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ANNUAL REPORT

FOR THE PERIOD
1 JULY 2015 TO 30 JUNE 2016

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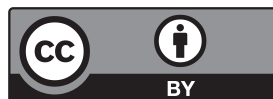

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Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

open
FOR BETTER CARE
Hāpai ake te toiora

Patient story – making a difference for mum

Shirley Hope

Patient stories keep the focus on the user's perspective, which is important when planning and providing integrated services. One of our reducing harm from falls programme team members has described the 'patient journey' in relation to a parent's recent fall and fracture using quotes from the parent's experience. Her mum's story illustrates the difference the Health Quality & Safety Commission is trying to make for people and the system.

While preparing the evening meal, I overbalanced and fell heavily on my side, fracturing my femur and detaching my hip replacement. I was taken by ambulance to hospital. I thought I would have surgery very soon as I felt my injuries were reasonably severe, but I was in traction with a catheter for six days and seven nights before I finally went for surgery after it was cancelled twice. When I got home it took some time for someone to come and assess my needs, then the helpers from the support organisation didn't come when they were supposed to. After three weeks of no action on that, we decided to employ our own helper. Then my hip dislocated and I had to go to the emergency department to have it re-set. I didn't really know what I should and shouldn't do in case it happened again, and it was quite worrying.'

Her mum's fall had a significant impact on the family. Her surgery was delayed and bedrest caused her a lot of problems. The family felt she lost confidence not knowing what she could and couldn't do, and she was quite cautious until she arranged a private consultation for advice.

The Commission's reducing harm from falls programme supports a number of interventions which, had they been in place, may mean this fall could have been avoided or her fracture managed better. These include:

- screening for risk of falling at least yearly at a general practice
- undertaking a multi-factorial risk assessment and plan of care at 75 years of age and/or when she changed general practitioner (GP), including assessment of bone health and whether prescribed vitamin D supplements were needed
- referral to a local balance and strength programme and consideration of a home safety assessment
- receiving surgery within 48 hours
- good communication, and timely home care support and advice from the clinical team
- the patients GP being advised of discharge, and the practice getting in touch for a follow-up appointment within 48 hours
- support and information, perhaps through a fracture liaison service.

Our vision

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

Our values

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

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

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

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

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

Adding value – We focus on adding and demonstrating our value to the health and disability system and to the health of communities.

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Foreword

The Health Quality & Safety Commission (the Commission) has been working for nearly six years, and we are proud of the difference it is making, both in the health and disability sector and to the lives of ordinary New Zealanders. We work with a wide range of health organisations, both behind the scenes and in more prominent roles, to improve the quality and safety of services. Our work covers an ambitious range of programmes that target critical improvement opportunities throughout New Zealand, in health care facilities large and small, rural and urban. Often, we are able to provide leadership and guidance to help clinicians make the improvements they know are necessary but that they lack the time and resources to make alone. We take our national legislative mandate to lead and coordinate health quality and safety activity in New Zealand extremely seriously, because we know it has the potential to deliver sustainable advances in quality and better value for money for all New Zealanders.

We would like to congratulate health care professionals for their diligent work and commitment to quality improvement and safer care in 2015/16. Without their hard work to implement Commission initiatives and change organisational culture, we could not spread these essential ideas and change practice for the better. It also takes time and effort to involve health care consumers and their families/whānau in co-designing care so it responds to their needs first and foremost, rather than to the needs of the system.

It is equally important to acknowledge the hard work of the Commission's dedicated staff over the past year. Through their tireless efforts, commitment to helping others, and positive problem-solving expertise, we have been able to bring the Commission's work to an ever-larger number of organisations, and let more and more people know the Commission is a team that can help get important work moving in a sector where it can be hard to change 'the way things have always been done'.

In 2015/16 we welcomed the future vision set out by the Minister of Health in the 2016 New Zealand Health Strategy. This presents an exciting opportunity to cement the commitment to improving quality and safety in partnership with the sector. The strategy's five themes – people-powered, closer to home, value and high performance, one team and smart system – are guiding our current work and future planning.

We welcome the chance to look back on our successful year in 2015/16, and are excited by the continued progress and improvement we anticipate in the year ahead.

