinate quality related activities and quality improvement initiatives at a national level, with strong clinical engagement and support.

We are committed to embedding Te Tiriti o Waitangi (Te Tiriti) in, and supporting mana motuhake to guide, our strategic direction throughout our Statement of Intent and within our Statement of Performance Expectations. Te ao Māori realities and worldviews are becoming central to our work and are reflected in our strategic priorities; in the way we interact with one another and with the people and organisations we work with.

This report outlines what we have achieved, our challenges, our progress against our performance measures and how we have managed our business.

During the early part of 2020, Aotearoa New Zealand went into a national lockdown in response to the first wave of the COVID-19 pandemic. On a global scale, this pandemic has disrupted many things we have taken for granted. Economic health consequences have been severe and will continue to have an impact for years to come. Aotearoa New Zealand responded early and vigorously to the threat this new virus posed. In particular, the health system had to rapidly learn and accelerate their response to the extraordinary threat the virus represented.

As a Commission we remained on track to meet our agreed deliverables until March when the effects of COVID-19 required us to stop, listen and act with haste in supporting and working with others. During this time, we continued to work on our deliverables.

From late March, the Commission responded and contributed to the COVID-19 response.

1 A whakataukī used by Marama Royal, Chair, Ngāti Whātua Ōrākei Trust in her he kupu nā te heamana (Ngāti Whātua Ōrākei Trust Deed proposed amendments).

2 A Crown agent must give effect to government policy when the responsible Minister directs it.

We released 13 staff on 'loan' to several agencies, and we aligned work across our infection, prevention and control and aged residential care programmes to provide guidance and practical help to the sector, including a suite tools and templates to help aged residential care facilities. Our advance care planning team reminded the sector that COVID-19 was an opportunity for people to plan for a scenario where they may become suddenly unwell. We were asked to develop a central repository of advice for the health workforce on staying safe and well physically and mentally.

Throughout the year, we strived to focus our work on achieving equitable health outcomes for all but particularly whānau Māori and Pacific peoples. We provided advice, data analytics, quality improvement programmes and educational workshops that contributed to ensuring services aim to achieve equitable outcomes and are contributing to a high performing health system. A safe and equitable recovery plan for COVID-19 remains a priority for the Commission into 2020/21.

The Commission continues to focus on fostering and expanding strategic partnerships that include iwi, hapū and Māori leaders, disability advisory groups, consumer advisory groups, health workforce leadership groups, Pacific advisory partnerships and primary health care partners. This year, we focused on embedding Te Tiriti and supporting mana motuhake throughout the organisation. To build a better understanding of te ao Māori worldview, the Commission's senior leadership team and staff engaged in further Te Tiriti workshops.

We worked with the Ministry of Health's Māori Health Directorate on the Māori Health Action Plan. This will help guide our activities to achieve equitable Māori health outcomes with the broader health sector goal of Pae Ora (healthy futures).

We welcome the opportunity to share the story of our year in 2019/20 and look forward to continued achievement and successful partnerships in the year ahead.

We remain grateful for this opportunity to share our performance story with you all.

Dr Dale Bramley
Chair
4 December 2020

Dr Janice Wilson
Chief Executive
4 December 2020

1 Introduction
Kupu arataki

The Health Quality & Safety Commission (the Commission) is a Crown entity operating within the complex landscape of the health and disability system. The Commission has worked to fulfil its health quality function by promoting a culture of continuous examination and quality improvement:

- through encouraging a focus on information, evidence and experience
- by coordinating quality interventions at a national level and promoting strong clinical leadership and engagement in quality and patient safety.

Our aim is to support a high-quality health system to:

- improve the experiences of people using health and disability services
- embed and enact Te Tiriti o Waitangi (Te Tiriti), and support mana motuhake for Māori
- achieve greater health equity
- support strong systems that enable safe, high-quality services.

Our work is based on a shared-improvement model: The New Zealand Triple Aim. We work alongside our partners and stakeholders to improve health and disability services across three domains:

- **Individual:** Improved quality, safety and experience of care for people and their whānau
- **Population:** Improved health and equity for all populations
- **System:** Best value for public health system resources.

We acknowledge the health and disability workforce as crucial in enabling health quality, equity and safety. We work with the workforce to build skills and capability across all that we do. We build sector leadership and capability to help the sector bring about change. Together with consumer engagement and evaluation, building leadership and capability in quality and safety underpins all the Commission's programmes.

We view health equity and Māori health advancement as separate but interlinked areas, with Māori health equity overlapping the two. We see how equity, Māori health equity and Māori health overlap, and how Te Tiriti provides the foundation for both. We recognise that Māori have their own health aspirations, priorities, goals and ways of working. We aim to work with Māori in Te Tiriti-based partnerships, offering tools, resources and support to advance Māori health, so all Māori can live long, healthy lives.

This annual report is presented in three sections.

Section 1 introduces the organisation and discusses our response to the health sector's call to action on COVID-19; how we have shaped our priorities through this disruptive time, and how we know our work is making a difference to the quality and safety of the health and disability sector over time.

Section 2 details what we set out to do in 2019/20 and what we have achieved. It covers our third party partnership work and work we have been doing with our partners.

Section 3 provides information about our organisation and what we are doing to strengthen and operate it well. This section covers our governance structures and finances.

Shaping our priorities in a disruptive period

In the last year of the Statement of Intent (SOI) 2017–21, the Commission sought to broaden engagement with the sector to understand what more could be done to influence health quality and safety improvement. The Commission did this through a performance improvement framework (PIF) self-review process that was completed in 2019.

The Commission worked with Māori partners and stakeholders to gain a better understanding of how it could support the health sector to advance Māori health and improve its performance. In the first half of 2020, the Commission completed its SOI 2020–24. The Commission also completed a new statement of performance expectations (SPE) adapted for COVID-19 priorities.

In recognition of its responsibilities under Te Tiriti, the Commission reviewed the widely accepted interpretation of Te Tiriti principles of partnership, participation and protection of Māori and chose to use the three articles of Te Tiriti and the Ritenga Māori declaration to underpin its work.

From the four main areas challenged by the PIF self-review stakeholders, the Commission has reshaped its priorities and strengthened its commitment to embedding and enacting Te Tiriti and supporting mana motuhake in all its work.

The table below highlights the Commission's strategic shift in the way it thinks, does and acts on the work it has committed to in its SPE, which is always based on its strategic priorities in the SOI.

Statement of Intent 2017–21 – strategic priorities and SPE 2019–20	**Four main areas challenged to improve our performance (PIF 2019)**	**Statement of Intent 2020–24 – strategic priorities**
Advancing Māori health	Embed and enact Te Tiriti o Waitangi within the Commission and all its work, supporting mana motuhake	Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake
Improving consumer–whānau experience	Outline a clear strategy that places equity at the centre of quality (and cultural safety at the centre of safety)	Improving experience for consumers and whānau
Achieving health equity for all	Develop a new operating model, moving from targeted quality improvement projects to supporting and facilitating system improvement	Achieving health equity
Improving patient safety and reducing mortality	Build a system more strongly focused on consumers and whānau	Strengthening systems for quality services
Reducing unwarranted variation in patterns of care		

Our call to action on and response to COVID-19

Our organisation, like others, responded to the challenges that the COVID-19 pandemic presented to the health and disability sector, to our own workforce, to users of health services and to our partners.

In the short term:

- we refocused our work to help the health and disability sector
- we refreshed and expanded resources on infection prevention and control, including focused support for the aged residential care (ARC) sector. We developed shared decision-making resources to support conversations between clinicians, whānau and consumers
- we developed a web-based hub to provide the health and disability workforce with online resources and webinars on keeping themselves well and safe.

We also supported and contributed to the sector response by loaning staff to:

- work in the Ministry of Health
- work with health providers providing essential services
- work with mental health services
- provide communications advice
- work with aged care providers with resources and advice
- provide clinical advice for health line enquiries
- work with whānau, and those providing services to whānau, with advance care planning.

We have reflected on our experiences and those of others during this time and considered what changes we need to make as a result of COVID-19. Analysis of the broader effects of our COVID-19 response highlights that a strong health quality focus is needed to support the health system to identify and manage emerging quality, equity and safety risks proactively.

Our work has changed in areas to let us:

- focus on developing a stronger and more flexible digital environment, not only internally but throughout the health sector. This will strengthen engagement with whānau Māori, Pacific peoples and all recipients of health services across the sector
- gain an understanding of the effects of the economic recession, which are significant post-COVID-19. The working environment has changed, telehealth is an emerging option of triage and access to health services and the effects of this need to be understood
- analyse data on quality, safety and equity; data held in the Atlas of Healthcare Variation domains and inpatient experience surveys of in-hospital and primary care patients; and data gained from the Commission's mortality review committees. This information will provide us with important monitoring channels to reduce the current and future health impacts of Māori, Pacific peoples and other population groups
- consider the effects of delays in diagnosis and treatment of other conditions resulting from our COVID-19 response.

In the medium term, our analysis will focus on highlighting the broader effects of COVID-19 on the health system, in particular, on equity of access and quality of treatment and outcome. This information will be shared, to support the health system 'recover' after the disruption caused by COVID-19.

Measuring our input and the value we add[3,4]

It is not always possible to attribute the results of change directly to our improvement programmes, because many people and organisations work with us and share these achievements. We can show, however, the measurable improvement, in terms of harm prevented and money saved, in those areas we have worked with our stakeholders to improve.

Child and Youth Mortality Review Committee

To reduce **deaths** of children and young people aged **28** days to **24** years

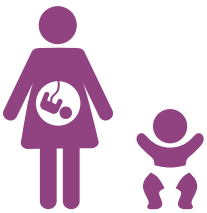
Since 2010, there have been **1,248 fewer deaths** than would have been expected given historical trends

The greatest reduction in deaths has been in sudden unexpected death in infancy (SUDI) and motor vehicle crashes

Equates to **$640 million** cumulative value to date

Note: Based on the value of a statistical life ($4m) discounted across average life expectancy

Perinatal and Maternal Mortality Review Committee



To reduce maternal deaths and deaths of infants after **20** weeks gestation up to and including **28** days of life or **400** grams weight

Since 2015 there have been **133 fewer** foetal deaths

Equates to **$43 million** cumulative value to date

Note: Based on the value of a statistical life ($4m) discounted across average life expectancy

Healthcare associated infections

To reduce the incidence and impact healthcare associated infections in New Zealand

Surgical site infection (SSI) rates for hips and knees have reduced from **1.2%** to **0.9%** since August 2015 resulting in **92** fewer infections and **$3.7** million in avoided costs

Equates to **46** additional years of healthy life from avoided SSIs worth **$8.3 million**

3 Measuring value and costs saved. Value and costs saved can be measured in two ways. The first is spending health care dollars more effectively. The second way to provide value is for people to live longer, healthier lives. Based on what New Zealanders say they are prepared to spend to save a life, we can calculate the value of a life at $4 million. This can be changed to give a value for a year of life in good health, which is estimated at $180,000.

4 Infographic and data displayed on pages 8 and 9 have not been audited.

Measurement and evaluation

Stimulate improvements through the use and publication of information
6/6 updated Atlas Of Healthcare Variation domains showed either a significant reduction in variation or an improvement at an overall national level for at least one measure

7,350 more people with diabetes regularly receiving metformin or insulin

12,300 fewer people 65+ dispensed 5 or more medications

250 fewer infections following major surgery

225 fewer admissions for asthma in adults

Falls

The original aim of the programme was to achieve and sustain a 20% reduction in the number of inpatient fractured necks of femur (FNOF)

Maintained processes for falls risk assessments in hospitals for older people (**88%** in quarter 4, 2019)

Increased completion of individual care plans (**93%** in quarter one, 2018)

OUTCOME

168 fewer falls with FNOF (Sept 2014-Mar 2020)

$7.9 million in avoided costs (Sept 2014-Mar 2020)

VALUE

268 additional years of healthy life from avoided FNOF, **$48.5** million value

Patient deterioration

Reduce harm from failures to recognise or respond to physical deterioration nationally for all adult inpatients (excl maternity) by July 2021

District Health Boards using the New Zealand early warning score through the national system (15/20 at baseline January 2018)

67% of patients correctly escalated (58% at baseline April 2018)

In-hospital cardiopulmonary arrests **1.1** per 1,000 admissions

2 What we did
Ngā mea i mahia e mātou

Section 1 outlines the challenges presented to our organisation by the COVID-19 pandemic and how we responded. Despite the 'call to action' that we had from March to May 2020, we still met almost all of the expectations we set for ourselves.

This section presents the Commission's Statement of Performance and highlights what it set out to do and what it did. It gives an overview of other work completed in partnership with and funded by third parties. This work adds to the quality and safety of the health and disability system but is not part of the Commission's formal performance expectations.

Statement of Performance

The Commission provided the Ministry of Health and Minister of Health with information to allow monitoring of its 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 Public Finance Act 1989.

Section 50D(3b) of the New Zealand Public Health and Disability Act 2000 requires the Commission to, at least yearly, report to the Minister of Health on the progress of mortality review committees. It must also include each report in the next year's annual report, which provides the Commission's report against its Statement of Performance Expectations (SPE).

Report against the Statement of Performance Expectation

The 2019/20 SPE was prepared in line with generally accepted accounting practice. It describes progress on our two output classes during 2019/20. For each class of outputs, it includes:

- the standards of delivery performance we achieved, compared with the forecast standards included in our statement of forecast performance for 2019/20
- the actual revenue earned, and output expenses incurred, compared with the expected revenues and proposed output expenses included in our SPE for 2019/20.

The following section reports on our output performance measures in their respective output classes.

Output class 1: Intelligence

Good intelligence is essential for driving improvement, and does so in three ways:

- by providing an understanding of the quality of health services and how well they meet the needs of the population they serve – this is a prerequisite for improvement
- by providing information for publication about the quality of services – when done well, this is shown to stimulate improvement
- by evaluating the effects of improvement activities on services – without this, it is not possible to know if improvement activities have worked.

Performance measures overview: Intelligence

SPE no	Deliverable/activity output	Performance measure	2018/19	2019/20
1	Implement a new consumer engagement quality and safety marker[5]	The number of district health boards (DHBs) submitting data to the supporting, understanding, responding and evaluating (SURE) framework by June 2020[6]	NM	A
2	Publish four reports on patient experience of hospital services and four reports on patient experience in primary care	(M1) The percentage of DHBs that have explicit actions in their annual plans to address specific results of the patient experience survey(s)[7, 8]	A	A
		(M2) Improvements in the reported patient experience maintained[9, 10]	NM	A
3	Publish at least two mortality review committee reports	(M1) Evidence-based reports are published and recommendations for improvements are made by June 2020[11]	SA	A
		(M2) Recommendations for improvement from previous reports are implemented by DHBs, health providers and professionals and monitored over five years[12]	NM	NA
4	Publish four updates of the quality and safety markers (QSMs)	(M1) Performance against process level thresholds maintained across QSMs[13 14]	A	A
		(M2) Improvements in outcome markers maintained[15]	A	A
5	Six Atlas of Healthcare Variation domains and updates will be published	(M1) Number of website hits to the Atlas of Healthcare Variation remain at current levels (an average of 1,500 hits per month)[16 17]	A	A
		(M2) All DHBs have explicit actions in their annual plans using the Atlas of Healthcare Variation (100%)[18]	A	A

Note: A = achieved; NM = new measure; SA = substantially achieved; NA = not achieved

5 https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/news-and-events/news/4043/

6 Four district health boards (DHBs) are taking part in the project, all DHBs have consumer engagement in the quality improvement section of their Annual Plan 2021. Links can be found here to project feedback: www.hqsc.govt.nz/our-programmes/partners-in-care/work-programmes/co-design/#[2019-20.

7 www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/patient-experience/adult-inpatient-experience/survey-results

8 https://public.tableau.com/profile/hqi2803#!/vizhome/Primarycarepatientexperiencesurveyresults/Story1

9 www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/4050

10 www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/4045

11 Refer to Mortality Review Committee narrative page 16 of this annual report.

12 Refer to Mortality Review Committee narrative page 17 of this annual report.

13 All reports quality and safety markers: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers.

14 https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/news-and-events/news/3987

15 All reports quality and safety markers: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers.

16 This was monitored each month and reported quarterly.

17 https://nsfl.health.govt.nz/system/files/documents/pages/june_update_2019-20_dhb_annual_plan_guideline_2.docx

18 All DHBs are expected to have quality improvement covered off page 53 of the June update of the DHB Annual Plan and Planning Priorities Guidance 2019/20, page 53: https://nsfl.health.govt.nz/annual-plan-guidelines-201920.

Output class 2: Improvement

The Commission's improvement work advances its strategic priorities in tangible ways. We have an increasing focus on partnering with Māori leaders, non-governmental organisations, consumers and whānau. We work with our intelligence hub to guide specific indicators and measures to help test and implement our improvement work.[19]

This work includes:

- building the capability of providers, consumers, families and whānau to work together as partners in care
- increasing the number of health professionals who take up evidence-based practice by translating evidence into tools and resources for frontline staff
- supporting networks to build momentum, champion and lead quality improvement, and sustain change in the longer term
- building quality improvement and clinical leadership capability.

Performance measures overview: Improvement

SPE no	Deliverable/activity output	Performance measure	2018/19	2019/20
6	Advancing Māori experience of adverse events within a hospital environment	Develop a kaupapa Māori quality improvement framework and resources that can guide improvement initiatives	NM	NA
7	Improve Māori experience of adverse events within a hospital environment	(M1) Complete the report on Māori experience of adverse events by 30 June 2020[20]	NM	A
		(M2) Quality improvement actions are identified[21]	NM	A
8	Expand and spread Kōrero mai	(M1) Two additional cohorts of the Kōrero mai programme under way in district health boards (DHBs) [22]	A	A
		(M2) DHBs measure the effect of Kōrero mai[23]	A	A
		(M3) Evaluation report due 30 June 2020[24]	NM	NA
9	Deliver a co-design programme nationally for consumer–provider teams focused on cancer	Teams will report on how the learnings from their co-design projects have contributed to improving services for consumers and whānau[25]	NM	A
10	Implement the chosen Whakakotahi 2019 primary care improvement projects	(M1) An evaluation shows the effect of the initial three 3-year phase of the programme and informs the future design and options for scale and spread in primary care by 30 June 2020[26]	A	A
		(M2) Final evaluation report due 30 June 2020[27]	A	A

19 See the 'Measuring our input and the value we add' section of the Annual Report pages 8 and 9.

20 www.hqsc.govt.nz/assets/Reportable-Events/Publications/Nga_Taero_a_Kupe_final_web.pdf

21 *IBID section I Findings pages 20-36.*

22 www.hqsc.govt.nz/our-programmes/patient-deterioration/news-and-events/news/4020/

23 https://www.hqsc.govt.nz/our-programmes/patient-deterioration/publications-and-resources/publication/3551/

24 https://www.hqsc.govt.nz/assets/Deteriorating-Patient/PR/Synergia-rapid-summary-report-Korero-mai-cohort-two-Oct-2019.pdf

25 www.hqsc.govt.nz/our-programmes/partners-in-care/work-programmes/co-design/#[2019-20

26 www.hqsc.govt.nz/our-programmes/primary-care/resources-for-providers-starting-quality-improvement-projects

27 www.hqsc.govt.nz/our-programmes/primary-care/publications-and-resources/publication/3892

SPE no	Deliverable/activity output	Performance measure	2018/19	2019/20
11	Implement a mental health and addiction quality improvement programme with a focus on zero seclusion, connecting care and the start of learning from adverse events	(M1) Sustainable approach to zero seclusion, delivery of connecting care collaborative and initiation of learning from adverse events[28]	A	A
		(M2) DHB engagement framework shows achievement against milestone (eg, attendance at events, key documents and plan–do–study–act (PDSA) testing of changing ideas)[29]	A	A
		(M3) Measurement framework in place for zero seclusion and connecting care, which includes outcome, process and balancing measures[30]	NM	A
12	Development of the healthcare associated infection hub in partnership with DHBs	(M1) Continued implementation of evidence-informed process improvements to reduce surgical site infections[31, 32]	A	A
		(M2) Point prevalence survey implemented and agreement on priorities for the healthcare associated infection hub	A	A
13	Strengthen improvement science capability in primary and secondary care settings	Sponsor participation in quality improvement advisor and quality improvement facilitator training programmes for primary care and mental health and addiction services[33]	A	A
		Scope a programme aimed at developing senior clinician leadership capability for quality and safety[34]	A	A

Note: A = achieved; NM = new measure; PA = partially achieved; SA = substantially achieved; NA = not achieved

All our work is aligned to the SOI. In 2019/20, a new SOI was developed. For this reporting period, we show in the performance measures where the deliverables align to the SPE 2019/20.

28 https://www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/news-and-events/news/4140/

29 https://www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/news-and-events/news/4140/ pages 29–30.

30 www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/projects/surgical-site-infection-improvement.

31 www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/publications-and-resources/publication/3560

32 www.hqsc.govt.nz/our-programmes/health-quality-evaluation/news-and-events/news/3987

33 www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/news-and-events/news/4056

34 Open Forum: Why is it so hard to be open? The pitfalls and promise of transparency in health care: www.hqsc.govt.nz/news-and-events/event/3885 as part of understanding the scoping exercise.

Our work in 2019/20

Consumer engagement quality and safety marker

Quality and safety markers (QSMs) are designed to track progress to help improve health care and reduce patient harm.

During the year, we piloted the consumer engagement QSM (with oversight from the reference group) with four district health boards (DHBs). Guidance was also developed, but wider implementation scheduled for February 2020 with more DHBs was delayed due to the COVID-19 lockdown and competing priorities.

Working with the Ministry of Health, the Commission was successful in getting the QSM into the DHBs' Annual Planning Quality Improvement section for the 2020/21 year. All DHBs will report at least once a year on their progress with implementing the consumer engagement QSM within their respective areas.

Did we do what we set out to do?

Deliverable (SPE 1)	**Performance measure**	**Strategic priority** ***Improving consumer and whānau experience (2)***[35]	**Achieved** **Partially achieved** **Not achieved**	**Outcome**
Deliverable (SPE 1): Implement the new consumer engagement quality and safety marker			A new consumer engagement quality and safety marker has been produced and is in all DHBs improving health quality sections of their Annual Plans **(Achieved)**	Support involvement of consumers and their families and whānau in an equal partnership leading to improvements in health and disability services[36]
Performance measure: The number of district health boards (DHBs) submitting data to supporting, understanding, responding and evaluating (SURE) framework by 30 June 2020			Framework developed and four DHBs involved. In 2020/21, all DHBs will report against this **(Achieved)**	

Patient experience surveys (in-hospital and primary care)

Growing evidence tells us that patient experience is a good indicator of the quality of health services. Better experiences, stronger partnerships with consumers, and patient- and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes.

Each financial year, the Commission conducts two national patient surveys (adult inpatient experience and adult primary care experience) to collect, measure and then use patient experience information. In June 2020, the Commission contracted a service to run an additional survey to explore patients' experience of care during the COVID-19 pandemic.

Along with running the two surveys in 2019/20, the Commission published four reports, which are relevant to both surveys:

- Q1: May 2019 reported in August 2019[37]
- Q2: August 2019 reported in November 2019
- Q3: November 2019 reported in February 2020
- Q4: February 2020 no survey due to change in provider but a report of national findings issued 30 June.

Because of the disruption caused by COVID-19, the May survey round was not run and was replaced by a report. The intended survey will be added as part of a new SPE deliverable in 2020/21.

35 The strategic priority was changed in 2018/19 and, although improving consumer and whānau appears as (1) in the Statement of Intent 2017–21, the priority changed to advancing Māori health, to reflect the commitment to incorporate Māori as an overarching link to Te Tiriti o Waitangi and was changed to reflect this. It is now referred to as priority (2).

36 Statement of Intent 2017–21, page 12.

37 Audit completed on the basis that reporting has been performed for each quarter stated and published to the website by the 30 June 2020.

Adult inpatient experience survey

The adult inpatient experience survey covers four main domains of hospital inpatient experience: communication, partnership, coordination and physical and emotional needs. Every three months, adult patients who spent at least one night in hospital are selected from DHBs nationally and invited to take part in the survey.

Results from the adult inpatient experience survey are published on the Commission's website.[38] In June, the Commission also published the report *Adult hospital patient experience survey: What have we learned from 5 years' results*.[39]

Primary care patient experience survey

All **20** DHBs have explicit actions in their annual plans to address results of their lowest scoring patient experience surveys. Response rates and domain scores were consistent with previous quarters across both surveys.

The primary care patient experience survey provides information about what the experience of patients in primary care is like and how overall care is managed between their general practice, diagnostic services, specialists and/or hospital staff. Every three months, a national selection of adult patients who are enrolled with and seen by participating general practices are invited to take part.

Results of the adult primary care experience survey are published on the Commission's website.[40] In June, the Commission also published the report *Primary care patient experience survey 2019: A review of responses in the general practice module and suggestions for the future*.[41]

Did we do what we set out to do?