Prof Alan Merry ONZM FRSNZ
Chair

Dr Janice Wilson
Chief Executive
28 October 2016

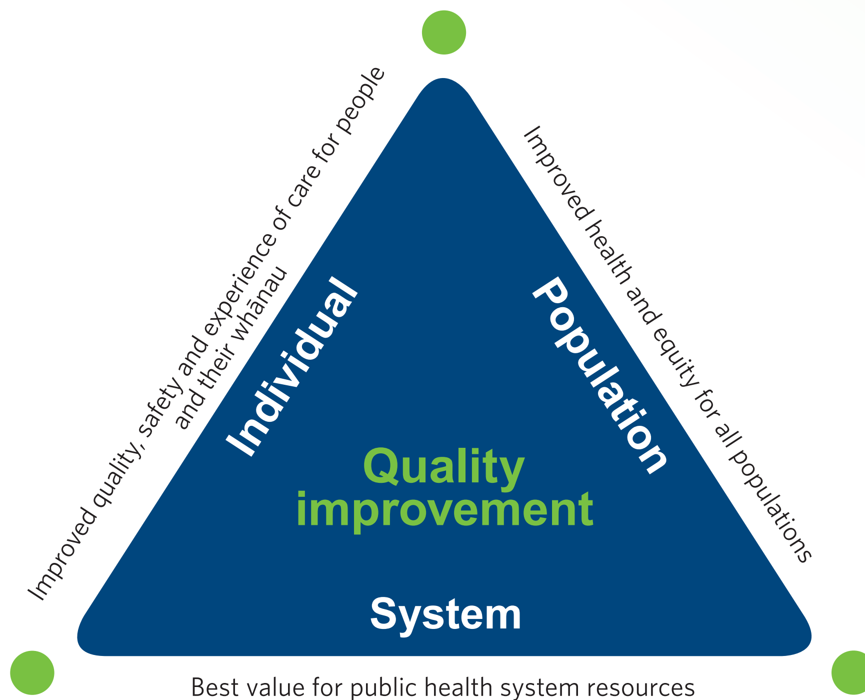
Part **one**

1.0 Who we are and what we do

The Health Quality & Safety Commission (the Commission) is a Crown entity established under the New Zealand Public Health and Disability Act 2000 (the Act). It is categorised as a Crown agent for the purposes of the Crown Entities Act 2004,[1] and was established in November 2010.

Our objectives, as set out in the Act, are to lead and coordinate work in quality and safety across the health and disability sector, to measure, monitor and improve the quality and safety of health and disability support services and to help providers across the sector improve these services.

The broad strategy and outlook of the sector are set out in the New Zealand Health Strategy 2016, and are summarised in its motto, 'All New Zealanders live well, stay well, get well'. Within this framework, we focus on our quality improvement agenda described in the New Zealand Triple Aim (adapted from the Institute for Healthcare Improvement's Triple Aim), which simultaneously addresses quality improvement for individuals, populations and the system (see diagram below).



Achieving this purpose depends on doing the right thing, and doing things right first time

1 A Crown agent must give effect to government policy when directed by the responsible Minister.

2.0 Achievements and strategy

2.1 Our achievements

Our work prevents harm and improves the quality of experience of care for all New Zealanders. This avoids the costs of harm and reduces ineffective spending, which benefits both individuals and the whole health care system. In addition, a healthier population has a measurable value to society, and by using economic methodologies common in the public sector but not often used in the health sector, we can estimate this value. Some of the ways we prevent avoidable harm and costs follow.

Falls rate reductions – The Commission has run its programme to reduce harm from falls in our hospitals since 2013. In 2015, for the first time, there was a clear, sustained reduction in falls in hospital that led to a fractured neck of femur (broken hip). By March 2016 there had been 52 fewer such events, avoiding $2.5 million in hospital costs, and adding 85 quality adjusted life years (QALYs), worth $15.4 million to New Zealand.

Surgical site infection (SSI) rate reductions – SSIs following hip and knee replacement surgery have reduced to an infection rate of 0.8 percent in the quarter ending March 2016, compared with a long-run average of 1.2 percent. This is 45 fewer infections. It is still too early to confirm a statistically significant, sustained change.

Cumulative impact of mortality review committee recommendations – Deaths of children and young people continue to decline. In 2014, 488 children and young people aged 28 days to 24 years died, compared with 620 deaths in 2010. Since 2010 there have been 550 fewer deaths in this age group. In addition to the avoided loss and human suffering associated with these deaths, based on the New Zealand estimate of the value of a statistical life, the value of these avoided deaths is already $175 million.

The Commission's work also builds the capacity of the system, essential to achieve and sustain these sorts of improvements.

The role of the Family Violence Death Review Committee (FVDRC) as a trusted advisor in the review of domestic violence legislation – FVDRC chair Assoc Prof Julia Tolmie has met the Minister of Justice twice in 2015/16 at the Minister's request to continue the FVDRC's contribution to the review process and provide advice informed by her expertise and the committee's recommendations.

Increasing uptake of co-design methodology – The Partners in Care programme has helped raise awareness of the benefits of and the need for change, and has increased knowledge of how to change, and how to monitor and sustain change.

Developing the primary care patient experience survey – The primary care patient experience survey, developed in partnership with the Australian National Health Performance Authority, is now being implemented by practices across New Zealand.

2.2 Our strategy

The 2016 New Zealand Health Strategy guides all work across the health sector. Since it was published in April 2016 it has informed the Commission's strategy development at all levels. As it was introduced towards the end of the reporting year, its main impact will be more evident in our next annual report.

Our strategic direction is currently determined by our Statement of Intent for 2014–18, which was agreed in June 2014. It defines our three strategic priorities.