Deliverable (SPE 2)	**Performance measure**	**Strategic priority** ***Improving consumer and whānau experience (2) and Advancing Māori health (1)***	**Achieved** **Partially achieved** **Not achieved**	**Outcome**
Deliverable (SPE 2): Publish four reports on patient experience of hospital services and four reports on patient experience in primary care			Four reports were published on patient experience of hospital services and four reports were published on patient experience in primary care **(Achieved)**	Strengthen consumer leadership across the health and disability sector, creating a system of care that better reflects the needs of consumers and their families and whānau[42]
Performance measure: The percentage of district health boards (DHBs) that have explicit actions in their annual plans to address specific results of the patient experience survey(s)			All 20 DHBs (100%) have explicit actions in their annual plans to address results of their lowest scoring patient experience surveys **(Achieved)**	
Performance measure: Improvements in reported patient experience maintained			In-hospital and primary care patients experience survey results published online **(Achieved)**	Improvement stimulated in the areas the patient experience survey has highlighted for patients and their families and whānau[43]

38 www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/patient-experience/adult-inpatient-experience/survey-results

39 www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/4050

40 https://public.tableau.com/profile/hqi2803#!/vizhome/Primarycarepatientexperiencesurveyresults/Story1

41 www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/4045

42 Statement of Intent 2017–21 – Outcomes: What we intend to achieve (page 12).

43 Statement of Intent 2017–21 – Impact: What success will look like (page 12).

Mortality review committees

Mortality review committees are statutory committees that review particular deaths, or the deaths of particular people, to learn how to best prevent these deaths.

Five committees are dedicated to reviewing deaths of children and young people, maternal deaths and all deaths of babies from 20 weeks' gestation up to 28 days after birth (including death as a result of pregnancy or childbirth), deaths resulting from family violence, deaths associated with surgery and deaths by suicide.

Ngā Pou Arawhenua (the Māori caucus of the committees) developed *Te Pou – Māori responsive rubric and guidelines*[44] to improve the mortality review committees' capability to analyse mortality data, its interpretation and the recommendations for preventing deaths.

The implementation of Te Pou led to the development of a framework to guide the application of Māori data sovereignty principles across the work of the mortality review committees. Initially developed in conjunction with the Perinatal and Maternal Mortality Review Committee, the framework is designed to ensure data points for gathering, collecting, storing, analysing and interpreting align with Māori data sovereignty principles; that data does not further perpetuate a deficit view of populations and prioritises strength-based approaches; increases our understanding and use of Māori models of care and kaupapa Māori concepts; elevates the voice of Māori; and gives greater support to the consumer and whānau voice in mortality review processes.

The committees published six evidence-based mortality review committee reports in 2019/20, as noted in the following table.

Deliverable: Publish at least two mortality review committee reports by 30 June 2020	**Date published**
Thirteenth Annual Report of the Perinatal and Maternal Mortality Review Committee (PMMRC)[45]	23 September 2019
Understanding deaths by suicide in the Asian population of Aotearoa New Zealand[46]	9 October 2019
Eighth report of the Perioperative Mortality Review Committee[47]	17 December 2019
'Nuggets of gold': Insights from voices of lived experience[48]	11 February 2020
Te Mauri – The Life Force I Rangatahi Suicide Report[49]	26 March 2020
Family Violence Death Review Committee Sixth report: Men who use violence[50]	30 April 2020

44 www.hqsc.govt.nz/assets/Mortality-Review/RUBRIC.Visual.Dec.2019.pdf
45 www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/3823/
46 www.hqsc.govt.nz/assets/SUMRC/PR/Understanding-deaths-by-suicide-Asian-population.pdf
47 www.hqsc.govt.nz/assets/POMRC/Publications/POMRC8thReport2019_web.pdf
48 www.hqsc.govt.nz/our-programmes/mrc/sumrc/publications-and-resources/publication/3938/
49 www.hqsc.govt.nz/assets/SUMRC/PR/TeMauriTheLifeForce_final.pdf
50 www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC6thReport_FINAL.pdf

The committees and secretariat (hosted within the Commission) collect data on the scope of deaths, and monitor the number, categories and demographics of deaths relevant to the scope. To identify patterns and trends over time, we develop and publish reports to inform and provide advice and recommendations to help improve systems and practice. The aim is to avoid preventable deaths and reduce morbidity and mortality in Aotearoa New Zealand.

Child and Youth Mortality Review Committee*

112 recommendations across six reports, from 1 July 2011 to 30 June 2016. Of these, **85** have been successful (achieved, mainly achieved or partially achieved). This has helped to reduce the number of child and youth deaths each year from **638** in 2002 to **483** in 2016. These saved lives equate to **$271** million cummulative value to date.

*Note: Numbers in this box have not been audited

Throughout the year, the committees and secretariat work with government agencies and within the health and social sectors to source and validate information, and implement and advance recommendations, to improve systems and practices within services and communities.

Ongoing monitoring, to review the implementation and effect of recommendations, is an important part of the quality improvement process for the committees and secretariat.

Did we do what we set out to do?

Deliverable (SPE 3)	**Performance measure**	**Strategic priority** ***Improving patient safety and reducing mortality (4) and Advancing Māori health (1)***[51]	**Achieved** **Partially achieved** **Not achieved**	**Outcome**
Deliverable (SPE 3): Publish at least two mortality review committee reports		Six reports were published against an output deliverable of at least two **(Achieved)**		Reduce harm and mortality by investigating deaths and making recommendations to partner agencies, to reduce the chances of deaths recurring[52]
Performance measure: Evidence-based reports are published and recommendations for improvement are made by 30 June 2020		Recommendations for improvement are included within each of the evidence-based reports published **(Achieved)**		
Performance measure: Recommendations for improvement from previous reports are implemented by DHBs, health providers and professionals and monitored over five years		Monitoring processes have been developed and will be implemented further in 2020/21. Recommendations are continually followed up and reported on at quarterly periods **(Not achieved)**		

51 Advancing Māori health was introduced as a strategic priority in 2018/19.

52 Advancing Māori health and reducing harm and mortality – Statement of Intent 2017–21, page 12.

Quality and safety markers

QSMs help us evaluate the success of programmes and determine whether the desired changes in practice and reductions in harm and cost have occurred. During the year, we started reporting on a new set of QSMs relating to the safe use of opioids. These focus on reducing opioid-related harm in adult surgical inpatients.

The QSMs were developed in partnership with DHBs, all of which commented on the QSMs' early designs, resulting in an improved set of measures.

Because of the disruption caused by COVID-19, the Commission temporarily suspended, until 30 June 2020, the requirement for DHBs to collect and report on QSMs that are manually collected. During the lockdown period (March to May), the Commission continued to monitor and publish outcome measures where data is obtained from the National Minimum Dataset. Three outcome measures were published on:

1. in-hospital falls causing fractured neck of femur
2. risk-adjusted postoperative deep vein thrombosis (DVT) and pulmonary embolism (PE) cases
3. opioid-related harm for surgical episodes of care.

Our fourth report was shortened, again because of the disruption caused by COVID-19 (we delivered it on time but with less information than we would normally provide). Improvements in outcomes for falls remain at the maintained level. However, higher than the long-term average of observed versus expected ratios of postoperative DVT and PE have been shown for 2018 and 2019, but the average observed number of DVT and PE cases is still lower than the expected.

The measures are:

- percentage of patients whose sedation levels are monitored and documented following local guidelines
- percentage of patients who have had bowel function activity recorded in relevant documentation
- (balance measure)
- percentage of patients prescribed an opioid who have uncontrolled pain
- opioid-related harm for surgical episode of care.*

*Note: Numbers in this box have not been audited

Did we do what we set out to do?

Deliverable (SPE 4)	**Performance measure**	**Strategic priority** ***Improving patient safety and reducing mortality (4) and Reducing unwarranted variation in patterns of care (5)***	**Achieved** **Partially achieved** **Not achieved**	**Outcome/impact**
Deliverable (SPE 4): Publish four updates of the quality and safety markers		Four updates published (September and December 2019, March and June 2020). Fourth update was shorter than usual as some data not collected during the COVID-19 pandemic **(Achieved)**		Reduce unwarranted variation in patterns of care, outcomes and experience of patients[53]
Performance measure: Performance against process level thresholds maintained across quality and safety markers (QSMs)		Performance against process thresholds maintained **(Achieved)**		
Performance measure: Improvements in outcome markers maintained		Improvements in outcomes were maintained during this annual period **(Achieved)**		Reduce harm in high-harm and focus areas, such as surgical site infections, falls, patient deterioration, safe surgery and medication safety[54]

53 Statement of Intent 2017–21, Reducing unwarranted variation in patterns of care, page 12.

54 Statement of Intent 2017–21, Reducing harm and mortality, page 12.

Atlas of Healthcare Variation

The Atlas is designed to prompt debate and raise questions about health service use and provision amongst clinicians, users and providers of health services about why any differences exist, and to stimulate improvement through this debate.

The Atlas is organised by domains, which cover specific clinical areas. Some domains also have analysis available at a primary health organisation level. The Atlas highlights variation but does not suggest an ideal level. This means it should not be used as a tool for judging the performance of one geographical area against another.

Annually, we have had **26,839** hits against a target of **18,000**. The number of website hits to the Atlas has exceeded the annual target, performing at a rate of 149 percent. The highest annual domain of interest was **diabetes**, with 4,815 views, the next domain was **asthma**, with 3,835 views and the third was the **opioid** domain, with 2,350 views.*

*Note: Numbers in this box have not been audited

The Commission committed to updating six Atlas domains in 2019/20 and publishing them online. DHBs are required to address specific findings, with a focus on equity, in their annual plans.

The three domain areas that DHBs chose to report their activities against were: gout (20 percent of DHBs chose this domain), asthma (30 percent of DHBs) and diabetes (50 percent of DHBs).

Did we do what we set out to do?

Deliverable (SPE 5)	**Performance measure**	**Strategic priority** ***Reducing unwarranted variation in patterns of care (5) and Achieving health equity (3)***	**Achieved** **Partially achieved** **Not achieved**	**Outcome**
Deliverable (SPE 5): Six Atlas of Healthcare Variation domains and updates will be published		Six Atlas of Healthcare Variation domains and updates were published **(Achieved)**		Reduce unwarranted variation in patterns of care, outcomes and experiences of patients[55]
Performance measure: Number of website hits to the Atlas remains at current levels (an average of 1,500 page views a month)		The website hits annually exceeded the annual target, performing at a rate of 149 percent (26,839 against a target of 18,000) **(Achieved)**		
Performance measure: The percentage of DHBs that have explicit actions in their annual plans to address specific findings		All DHBs have explicit actions in their annual plans using the Atlas of Healthcare Variation (100 percent) **(Achieved)**		Achieve a more equitable health system that both improves outcomes for individuals and groups, and makes the system more sustainable and affordable for all[56]

55 Statement of Intent 2017-21, Reducing unwarranted variation in patterns of care, page 12.

56 Statement of Intent 2017-21, Improving Health Equity, page 12.

Advancing Māori health

Our aim this year was to enhance the identification, interpretation and recommendations for improvements for whānau, hapū and iwi by having specifically tailored reports that respond to the issues Māori face in the health and social system. As noted in the mortality review committee's section, we used *Te Pou – Māori responsive rubric and guidelines* to help produce the mortality review committee reports (see page 16). Te Pou also helped in our undertaking of the Ngā Poutama consumer, family and whānau experience survey.

We prioritised Te Tiriti by embedding the Māori worldview into our everyday organisational thinking and programme management and started reviewing our operational policies with an overlaying Te Tiriti lens.

During the year, we worked with others on a project charter to develop a te aō Māori quality framework. This was completed and later redeveloped into a detailed project plan that outlines the aim, scope and activities required to help in the survey design process.

A literature review was completed to help develop a framework for, and outline the international and national evidence on, indigenous quality-improvement models and initiatives.

A working advisory group was established. This has met several times to discuss external engagement planning activities and timings with Māori providers and Māori experts.

Main themes for advancing Māori health will include indigenous leadership and staff, whānau-centred care, establishing and maintaining relationships, holistic approaches, preventative care, innovative practice and upholding indigenous cultures.

Unfortunately, our progress on this programme of work was disrupted by the COVID-19 pandemic. Resources were reprioritised to help with clinical support, as part of the COVID-19 response team, and face-to-face engagement was put on hold until Alert levels returned to normal. We were able, however, to work with the Ministry of Health to support the development of a Māori health response plan.

Due to the delays, this deliverable was deferred for completion in 2021. It was also reviewed in its entirety because of the lessons learned from our response to COVID-19.

Did we do what we set out to do?

Deliverable (SPE 6)	**Performance measure**	**Strategic priority** ***Advancing Māori health (1) and achieving health equity (3)***	**Achieved** **Partially achieved** **Not achieved**	**Outcome**
Deliverable (SPE 6): Advancing Māori Health: Strengthen partnerships with Māori and develop kaupapa Māori improvement methods that will improve the quality and safety of health and disability services for Māori		COVID-19 affected the progress on this programme of work. Resources were reprioritised to help with clinical support as part of the response team. Face-to-face engagement was put on hold until Alert levels were back to normal **(Not achieved)**		• Reduce inequities in health outcomes and access to and experience of health services[57] • Partnering with local Māori communities on improvement projects, using a co-design methodology to support self-determination of priorities and approaches[58]
Performance measure: Develop a kaupapa Māori quality improvement framework and resources that guide improvement initiatives		A kaupapa Māori quality improvement framework and resources could not be developed due to engagement restrictions with COVID-19. Engagement with DHBs & Māori health providers are scheduled to be completed in 2020/21 **(Not achieved)**		

57 Statement of Performance Expectations (SPE) 6 deliverable contributed to SPE 7, which reports and highlights Māori experiences of adverse events. Statement of Intent 2017–21, Improving health equity, page 12.

58 Engagement with iwi, hapū and whānau Māori in the development of a framework or in any engagement activity planned with whānau Māori (SPE 7) or in the development of a kaupapa Māori framework and what that means to Māori (SPE 6).

Adverse events

Each year, health care adverse events are reported to the Commission by DHBs and other health care providers. The Commission works with these providers to encourage an open culture of reporting, to learn from what happened, and put in place systems to reduce the risk of recurrence.

Our year in review saw us undertaking research into whānau Māori experiences of adverse events. *Ngā Taero a Kupe – Ngā wheako pānga kino ki ngā whānau Māori i rō hōhipera I Whānau Māori experiences of in-hospital adverse events* was completed and published on the Commission's website.[59]

It is commonly known that Māori, who make up 19.1 percent of the total population of Aotearoa New Zealand (Statistics New Zealand 2019), experience the poorest health outcomes across the population.

To understand and support much-needed change to improve Māori health outcomes within the health care system, the Commission completed a research project that investigated whānau Māori experiences of in-hospital adverse events. This project focused mainly on whānau Māori views and experiences of an in-hospital adverse event and how that experience was managed. The Commission considered that understanding whānau Māori experiences of adverse events would allow directed and focused system improvements to occur.

As highlighted in the infographic below, five major themes and two sub-themes were identified from comments collected from a group of whānau Māori.

Culture was not included or considered at any point of their care.

a. Unconscious bias – another sub-theme that is included because whānau believed being Māori affected the care they received.

Whānau were not updated or informed about what was going on with their care.

a. Am I being heard? – a subtheme of communication issues; whānau believed that, when voicing concerns, these were unheard.

This is a major theme that adds value and insight into elements of change that may improve the safety and quality of care provided to whānau.

Whānau views were strong about a general lack of respect, including a real lack of empathy.

59 www.hqsc.govt.nz/assets/Reportable-Events/Publications/Nga_Taero_a_Kupe_final_web.pdf

Clinician perspectives were also surveyed on in-hospital adverse events, to identify and determine the processes involved with reporting and managing the event. Similar to the questions put to whānau, clinicians were asked to explain their involvement with a Severity Assessment Criteria (SAC) 1 or 2 adverse event (as a reviewer or provider of care).

Three major themes:

1. *open and clear communication and disclosure*
2. *preparedness to review events*
3. *culturally appropriate review processes.*

Like whānau, clinicians believe putting in place a follow-up process for when adverse events occur would keep them updated and informed about the review outcomes.

The Commission plans to use this research to develop recommendations for providers on how to better meet the needs of Māori who have experienced adverse events.

Publication of adverse events

Historically, we have received feedback from internal and external stakeholders that the current format of the *Learning from adverse events* annual report overemphasises the numbers of adverse events and under emphasises the lessons learned, and improvements made as a result of adverse event reviews.

Based on this feedback, and with approval from key stakeholders, our expert advisory group, senior leadership team and Board, we will move to quarterly online reporting of adverse events from 1 July 2020. This will give us the ability to integrate adverse event reporting with the Commission's other quality and safety reporting, allowing for a more integrated picture of quality and safety within organisations.

Quarterly reporting will follow a similar format to the existing QSMs, will always report and review events, and include (but not be limited to) the following data:

1. numbers of events
2. events categorised by World Health Organization classification codes
3. demographic information.

Publicly available data aggregated at a national level will be available quarterly from May 2021 and an annual summary will be published within the Commission's annual report. The annual summary will focus on analysis of adverse events part Bs received and include additional in-depth thematic analysis on areas of concern.

Due to pressures on the health and disability sector caused by the COVID-19 pandemic, the Commission delayed reconciliation of 2019/20 adverse event data. As a result, we are not able to include an annual summary of aggregated adverse event data at a national level for this 2019/20 annual report. To meet our reporting obligations, the annual summary will be published on our website in November 2020.

Did we do what we set out to do?

Deliverable (SPE 7)	**Performance measure**	**Strategic priority** ***Improving patient safety and reducing mortality (4), Advancing Māori health (1), Achieving health equity (3) and Improving consumer, whānau experience (2) and Reducing unwarranted variation in patterns of care (5)***	**Achieved** **Partially achieved** **Not achieved**	**Outcome**
Deliverable (SPE 7): Improve Māori experience of adverse events within a hospital environment		As a result of this report, a review of the Adverse Events Policy will be completed in 2020/21 **(Achieved)**		(4) Reducing harm and mortality[60] (2) Improving consumer whānau experience[61]
Performance measure: Complete the report on Māori experience of adverse events by 30 June 2020		The report was published online. Whānau and clinicians were consulted with and their feedback fed into the final report that was published **(Achieved)**		
Performance measure: Quality improvement actions identified		A quality improvement action has been the completion of a Te Tiriti analysis of the National Adverse Event Reporting Policy report. A review of the policy will be completed by 2021 as a result of this report **(Achieved)**		(1) Strengthening our Te Tiriti o Waitangi work and more actively promoting Te Tiriti o Waitangi as a tool[62] and approach for improvement[63]

60 Statement of Intent 2017–21, Reduce harm and mortality by investigating deaths and making recommendations to partner agencies to reduce the chances of deaths recurring.

61 Statement of Intent 2017–21, Strengthen consumer leadership across the health and disability sector, creating a system of care that better reflects the needs of consumers and their families and whānau.

62 Statement of Intent 2017–21, Output – work with other agencies and consumer groups to promote and increase co-design methodology.

63 Outlined in SPE 2019–21, Advancing Māori Health priority (page 12) and reducing harm and mortality SOI 2017–24 – Impact: Increased working in partnership with consumers, families, whānau and providers to reduce harm and waste (page 12).

Kōrero mai programme

Through its patient deterioration programme, the Commission helped develop patient, family and whānau escalation processes by:

- providing information and training to support co-design methods
- providing expert advice on patient and whānau escalation processes
- showcasing the development of patient and whānau escalation processes nationally
- facilitating national discussion and learning.

The Commission committed to expand and spread the Kōrero mai programme for patient and whānau escalation in DHBs.

Cohort one: three DHBs in the programme
Cohort two: four DHBs in the programme
Cohort three: two DHBs in the programme
Cohort four: two DHBs in the programme

During the year, five DHBs were confirmed for cohorts three and four. One DHB withdrew post-COVID-19 because of resourcing issues. Both cohorts are under way, although are still in the early stages of implementation. Work on Kōrero mai was paused due to disruptions from COVID-19 and, as a result, progress has been slower than expected. Two DHBs are implementing Kōrero mai independently of the Commission. Across all cohorts, case studies are being developed and some have been published on the Commission's website. Those DHBs that have launched their escalation processes continue to monitor use in their practice of providing health care services. Because of the delay created by the emergence of COVID-19, the summative evaluation report was not finished by 30 June 2020. COVID-19 Alert level restrictions also meant stakeholder interviews were delayed, and this part of the work will be deferred for completion in December 2021.

Did we do what we set out to do?

Deliverable (SPE 8)	**Performance measure**	**Strategic priority** ***Advancing Māori health (1) and Improving health equity (3)***	**Achieved** **Partially achieved** **Not achieved**	**Outcome**
Deliverable (SPE 9): Expand and spread the Kōrero mai programme for patient and whānau escalation in DHBs		The kōrero mai programme for patient and whānau escalation in DHBs has expanded to include four extra DHBs. This brings the total DHBs involved in the programme to 11 DHBs **(Achieved)**		Partnering with Māori to develop kaupapa Māori improvement methods that will improve the quality and safety of health and disability services for Māori[64]
Performance measure: Two additional cohorts of the Kōrero mai programme under way in DHBs		DHBs have been confirmed for cohorts 3 and 4. Both cohorts are under way. Further work has been slowed due to delays resulting from COVID-19 **(Achieved)**		Increasing uptake of evidence-based interventions to encourage a consistent best-practice approach to reducing variation, harm and waste[65]
Performance measure: DHBs measure the impact of Kōrero mai		Across three cohorts, case studies have been developed. Those DHBs that have launched their escalation processes continue to monitor the use of these **(Achieved)**		
Performance measure: Evaluation report due 30 June 2020		The programme evaluation report was not completed within the timeframe due to COVID-19 Alert level restrictions. This performance measure has been deferred for completion in quarter two 2021 **(Not achieved)**		Reduce inequities in health outcomes and access to and experience of health services[66]

64 Statement of Performance Expectations 2019/20, Advancing Māori Health, page 12.
65 Statement of Intent 2017–21, Reduce unwarranted variation in patterns of care outcomes and experience of patients, page 12.
66 Statement of Intent 2017–21, Improving health equity, page 12.

Co-design with consumers, whānau and health service providers

Co-design is an important part of the engagement process. Involving consumers, family and staff captures their experiences and ideas, which helps to create a new understanding of and insight into their care and emotional journey. Such partnerships allow for the review of learning and ideas, planning and implementation of improvements and, finally, review of what differences have made.

Through the Partners in Care programme, we are working to improve the experience of care and participation of consumers and whānau, and to develop the leadership capability of providers and consumers.

During the year, the Commission worked with partners to deliver specific projects with a national focus on cancer. Several case studies have been published on the Commission's website.

Did we do what we set out to do?

Deliverable (SPE 9)	**Performance measure**	**Strategic priority** **Improving consumer and whānau experience (2)**	**Achieved** **Partially achieved** **Not achieved**	**Outcome**
Deliverable (SPE 9): Deliver a co-design programme nationally for consumer–provider teams focused on cancer		During the year, the Commission worked with partners to deliver specific projects with a national focus on cancer. Several case studies have been published on the Commission's website **(Achieved)**		Support involvement of consumers and their families and whānau in an equal partnership leading to improvements in health and disability services[67]
Performance measure: Teams will report on how the learnings from their co-design projects have contributed to improving services for consumers and whānau		All co-design teams have presented on their progress, focusing on how the lessons learned from projects will be applied beyond the co-design programme **(Achieved)**		

67 Statement of Intent 2017–21, Improving consumer/whānau experience, page 12.

Increasing quality improvement capability using co-design through Whakakotahi

The aim of the Whakakotahi primary care quality improvement programme is to increase quality improvement capability in primary care. The three priorities for Whakakotahi are: consumer engagement, integration and equity. Primary care teams are supported by the Commission to implement quality improvement projects in an area of patient care they want to improve that is important to their patients and community and to them as providers of care.

The Commission supported primary care led quality improvement initiatives, to inform the future design and options for scale and spread of improvement activity. The Commission also supported knowledge sharing of the work undertaken, which included refreshing its primary care website page, so material was more readily available by topic choice.[68]

We published case studies showing the effects of the improvement work, and a selection of consumer videos that capture the importance of having consumers engaged at all levels of the programme.[69]

Finally, we published the summative evaluation online. This shows the impacts of the programme and learning, which will inform sustainable quality improvement for a strengthened primary care sector in Aotearoa.[70]

Did we do what we set out to do?

Deliverable (SPE 10)	**Performance measure**	**Strategic priority** *Improving consumer and whānau experience (2)* **Achieved** **Partially achieved** **Not achieved**	**Outcome**
Deliverable (SPE 10): Implement the chosen Whakakotahi 2019 primary care improvement projects		The Commission supported primary care led quality improvement initiatives and knowledge sharing of the work undertaken. Case studies were published on the Commission's website **(Achieved)**	**Impact** – empowered consumers, families and whānau, with the sector involving them in co-designing responsive, effective services and in governance at every level[71]
Performance measure: An evaluation shows the effect of the initial three-year phase of the programme and informs the future design and options for scale and spread in primary care by 30 June 2020		Published case studies from projects completed, profiled exemplar work, and learnings from the annual formative evaluation reports have been used to refine the programme over the three-year period **(Achieved)**	
Performance measure: Final evaluation report due 30 June 2020		The final evaluation report was completed by 30 June 2020 **(Achieved)**	Improve consumers' experience of care at DHB and primary care level, as measured through the patient experience survey[72]

68 www.hqsc.govt.nz/our-programmes/primary-care/resources-for-providers-starting-quality-improvement-projects

69 www.hqsc.govt.nz/our-programmes/primary-care/publications-and-resources/publication/4105

70 www.hqsc.govt.nz/our-programmes/primary-care/publications-and-resources/publication/3892

71 Statement of Intent 2017–21, Improving consumer/whānau experience – Impact, page 12.

72 Statement of Intent 2017–21, Improving consumer/whānau experience – Outcome, page 12.

Mental health and addiction quality improvement programme

Many mental health staff, consumers and their families and whānau are starting on a unique and exciting journey to improve the consumer experience of mental health and addiction (MHA) services in New Zealand, making it safer for all.

The Commission is coordinating a national five-year MHA quality improvement programme to ensure people who experience mental health and addiction issues receive high-quality care and support. The following five priority areas have been identified by the MHA sector and are included in the Commission's quality improvement programme:

- **Aukatia te noho punanga: E whai ana ki te whakakore i te noho punanga i mua o te 2020**
  Zero seclusion: Towards eliminating seclusion by 2020
- **Te tūhono i ngā manaakitanga, te whakapai ake i ngā whakawhitinga ratonga**
  Connecting care: Improving service transitions
- **Te ako mai i ngā pāmamaetanga me te wheako tangata whaiora me te whānau**
  Learning from adverse events and consumer and whānau experience
- **Te whakanui ake i te hauora ā-tinana**
  Maximising physical health
- **Te whakapai ake i te whakahaere rongoā, i te tūtohu rongoā hoki**
  Improving medication management and prescribing

The Commission has worked closely with sector partners to progress three of the five priorities in the five-year programme plan. Highlights include:

- delivery of workshops and online tutorials on implicit bias for DHB project teams
- continued use of online meetings for the Connecting care project to draw together participants on a regular basis, to share learnings and improvements on service transitions in their DHB areas
- establishment of the learning from adverse events for consumers, family and whānau experience project, along with delivery of co-design and quality improvement workshops
- establishment of a DHB engagement framework for each active project, confirming engagement in programme activities and deliverables
- development of an interactive dashboard for Zero seclusion and Connecting care. The collection and reporting of process and balancing measures has been problematic but will be worked through more thoroughly during 2020/21.

Did we do what we set out to do?

Deliverable (SPE 11)	Performance measure	Strategic priority *Achieving health equity for all (3)*	● Achieved ● Partially achieved ● Not achieved	Outcome
Deliverable (SPE 11): Implement a mental health and addiction quality improvement programme with a focus on zero seclusion, connecting care and the start of learning from adverse events		The Commission has worked closely with sector partners, progressing the three priorities agreed to in the five-year programme plan during 2019/20 **(Achieved)**		Achieve a more equitable health system that both improves outcomes for individuals and groups and makes the system more sustainable and affordable for all[73]
Performance measure: Sustainable approach to Zero seclusion, delivery of Connecting care and collaboration on and initiation of Learning from adverse events		Zero seclusion, connecting care and Learning from adverse events have been achieved for this financial year **(Achieved)**		
Performance measure: District health board engagement framework shows achievement against milestones (eg, attendance at events, key documents and plan–do–study–act (PDSA) testing of changing ideas)		A district health board engagement framework has been developed for each project **(Achieved)**		Reduce inequities in health outcomes and access to and experience of health services[74] Output: Design and measure quality improvement programmes and activities that aim to reduce health inequities[75]
Performance measure: Measurement framework in place for zero seclusion and connecting care, which includes outcome, process and balancing measures		An interactive dashboard has captured outcome measures for zero seclusion and connecting care **(Achieved)**		

Healthcare associated infection hub in partnership with district health boards

Over the past year, the Commission's infection prevention and control programme team has planned a second collaboration to implement a preoperative anti-staphylococcal bundle within the Surgical Site Infection Improvement (SSII) programme.

This project aims to reduce the surgical site infection (SSI) rate by implementing well-established interventions to reduce the SSI risk for cardiac and orthopaedic surgery. The Commission is working with interested hospital teams to roll out the bundle using collaborative and quality improvement methodology. Ten hospital teams (five district health boards and five private surgical hospitals) are taking part. Training manuals have been produced, and the first training workshop was scheduled for March 2020. However, because of the disruption caused by the COVID-19 pandemic, the project was postponed until October 2020.[76]

Planning and preparation have been done for a pilot point prevalence survey, but this has also been deferred until 2020/21, due to COVID-19. The programme team developed priorities but was not able to discuss and confirm these with the strategic infection prevention and control (IPC) advisory group by 30 June because of COVID-19 disruptions.[77] Plans are under way to progress this work during 2020/21, which will involve sector engagement and pilot testing, leading to a national rollout.

73 Statement of Intent 2017–21, Improving health equity – Outcome, page 12.

74 Statement of Intent 2017–21, Improving health equity – Outcome, page 12.

75 Statement of Intent 2017–21, Improving health equity – Outcome, page 12.

76 www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/projects/surgical-site-infection-improvement/resources/

77 www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/about-us/strategic-advisory-group/

Healthcare associated infection*

This work has contributed to the health workforce achieving **85 percent** compliance with the World Health Organization's hand hygiene guidelines quarter 4. Surgical site infections (SSIs) **97 percent** compliance with antibiotic dose and **96 percent** compliance with antibiotic timing quarter 4, 2019. Surgical rates for hips and knees have reduced from **1.2 percent** to **0.9 percent** since August 2015, resulting in **92** fewer infections and **$3.7 million** in avoided costs. This equates to **46** additional years of healthy life from avoided SSIs, worth **$8.3 million**.

*Note: Numbers in this box have not been audited

Did we do what we set out to do?

Deliverable (SPE 12)	Performance measure	Strategic priority ***Reducing unwarranted variation in patterns of care (5)***	● Achieved ● Partially achieved ● Not achieved	Outcome
Deliverable (SPE 12): Development of the health-care associated infection hub in partnership with district health boards		The surgical site infection improvement programme recommends interventions to reduce the risk of infection and collects and reports data from all 20 DHBs **(Achieved)**		Increased uptake of evidence-based interventions to encourage a consistent best-practice approach to reducing variation, harm and waste[78]
Performance measure: Continued implementation of evidence-informed process improvements to reduce surgical site infections		The reported data from the DHBs is published quarterly via a dashboard. DHBs were given an extension to submit their data during the COVID-19[79,80] response **(Achieved)**		
Performance measure: Point prevalence survey implemented and agreement on priorities for the healthcare associated infection hub		Late 2019, recruitment of participating hospitals for a 2nd anti-staph bundle collaborative project began, supporting hospitals to implement additional interventions in the form of a patient bundle to reduce staph infections[81] **(Achieved)**		

78 Statement of Intent 2017–20, Reducing unwarranted variation in patterns of care – Impact, page 12.

79 Public cardiac surgery dashboard - https://public.tableau.com/profile/hqi2803#!/vizhome/SSIcardiacdashboardpublic/SSIIPcardiacsurgery?publish=yes

80 Public orthopaedic surgery dashboard - https://public.tableau.com/profile/hqi2803#!/vizhome/SSIorthopaedicdashboardpublic/SSIIPorthopaedicsurgery?publish=yes

81 www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/news-and-events/news/3733/

Strengthening improvement science capability in primary and secondary care settings

The building leadership and capability programme puts quality and safety at the heart of New Zealand's health and disability services.

The Commission has sponsored 12 quality improvement advisor learning scholarships, which have been distributed across the health sector (six places secondary care, four primary care and two aged residential care). The actual programme has been deferred until quarter 2 in 2021 due to COVID-19 restrictions.

The mental health quality improvement facilitators course third cohort was held on 1–2 July 2019. Participants were from DHBs and a primary mental health provider. Eighteen participants successfully graduated in March 2020.

12 quality improvement advisor learning scholarships distributed

18 participants graduated in March 2020

Open for leadership awards

Timaru physiotherapist Sonya Veale is the latest recipient of an *Open for leadership* award 2020.

The awards are part of the Commission's work to build capability and leadership in the health sector. They recognise and celebrate health professionals who show excellent practice, quality improvement and leadership skills.

By building clinical leadership for quality and safety, we can change and improve service delivery in a more effective and efficient way. This benefits the patient and community and achieves the best value for public health resources.

An Open Forum (our International Speaker Series) was held with Helen Bevan, NHS Horizons, on 18 November 2019. Through virtual collaboration, participants were able to interact with one another using a toolkit of practical change tactics where achieving large-scale improvement in the future can be explored.

Did we do what we set out to do?

Deliverable (SPE 13)	**Performance measure**	**Strategic priorities** ***Achieving health equity for all (3)***	**Achieved** **Partially achieved** **Not achieved**	**Outcome**
Deliverable (SPE 13): Strengthen improvement in science capability in primary and secondary care settings		The Commission committed to building the capability of the health workforce by providing quality improvement workshops, leadership forums, sponsorships and practical tools **(Achieved)**		**Impact**: Equity improvement priorities incorporated into all our work. An aim of improving equity will be an important focus of our programmes[82]
Performance measure: Sponsor participation in quality improvement advisor and quality improvement facilitator training programmes for primary care and mental health and addition services		Twelve sponsorships were distributed this year, and 18 participants graduated from an 18-month course **(Achieved)**		
Performance measure: Scope a programme aimed at developing senior clinician leadership capability for quality and safety		The masterclass learning objectives and resources have been developed and will be delivered in 2020/21 **(Achieved)**		

82 Statement of Intent 2017–21, Improving health equity, page 12.

Third party initiatives and other work we do outside of our Statement of Performance Expectations

Along with carrying out work directly funded by the Government, the Commission partners with third parties when improvement goals fit with its priorities and mandate. DHBs, the Accident Compensation Corporation (ACC) and Ministry of Health have contributed funding to our third party revenue projects. This has helped the Commission expand the scope and scale of improvement work in specific areas.

By contributing to these projects, the Commission brings a focus on improving outcomes for Māori, equity of health outcomes for all and partnerships with consumers.

Trauma

In 2019, ACC contracted the Commission to provide support to the National Trauma Network by:

- building quality improvement knowledge and skills across the trauma system, to create a system that learns and evolves
- providing analytics and research so the Network's work is data driven and evidence based
- delivering a long-term outcomes survey to enable the Network to understand how injured people recover and to better support their recovery.

The contract runs until the end June 2023, and the Commission has established a programme of work to ensure its successful delivery.

Quality improvement projects

Five quality improvement projects were worked on during the year and are at various stages of progress.[83]

(1) Quality improvement facilitator course

The course started on 10 March 2020. It paused due to the COVID-19 lockdown but restarted in July, with 13 participants (a mix of district health board and ambulance service staff) expected to complete the course.

(2) Haemorrhage project

(3) Rehabilitation project

(4) Māori experiences of trauma rehabilitation project

(5) Patient reported outcomes project

83 www.majortrauma.nz/news-and-events/training-and-education/quality-improvement-facilitator-course

Analytics workstream

Analytics to support quality improvement

Analytical work to support the quality improvement projects is under way. For the haemorrhage project, data sharing arrangements have been formed between the New Zealand Trauma Registry (NZTR) and New Zealand Blood Service, St John Ambulance and Wellington Free Ambulance. Data sharing arrangements between the Australian and New Zealand Massive Transfusion Registry are being finalised.

Dashboard and business intelligence analytics to support district health boards and regions

A geospatial mapping tool was published on the National Trauma Network website members' page in May 2020.

The NZTR dashboard is being moved to a new platform, RShiny. This will improve user interactions with the dashboard and the data.

Analytics to support the National Trauma Network abbreviated injury scale coding audit

Following a successful initiative to audit the quality of the injury coding, we are in the process of writing up the findings for publication.

SORTED

The second phase of the Study of Road Trauma Evidence and Data (SORTED) is advancing, with a range of agencies involved in sharing data.

Ad hoc reports

Ad hoc reports regarding traumatic brain injury and critical haemorrhage have been completed.

Research workstream

Monash University in Melbourne, Australia, has been contracted as the research lead and is supporting the research workstream and patient reported outcomes project. A trauma research workshop was held on 4 November 2019.

Australia and New Zealand Intensive Care Society

The Commission holds the contract for the Australia and New Zealand Intensive Care Society (ANZICS) clinical register. This is funded by the Ministry of Health and goes directly and in total to ANZICS for the provision of the register to New Zealand intensive care units.

Te whakamahere tiaki i mua i te wā taumaha | Advance care planning

The five-year advance care planning (ACP) strategy[84] and roadmap of actions have created a positive and productive collaboration between the Commission, the regions and DHBs. District-level provision of quality ACP services is supported by national awareness raising, stakeholder engagement, training and implementation guidance.

The three-year funding provided by DHBs has resulted in major progress at a national and local level in the past 12 months to ensure advance care plans (ACPlans) are documented, shared, reviewed and used.

84 www.hqsc.govt.nz/our-programmes/advance-care-planning/publications-and-resources/publication/3189

The national programme team has worked closely with the DHB ACP teams to support implementation of local ACP services. The number of DHBs with the key enablers to implement ACP has increased, this includes full-time equivalent (FTE) positions, promotion, education and systems for ACP in their districts. All DHBs have systems to document and retrieve ACP plans.

The programme's equity focus has been strengthened through the formation of a Māori leadership group, adaptation of training materials, the development of a new whānau ACP resource to support whānau engagement with ACP, and work exploring consumer and whānau experiences of conversations.

The Commission's leadership of the ACP programme has allowed the support of and access to the Commission's Māori health outcomes team, ensuring a focus on increased ACP access for Māori.

Work with the Commission's patient deterioration programme, with its shared goals of care workstream for a consistent and joined-up approach, and the support of the Commission's partners in care programme give stronger consumer input to the ACP programme.

The way the Commission's various programmes work together was also invaluable in providing ACP support, tools and resources to clinicians during New Zealand's response to the COVID-19 pandemic.

The train-the-trainer programme has trained 103 DHB employees to deliver training in their districts. A substantial number of clinicians have attended ACP and Serious Illness Conversation Guide training.[85,86]

Response to the COVID-19 pandemic

- The ACP programme responded to the COVID-19 pandemic by quickly providing online resources to support clinicians to have person and whānau-centred conversations and shared decision-making with people who were COVID-19 positive or at higher risk if they did contract COVID-19.
- A new section on the Commission's website[87] – talkingCOVID/me kōrero COVID – was launched, with resources arranged by the main activity they support and focused on discussions and planning in hospital and ARC settings. The pages have been among the highest viewed on the Commission's website. TalkingCOVID shows the interconnectivity of the Commission's various programmes, tools and approach to person-centric care, planning and delivery, and brings together ACP, the Serious Illness Conversation Guide and the shared goals of care form for COVID-19.

Aged residential care programme

Our work to support and partner with the ARC sector delivered on key milestones through 2019/20. While the emphasis remains on three core areas (medicines optimisation, learning from adverse events and looking at improving the identification and management of resident decline), we had to change focus and timelines due to the disruptions caused by COVID-19. Highlights are noted below.

In late July 2019 we shared a collection of personal stories about what is important to people and their families/whānau when entering ARC in Aotearoa New Zealand. *Nau mai, haere mai ki tōku kainga hou | Welcome to my home: He kōrero mai i ngā tāngata e noho ana ki te tiakitanga ā-noho mō te pahake | Stories from people living in aged residential care*[88] summarises the stories of 13 people and whānau experiencing life in ARC. It is based on a series of questions focusing on 'What's important to me?'. It also includes a discussion guide, written by our clinical lead Dr Michal Boyd, covering topics for the purposes of quality improvement that are based on themes drawn from the interviews.

In September 2019, we published the Frailty Care Guides, which are a suite of 26 decision support tools aimed at the nursing workforce caring for our frail elderly population. These have been well received and we will investigate whether we can translate them into online learning modules in the year ahead through an innovative sector partnership model.

In April 2020 we published *Guidance for preventing and controlling COVID-19 outbreaks in New Zealand aged residential care*.[89] The document supports the prevention and control of COVID-19 outbreaks in ARC facilities in Aotearoa New Zealand. It is intended to align with and not substitute guidance from the Ministry of Health or local response guidance from DHBs. The Commission recognised that, while the whole population is at risk of COVID-19 (the infection caused by the SARS-CoV-2 virus), older people – who are often frail and subject to multi-morbidity – are at highest risk for severe and fatal disease. Older people in residential care are also more at risk because of communal living and the number of staff they are in close contact with from the community. Because of this high risk, the guidance is strongly focused on ARC facilities.

85 www.hqsc.govt.nz/our-programmes/advance-care-planning/projects/serious-illness-conversations

86 www.hqsc.govt.nz/our-programmes/advance-care-planning/projects/staff-information

87 www.hqsc.govt.nz/our-programmes/talking-covid

88 The initiative features the group picture www.hqsc.govt.nz/our-programmes/aged-residential-care/publications-and-resources/publication/3757.

89 www.hqsc.govt.nz/our-programmes/aged-residential-care/publications-and-resources/publication/3975

3 How we strengthen and operate our organisation
Ngā ara whakapakari me te whakahaere i tō mātou umanga

This section details the work we are doing to strengthen our organisation and the areas we have prioritised for improvement in 2019/20. Part of this work includes embedding and enacting Te Tiriti across all that we do, strengthening our partnerships and engagement abilities, working sustainably and supporting and developing our people and their diversity.

We also detail the Commission's governance structure (our Board) and how the Board is supported through sub-committees and advisory groups that help inform decision-making and best practice governance.

We also detail our financial management arrangements, including compliance and risk management, and provide our financial statements.

Monitoring and reporting

In 2019/20 we continued providing regular update reports and quarterly update reports on performance against our SPE to the Minister with delegated responsibility for the Commission. We met regularly with the Minister of Health and kept the Minister and Ministry of Health informed of any potentially contentious events or issues in a timely manner.

Embedding Te Tiriti o Waitangi in all that we do

As noted, because we are a Crown agency, we have responsibilities under Te Tiriti o Waitangi. We refer to Te Tiriti 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.[90] The three articles of Te Tiriti o Waitangi, and the Ritenga Māori Declaration,[91] now underpin and are applied to our work.[92]

In the past year, we stepped up to the challenges put to us by stakeholders in our PIF self-review. We recrafted our strategic direction and shaped our work more strongly to progress embedding the articles of Te Tiriti o Waitangi in everything we plan and do in our work.

Partnering and engaging

We are a partnership-focused organisation, we collaborate with and support others to work towards quality health for all. This means working across the system with our partners and stakeholders, including iwi, hapū, whānau Māori, Pacific peoples, clinicians, government agencies, academics, non-governmental organisations, the health sector workforce and professional health bodies. During 2019/20, we have developed our relationships and partnerships further and supported our staff to develop their expertise in working through and alongside others.

Environmental sustainability

The Government's Climate Change Response (Zero Carbon) Amendment Act 2019 sets a clear requirement for New Zealand to be net carbon neutral by 2050. While the Commission is a small agency, it aims to make a difference through its all-of-government procurement of services and to influence environmental behaviour changes within the Commission.

In operating with all-of-government contracts, associated spend and indicative savings over the life of the contracts, we have had 9.8 percent savings, which includes air travel, information technology hardware, mobile voice and data services and office consumables totalling $0.178 million.

Travel carbon is fully offset each year. For 2019/20, travel carbon reduced 33 percent. Carbon offset was 324 tonnes for the year down from 483 tonnes in 2018/19.

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

91 Sometimes also called the 'fourth article', the forgotten 'article' or the 'oral article'.

92 Statement of Intent 2020–24, Te Tiriti o Waitangi as our foundation, page 19.

Developing and strengthening our organisation through our people

Our people are our greatest asset. This year we focused on ensuring our workforce planning is fit for purpose and on building in continuous improvement. We provide equal employment opportunities and ensure our policies, practices and processes are fair and equitable for all job applicants and employees. We recognise the Crown's obligations under Te Tiriti and the aspirations of Māori, other ethnic or minority groups, and people with disabilities.

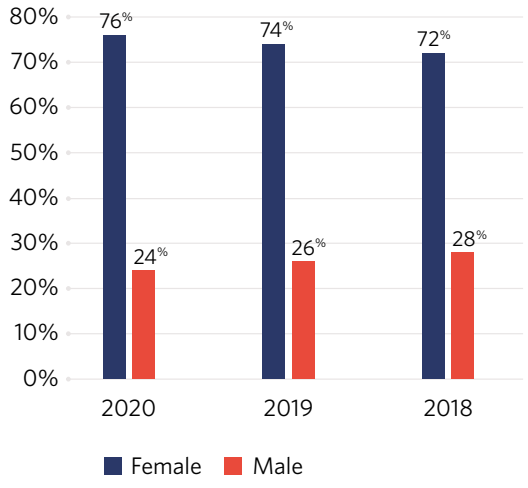
We are committed to fostering safe working environments that let our staff focus on quality improvement as their main priority. We are concentrating on human resources, infrastructure and leadership to improve working conditions and provide better health services for whānau Māori, Pacific peoples and all New Zealanders.

As at 30 June 2020, the Commission had 85 staff members (79 FTEs). Two of these FTEs were on secondment for the full year. Seventy were full-time (64 in 2019) and 20 were part-time (14 in 2019). Fifty-three percent had more than two years of service with the Commission (53 percent in 2019). Fourteen percent of staff were fixed-term, down from 18 percent in 2019. Eighty-two percent of the executive leadership team are female. Around 6 percent of our staff identify that they live with a disability.

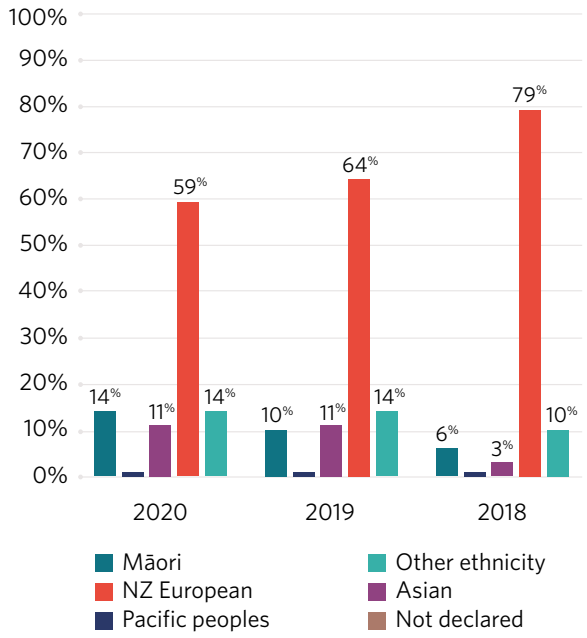
We have increased our Māori workforce over the past two years from 6 percent to 14 percent.

Wherever possible, we ensure the workplace environment is suitable for our people who experience a disability. The Commission is the latest signatory of the Government Accessibility Charter, which is a commitment to providing accessible information and online tools to all disabled people. An accessibility charter will be developed in 2020/21. The charter will require us to work on making information accessible, so everyone can interact with in a way that meets their individual needs and promotes their independence and dignity.

Gender



Ethnicity



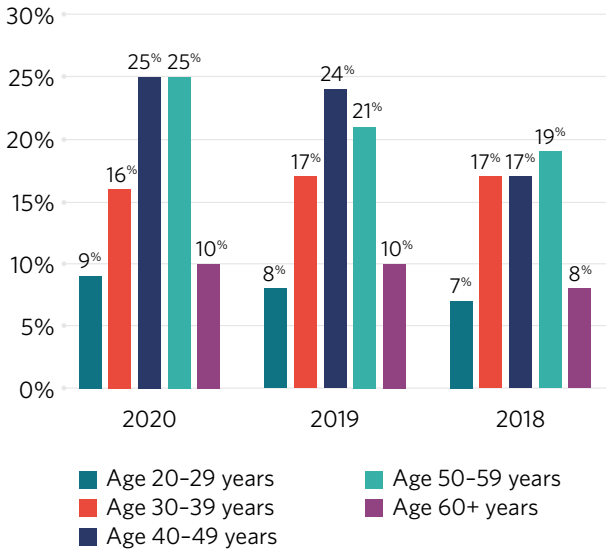
As an organisation, our focus has always been on creating a world-class and patient-centred health and disability support system in New Zealand. By signing the charter, we can realise our vision of 'Hauora kounga mō te katoa, quality health for all'.

Over the year, we continued planning, implementing and monitoring our work relating staff wellbeing. Our objectives include:

- reduced ethnic and gender pay gaps
- active flex-by-default work policies
- increasing the diversity of our staff through our recruitment plans, with a particular focus on Māori
- diversity of gender expression and sexuality through our rainbow tick
- gender-neutral recruitment and talent management
- religious, ethnic and cultural diversity, including Pacific peoples and other population groups
- accessibility and impairment.

The Commission values its people and emphasises the value of working together through the kaupapa of 'kotahitanga'.

Age demographics



Equal employment opportunities and the Rainbow Tick

The Commission has an equality and diversity policy in place and is committed to equal employment for all groups of people. We are also proud to have received the Rainbow Tick in June 2019. To get this certification, we completed a diversity and inclusion process that assessed that our workplace understands, values and welcomes sexual and gender diversity.

We have already made advances in promoting equal employment opportunities, including minimising any differences to employee entitlements while on parental leave; increasing meaningful reporting on diversity data; and separating remuneration from performance. All of these are important enablers of a more diverse and inclusive working environment.

Remuneration

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

Gender pay equity

Our gender pay gap has decreased significantly over the past 12 months. Based on average salaries for 2019/20, the gap is calculated at 2 percent down from 7 percent in 2019. This is lower than the last reported public service average pay gap, which was 10 percent in 2019. If the calculation takes median hourly earnings into account, the gap is also now 2 percent down from 10 percent in 2019. We are unable to calculate a 'motherhood penalty' total because we do not collect this level of personal detail from staff.

Flexibility and work design

The Commission supports flexible work arrangements for employees who have carer responsibilities[93] and for other reasons, such as study and career development. Flexible arrangements may include:

- changes to hours of work
- part-time work
- working from home.

The Commission's information technology and modern communication technologies also let staff work flexibly.

Staff wellness

Our staff are our greatest asset and resource. Staff are passionate about their work and invest a lot of energy and time working for the Commission. Their wellbeing is important to us and helps them to do the best job they can. We see immense value in supporting staff so they can carry out their work and still have time for their families, whānau and outside-of-work interests, as well as being supported in dealing with work-related stress. We want to be an employer of choice and operating with this recognition helps us to attract and retain the best people for our work.

Health and safety

The Commission has a primary duty of care to ensure the health and safety of its staff, contractors and visitors. To do this, the Commission ensures collective responsibility for proactively promoting and encouraging safe and healthy work practices. Managers, staff, contractors, facilities contractors and the health, safety and wellness committee all have a role in supporting health, safety and wellbeing in the Commission.

The Commission Board, through the chief executive, is updated regularly on all matters relating to the Commission's health and safety. Managers maintain a watching brief and are proactive in addressing and minimising any potential situations where stress or fatigue could develop. Managers and staff have the opportunity to take part in risk and hazard identification and regularly review work and systems to minimise any risks.

Staff who might suffer from a workplace injury or illness receive appropriate rehabilitative care. Staff also have the opportunity to take part in any external health and safety audits that are conducted. In all cases, staff are encouraged to take part in wellness activities while receiving ongoing education about health and safety. All health and safety, and wellness-committee representatives, are required and have received training to carry out their health and safety duties.

93 Meeting the provision of Part 6AA of the Employment Relations Act 2000.

Governance

The Board

The Commission is governed by a board of 10 members who are appointed by the Minister of Health and led by Dr Dale Bramley.

Sub-committees and advisory groups also support the Board in its governance decision-making.

Dr Dale Bramley
Nga Puhi, Ngāti Hine and Whānau Apanui

Rae Lamb

Shenagh Gleisner

Mena Antonio

Dr Colin Tukuitonga
Nuie

Dr Wil Harrison
Ngāti Pōrou

Dr Tristram Ingham
Ngāti Kahungunu ki Heretaunga, Ngāti Pōrou

Dr Jenny Parr

Dr Peter Crampton

Mr Andrew Connolly

Te Rōpū Māori Advisory Group

Te Rōpū Māori is an external group that advises our board and 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. Te Rōpū Māori also provides ongoing leadership in the development of Te Whai Oranga and oversees its implementation. Te Whai Oranga is a practical resource, linking strategic elements with practical examples and achievable goals.

In addition to Te Rōpū Māori, a network of clinical and expert advisors works with us across all that we do. Included in this network are Māori advisors who help us 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.

Te Rōpū Māori provides guidance and support for working in active Te Tiriti partnerships with Māori.

Chair – Ria Earp
Ngāti Whakaue, Ngāti Pikiao

Dr Fiona Cram
Ngāti Pāhauwera

Sue Crengle
Waitaha, Kāti Māmoe and Kāi Tahu

Marama Parore
Ngāti Whātua, Ngāti Kahu, Ngāpuhi

Muriel Tunoho
Ngāti Raukawa

Prof Denise Wilson
Ngāti Tahinga (Tainui)

Wikepa Keelan
Ngāti Porou, Te Whānau a Rongomai Wāhine

Ngā Pou Arawhenua

The Māori members of our mortality review committees have an operating Māori caucus (Ngā Pou Arawhenua) that helps to make each committee's reviews more responsive to Māori. With their input, they have helped the committees' processes, and our analysis and recommendations have become more culturally valid and appropriate. Ngā Pou Arawhenua works with Te Rōpū Māori and advises the Board on request.

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 Consumer Advisory Group has four members, and two of these identify as Māori. 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 safety and quality.

The Consumer Advisory Group provides input and advice from consumer partners.

Rowena Lewis (Chair)
Ngāi Tahu

Martine Abel-Williamson

Muriel Tunoho
Ngāti Raukawa

Frank Bristol
Whanganui

Audit Committee

The Audit Committee, which includes an independent member, provided assurance and help to the Board on our financial statements and internal control systems.

The Audit Committee is made up of Andrew Boyd, Shenagh Gleisner, Dr Dale Bramley and the Commission management.

The Audit Committee provides assurance and help to the Board on our financial statements and internal control systems.

Managing our finances

The Commission works carefully within its funding levels and annually delivers on the Government's expectations.

By using modern communication systems, such as videoconferencing, we have been able to work differently and reduce face-to-face meetings. Our accommodation and associated costs are considerably lower than most similar agencies. In addition, we keep costs low by outsourcing corporate support services such as legal, human resources and information technology services.

In 2019, the Commission committed additional funding to support advancing Māori health. In this model, a central team with Māori health expertise and a Māori health equity focus is available to work with and oversee other teams. This team is now in place and supporting the Commission to develop partnerships with iwi, hapū, Māori communities and organisations to start specific improvement initiatives that address the needs and issues of populations experiencing the worst health outcomes.

We maintain sound management of public funding by complying with relevant requirements of the Public Service Act 2020, the Public Finance Act 1989 and applicable Crown entity legislation. The annual audit review from Audit New Zealand provides useful recommendations on areas for improvement. We implement these recommendations, with oversight by our audit committee.

Compliance

We meet our good employer requirements and obligations under the Public Finance Act 1989, the Public Records Act 2005, the Public Service Act 2020, the Health and Safety at Work Act 2015, the Crown Entities Act 2004 and other applicable Crown entity legislation through our governance, operational and business rules. We continue to use the ComplyWith legislative compliance information, monitoring and reporting programme, which shows we have a consistently high level of overall compliance. We will continue to comply with all legislative requirements, and proactively implement processes to address any issues that arise wherever possible.

Risk management

All Commission staff are aware of the process for risk identification and management. The Board, chief executive, senior management team and programme managers identify strategic and operational risks in consultation with their teams, as appropriate. Programme managers are accountable for risks in their programmes.

Risk management is a standing agenda item at each board meeting. Our audit committee provides independent assurance and help to the Board on our financial statements and the adequacy of systems of internal controls.

Revenue/expenses for output classes

	Output class 1 Intelligence		Output class 2 Improvement		Total	
	$000s		$000s		$000s	
	Actual	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**
Revenue						
Crown revenue	8,541	8,541	5,712	5,713	14,253	14,254
Interest revenue	11	18	13	22	24	40
Other revenue	87	52	4,575	4,365	4,662	4,417
Total revenue	**8,639**	**8,611**	**10,300**	**10,100**	**18,939**	**18,711**
Expenditure						
Operational and internal programme costs	6,210	6,112	7,560	7,383	13,770	13,495
External programme cost	2,973	2,824	2,311	3,011	5,284	5,835
Total expenditure	**9,183**	**8,936**	**9,871**	**10,394**	**19,054**	**19,330**
Surplus/(deficit)	(544)	(325)	429	(294)	(115)	(619)

Financial statements

Statement of comprehensive revenue and expenses for the year ended 30 June 2020

Actual 2019		Notes	Actual 2020	Budget 2020
$000			**$000**	**$000**
	Revenue			
14,700	Revenue from Crown	2	14,253	14,254
60	Interest revenue		24	40
3,089	Other revenue	3	4,662	4,417
17,849	**Total revenue**		**18,939**	**18,711**
	Expenditure			
9,635	Personnel costs	4	10,595	10,885
191	Depreciation and amortisation	12, 13	180	166
3,022	Other expenses	6	2,995	2,444
3,545	External quality and safety programmes		3,532	4,051
1,892	External mortality programmes		1,752	1,784
18,285	**Total expenditure**		**19,054**	**19,330**
(436)	**Surplus/(deficit)**		**(115)**	**(619)**
0	Other comprehensive revenue		0	0
(436)	**Total comprehensive revenue**		**(115)**	**(619)**

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 2020

Actual 2019		Notes	Actual 2020	Budget 2020
$000			**$000**	**$000**
	Assets			
	Current assets			
2,215	Cash and cash equivalents	7	2,582	1,858
157	Goods and Services Tax receivable		121	317
802	Debtors and other receivables	8	264	261
128	Prepayments		107	56
3,302	**Total current assets**		**3,074**	**2,492**
	Non-current assets			
367	Property, plant and equipment	12	220	192
0	Intangible assets	13	0	0
367	**Total non-current assets**		**220**	**192**
3,669	**Total assets**		**3,294**	**2,684**
	Liabilities			
	Current liabilities			
1,365	Creditors and other payables	14	768	1,136
426	Employee entitlements	16	692	464
0	Revenue in advance		52	0
1,791	**Total current liabilities**		**1,512**	**1,690**
	Non-current liabilities			
90	Employee entitlements	16	110	90
90	**Total non-current liabilities**		**110**	**90**
1,881	**Total liabilities**		**1,622**	**1,690**
1,788	**Net assets**		**1,673**	**994**
	Equity	17		
1,724	General funds July		1,288	1,113
500	Contributed capital		500	500
(436)	Surplus/(deficit)		(115)	(619)
1,788	**Total equity**		**1,673**	**994**

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 2020

Actual 2019		Notes	Actual 2020	Budget 2020
$000			**$000**	**$000**
1,724	Balance at 1 July		1,288	1,113
	Comprehensive revenue and expenses for the year			
(436)	Surplus/(deficit)		(115)	(619)
1,288			**1,173**	**494**
	Owner transactions			
500	Capital contribution		500	500
1,788	**Balance at 30 June**	17	**1,673**	**994**

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 2020

Actual 2019		Notes	Actual 2020	Budget 2020
$000			**$000**	**$000**
	Cash flows from operating activities			
14,700	Receipts from Crown		14,253	14,254
2,856	Other revenue		5,251	4,386
60	Interest received		24	40
(9,635)	Payments to suppliers		(10,308)	(8,323)
(8,403)	Payments to employees		(8,856)	(10,885)
69	Goods and Services Tax (net)		36	11
(353)	Net cash flow from operating activities	18	400	(517)
	Cash flows from investing activities			
(131)	Purchase of property, plant and equipment		(33)	(40)
0	Purchase of intangible assets		0	0
(131)	Net cash flow from investing activities		(33)	(40)
	Capital flows from financing activities			
0	Capital contribution		0	0
0	Net cash flows from financing activities		0	0
(484)	**Net (decrease)/increase in cash and cash equivalents**		**367**	**(557)**
2,699	Cash and cash equivalents at the beginning of the year		2,215	2,415
2,215	**Cash and cash equivalents at the end of the year**	7	**2,582**	**1,858**

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. The Commission 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 2020 and were approved by the Board on 26 November 2020.

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.

Standards issued and not yet effective and not early adopted

Standards and amendments issues but not yet effective, that have not been early adopted, and which are relevant to the Commission are as follows:

Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBEIPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes.

This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The Commission does not intend to early adopt the amendment.

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 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.

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 the Commission's objectives as specified in the Statement of Intent. The Commission considers no conditions are 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. No provisions for impairment are in place in 2019/20.

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. No inventories are held for sale in 2019/20.

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 stops at the date the asset is derecognised. 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, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position. The net GST paid to or received from the IRD, 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 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 Kiwi Saver, 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.

Note 3: Other revenue

Total other revenue received was $4.662 million (2019: $3.089 million), consisting of:

- $1.500 million (2019: $1.500 million) from DHBs for the mental health and addiction quality improvement programme
- $0.892 million (2019: $0.793 million) from DHBs for the advance care planning programme
- $1.225 million (2019: $0.243 million) from DHBs for infection prevention and control
- $0.056 million (2019: $0.068 million) from additional workshop and event revenue
- $0.802 million (2019: $0.149 million) from ACC for the National Trauma Network
- $0.050 million (2019: $0.109 million) from adverse events training workshops
- $0.044 million (2019: $0.015 million) from ACC and PHARMAC for Patient Safety Week
- $0.067 million (2019: $0.056 million) from DHBs for patient experience surveys question set
- $0.019 million (2019: $0.038 million) from ACC and PHARMAC towards behavioural insights measurement
- $0.007 million (2019: $0.118 million) other revenue.

Note 4: Personnel costs

	Actual 2019 $000	Actual 2020 $000
Salaries and wages	8,456	9,546
Recruitment	98	54
Temporary personnel	687	380
Membership, professional fees and staff training and development	131	199
Defined contribution plan employer contributions	192	217
Increase/(decrease) in employee entitlements	71	199
Total personnel costs	**9,635**	**10,595**

Employer contributions to defined contribution plans include kiwi Saver, the Government superannuation fund, and the National Provident Fund.

Note 5: Capital charge

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

Note 6: Other expenses

	Actual 2019 $000	Actual 2020 $000
Audit fees to Audit New Zealand for financial audit	36	36
Staff travel and accommodation	356	295
Printing and communications	173	219
Consultants and contractors	455	619
Board costs and mortality review committees	732	491
Lease rental	417	526
Outsourced corporate services and overheads	818	803
Loss on property, plant and equipment	27	0
Other expenses	8	6
Total other expenses	**3,022**	**2,995**

Note 7: Cash and equivalents

	Actual 2019 $000	Actual 2020 $000
Cash at bank and on hand	2,215	2,582
Total cash and cash equivalents	**2,215**	**2,582**

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 2019 $000	Actual 2020 $000
Debtors and other receivables	802	264
Less: provision for impairment	0	0
Total debtors and other receivables	**802**	**264**

Fair value

The carrying value of receivables approximates their fair value.

Impairment

The impairment of short-term receivables is now determined by applying an expected credit loss model.

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 2019/20.

Note 11: Non-current assets held for sale

The Commission has no current or non-current assets held for sale in 2019/20.

Note 12: Property, plant and equipment

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

	Computer	Furniture and office equipment	Leasehold improvements	Total
		$000	$000	$000
Cost or valuation				
Balance at 1 July 2018	525	341	53	919
Additions	84	40	32	156
Disposals	(212)	0	0	(212)
Balance at 30 June 2019/1 July 2019	397	381	85	863
Additions	4	30	0	34
Disposals	(31)	(6)	0	(37)
Balance at 30 June 2020	371	405	85	860
Accumulated depreciation and impairment losses				
Balance at 1 July 2018	237	250	24	511
Depreciation expense	124	45	16	185
Elimination on disposal	(200)	0	0	(200)
Balance at 30 June 2019/1 July 2019	161	295	40	496
Depreciation expense	128	35	17	180
Elimination on disposal	(29)	(6)	0	(35)
Balance at 30 June 2020	260	324	57	641
Carrying amounts				
At 1 July 2018	288	91	29	408
At 30 June and 1 July 2019	236	86	45	367
At 30 June 2020	111	81	28	220

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 2018	119
Additions	0
Disposals	(118)
Balance at 30 June 2019/1 July 2019	**1**
Additions	0
Disposals	0
Balance at 30 June 2020	**1**
Accumulated amortisation and impairment losses	
Balance at 1 July 2018	**98**
Amortisation expenses	6
Elimination on disposal	(103)
Balance at 30 June 2019/1 July 2019	1
Amortisation expenses	0
Elimination on disposal	0
Balance at 30 June 2020	**1**
Carrying amounts	
At 1 July 2018	21
At 30 June and 1 July 2019	0
At 30 June 2020	0

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 2019 $000	Actual 2020 $000
Creditors	**609**	**373**
Accrued expenses	752	392
Other payables	4	3
Total creditors and other payables	**1,365**	**768**

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

The Commission does not have any borrowings.

Note 16: Employee entitlements

	Actual 2019 $000	Actual 2020 $000
Current portion		
Accrued salaries and wages	69	156
Annual leave and long-service leave	357	536
Total current portion	426	692
Non-current portion long-service leave	90	110
Total employee entitlements	**516**	**802**

No provision for sick leave or retirement leave has been made in 2019/20. Provision for long-service leave has been made in 2019/20.

Note 17: Equity

	Actual 2019 $000	Actual 2020 $000
General funds		
Balance at 1 July	1,724	1,288
Surplus/(deficit) for the year	(436)	(115)
	1,288	**1,173**
Capital contributions	500	500
Balance at 30 June	**1,788**	**1,673**

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

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

	Actual 2019 $000	Actual 2020 $000
Net surplus/(deficit)	**(436)**	**(115)**
Add/(less) movements in statement of financial position items		
Debtors and other receivables	(164)	574
Creditors and other payables	59	(546)
Depreciation	191	180
Prepayments	(56)	21
Employee entitlements	53	286
Net movements in working capital		
Net cash flow from operating activities	**(353)**	**400**

Note 19: Capital commitments and operating leases

Capital commitments

There were no capital commitments at balance date (2019: nil).

Operating leases as lessee

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

	Actual 2019 $000	Actual 2020 $000
Not later than one year	**314**	**354**
Later than one year and not later than five years	235	0
Later than five years	0	0
Total non-cancellable operating leases	**549**	**354**

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 one-year right of renewal. The value of the lease to March 2021 is $0.321 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 expiry date is December 2020.

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

Note 20: Contingencies

Contingent liabilities

The Commission has no contingent liabilities (2019: $nil).

Contingent assets

The Commission has no contingent assets (2019: $nil).

Note 21: Related party transactions

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

The Commission is a wholly 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[94] totalled $1.50 million, 5 FTE (2019: $1.15 million, 4 FTE).

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 2019/20 year was as follows.

	Actual 2019 $000	Actual 2020 $000
Prof Alan Merry* (outgoing Chair) – term expired	29	7
Shelley Frost (Deputy Chair) – term expired	8	0
Dr Bev O'Keefe – term expired	15	4
Dame Alison Paterson – term expired	15	6
Dr Dale Bramley* (new Chair)	17	26
Robert Henderson* – term expired	15	4
Mr Andrew Connolly	9	15
Gwendoline Tepania-Palmer – term expired	15	6
Dr Gloria Johnson* – resigned	15	6
Dr Jennifer Parr	0	13
Philomena Antonio	0	7
Dr Collin Tukuitonga	0	3
Professor Peter Crampton	0	4
Raewyn Lamb (new Deputy Chair)	0	14
Shenagh Gleisner	0	11
Dr Tristram Ingham	0	3
Dr Wil Harrison	0	3
Total board member remuneration	**138**	**132**

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.

94 Key management personnel for 2019/20 include the chief executive; director, health quality improvement and deputy chief executive (disestablished); director, health quality intelligence; medical director (new to key management 2020); and chief financial officer. Board members are reported separately.

The Commission has taken directors' and officers' liability and professional indemnity insurance cover during the financial year regarding 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 fee's framework, where they are eligible for payment. Generally, daily rates are $463 per day for chairs and $330 per day for committee members.

Note 23: Employee remuneration

Total remuneration paid or payable was as follows.

	Employees 2019	Employees 2020
$100,000–$109,999	3	8
$110,000–$119,999	8	4
$120,000–$129,999	7	9
$130,000–$139,999	3	6
$140,000–$149,999	1	0
$150,000–$159,999	2	4
$160,000–$169,999	1	1
$170,000–$179,999	3	2
$180,000–$189,999	1	2
$200,000–$209,999	0	1
$220,000–$229,999	2	0
$230,000–$239,999	0	1
$240,000–$249,999	1	1
$250,000–$259,999	0	1
$260,000–$269,999	1	0
$270,000–$279,999	1	1
$330,000–$339,999	0	1
$400,000–$409,999	0	1
$410,000–$419,999	1	0
Total employees	**35**	**43**

During the year ended 30 June 2020 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 2019/20 Statement of Performance Expectations follow.

Statement of comprehensive revenue and expenses

The year-end result for the year to 30 June 2020 is a $0.115 million deficit against a planned SPE deficit of $0.619 million.

Reduced expenditure on personnel and external quality and safety programmes compared with budgeted figures relates to revenue received and recognised in 2019/20 for suicide mortality review ($0.130 million), mental health ($0.124 million), the Surgical Site Infection Improvement programme ($0.250 million) and the residual of the maternal morbidity improvement programme ($0.75 million) where activity is now to be delivered in 2020/21 rather than 2019/20.

Wellington property lease rental costs were higher than budget by $0.113m per annum due to a rent review being finalised in November 2019. Travel, committee and advisory costs reduced significantly in the last three months of the year due to the disruption caused by the COVID-19 pandemic, which affected the Commission's ability to engage with the frontline health services.

Statement of financial position

Cash and cash equivalents were higher than budgeted due to revenue to the value of $0.579 million received in 2019/20 where the expenditure against this revenue will now occur in 2020/21. Employee entitlements increase cash and cash equivalents and are $0.248 million higher than budgeted due to a higher level of accrued annual leave during the last three months of the year while staff deferred taking holidays during the COVID-19 lockdown.

Statement of changes in cashflow

Because the Commission received an additional $0.660 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 and currently does not plan to do so.

Note 29: Responsibilities under the Public Finance Act

To comply with our responsibilities under the Public Finance Act 1989, we report here the activities funded through the Crown Vote Health and how performance is measured against the forecast information contained in the Estimates of Appropriations 2019/20 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 2019/20 $000	Budget 2019/20 $000	Location of end-of-year performance information
Crown Funding (Vote Health – Monitoring and Protecting Health and Disability Consumer Interests (M36))	12,976	12,976	The end-of-year performance information for this appropriation is reported in the Statement of Performance section page 10

The Commission also received Crown funding of:

- $0.750 million from Vote Health – Mental Health
- $0.215 million from Vote Health – National Personal Health Services
- $0.312 million from Vote Health – Primary Health Care Strategy.

Note 30: Impact of COVID-19

Due to the COVID-19 global pandemic, in late March 2020 the New Zealand Government declared a State of National Emergency. This resulted in New Zealand entering a 4-week national lockdown. Restrictions were then gradually relaxed and from early June 2020, New Zealand moved to alert level 1. At alert level 1, there are no significant restrictions within New Zealand however there continue to be significant border controls severely limiting access into New Zealand.

We have assessed the impact of the pandemic on the Health Quality & Safety Commission. We have also reviewed our financial statements on a line by line basis and made any adjustments necessary in accordance with NZ GAAP. Overall, we concluded that the impact of the COVID-19 pandemic was not material to the entity's operations or current year financial statements. The main factors contributing to this conclusion are:

- *Revenue* – This is mainly Crown and DHB revenue, which was not impacted by COVID-19
- *Cash* – No impact to the carrying value of cash on hand
- *Receivables* – No impact to the expected credit loss model when calculating impairment losses, the Commission deals with customers with little or no credit risk
- *Property, plant and equipment* – No impact on the impairment of these types of assets. The Commission purchases plant and equipment mainly from the All-of-Government panel of suppliers
- *Payables* – No accrued costs related to the expected impact of COVID-19 have been made
- *Employee liabilities* – No changes have been assessed as being required for calculations of employee liabilities associated with COVID-19.

Statement of responsibility

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 2020.

Signed on behalf of the board:

Dr Dale Bramley
Chair
4 December 2020

Shenagh Gleisner
Chair Audit Committee
4 December 2020

Auditor's report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of the Health Quality and Safety Commission's financial statements and performance information for the year ended 30 June 2020

The Auditor-General is the auditor of the Health Quality and Safety Commission (the Commission). The Auditor-General has appointed me, Stephen Usher, 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 44 to 59, that comprise the statement of financial position as at 30 June 2020, 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 10 to 30 and 43.

In our opinion:

- the financial statements of the Commission on pages 44 to 59:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2020; 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 the Public Benefit Accounting Standards Reduced Disclosure Regime; and
- the performance information on pages 10 to 30 and 43:
  - presents fairly, in all material respects, the Commission's performance for the year ended 30 June 2020, 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
    - what has been achieved with the appropriations; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 4 December 2020. This is the date at which our opinion is expressed.

The basis for our opinion is explained below, and we draw attention to the impact of Covid-19 on the Commission. 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.

Emphasis of matter – Impact of Covid-19

Without modifying our opinion, we draw attention to the disclosures about the impact of Covid-19 on the Commission as set out in note 30 of the financial statements and the performance information on pages 10 to 30.

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 9 and 31 to 42, 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 accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1: International Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Other than in our capacity as auditor, we have no relationship with, or interests, in the Commission.

Stephen Usher
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Te Kāwanatanga o Aotearoa

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