1. Identifying areas for quality and safety improvement.
2. Providing advice and commentary – being an intelligent commentator and advocate for change.
3. Assisting the sector to effect change – delivering improvement programmes and supporting the sector and consumers as they strive for high-quality, safe health care.

An updated statement of intent covering 2017–21 is being prepared and will be published in 2017.

The Minister of Health's December 2015 letter of expectations specified key priorities for the Commission in 2015/16.

- Expand the use of the patient experience tool into aged residential care.
- Support the Ministry of Health's work to capture performance information on the quality and safety of New Zealand's health services, including work on the eventual publication of health data.
- Work closely with the Ministry of Health to reflect a comprehensive, contextualised and joined-up picture of the health system.
- Continue to strongly develop greater sector capability in quality improvement.

Our work also supports the Government's broader priorities for the health and disability sector in a range of ways (see diagram on page 7).

Government outcomes

New Zealanders live longer, healthier and more independent lives

The health system is cost effective and supports a productive economy

The New Zealand Triple Aim

Individuals and their families/whānau
Improved quality, safety and experience of care for people and their whānau

Populations
Improved health and equity for all populations

System
Best value for public health system resources

Strategic priorities

Maximise patient benefit while:

Reducing harm, waste and cost and demonstrating this

Improving equity and health of key populations, and specifically for Māori and Pacific populations

Reducing unwarranted variation in care

Improved behaviour

Partnerships between consumers and health and disability practitioners

Uptake of good practice and transfer of improvement skills and expertise

Improved systems

System design supports and promotes quality and safety practice

The Commission's contribution

Identification of areas for quality and safety improvement

- Measure and report on the quality and safety of health and disability services
- Undertake regular reviews of important areas of mortality in health care
- Report and analyse serious adverse events

Advice and comment

- Provide strategic advice to Government on quality and safety issues
- Publish reports that inform public discussion and promote sector debate
- Publish advice and recommendations arising from mortality reviews

Assistance to the sector to effect change

- Lead and support, with tools and evidence, specific improvement programmes with a strong focus on Government priority areas
- Support consumers and providers to follow best practice in consumer engagement and being partners in care – which includes shared decision-making
- Assist clinicians to be leaders of quality and safety improvement and to follow best practice
- Build sector capability for quality and safety improvement

The year in review

The Commission worked in a wide range of programmes in 2015/16:

- medication safety
- mortality review committees (child and youth, family violence, perinatal and maternal, perioperative, suicide)
- primary care whakakotahi
- reducing harm from falls
- adverse events learning (adverse events, trigger tools)
- health quality evaluation (Atlas of Healthcare Variation, health quality and safety indicators, quality and safety markers, quality accounts)
- Partners in Care (consumer engagement, health literacy, leadership capability)
- infection prevention and control (hand hygiene, prevention of central line associated bacteraemia (CLAB), SSI improvement
- safe surgery NZ (surgical safety checklist, improving teamwork and communication)
- other topics (building capability, pressure injury prevention, deteriorating patient, *Open for better care* campaign, clinical leadership for quality and safety).

In 2015/16 the Commission grouped its reported activities into three output classes to explain its Statement of Performance Expectations deliverables:

Output class 1: Measurement and evaluation
Output class 2: Advice and comment
Output class 3: Assistance to the sector to effect change.

3.0 Output class 1: Measurement and evaluation

International literature shows that measuring the quality and safety of health care and publishing the findings in considered ways and settings stimulate improvement.

Used wisely, measurement of and reporting on quality and safety engages clinicians, managers and consumers, generates informed discussion, and improves the efficiency of the sector. Measurement and evaluation allow problems and key improvement opportunities to be identified, and examples of good practice to be provided, assessed and shared. Without good measurement and evaluation we don't know where waste due to poor quality lies or whether interventions to reduce waste have worked.

> *[R]eal, sustainable, active improvement depends far more on learning and growth than on rules and regulations. And that is the balance we are suggesting … between the hard guardrails that keep things in proper order and the culture of continual learning that helps everyone to grow. A phrase that I believe I heard first in England captures that sense: 'All Teach – All Learn.' In such a culture, measurement is not a threat, it is a resource; ambition is not stressful, it is exciting; defects are seen as opportunities to learn; and curiosity abounds.*
>
> Don Berwick, 'Letter to the clinicians, managers, and all staff of the NHS', 6 August 2013

3.1 Measuring quality and safety

In 2015/16 our measurement and evaluation activities included the following.

Quality and safety indicators (QSIs) – The annual QSI report was published in June 2016. QSIs are a set of whole-system summary indicators that provide a detailed picture of the quality and safety of the entire New Zealand health care system. We have published these since 2012 to provide the public and sector with a mathematically robust, clear understanding of the overall state of the quality and safety of health and disability support services, including changes over time and comparisons with other countries. The information is presented in an interactive online format known as a 'Prezi', which allows data and commentary to be presented graphically and allows users to delve into information that interests them in greater detail. The QSI data is also used to inform the reports *A Window on the Quality of New Zealand's Health Care* (see section 4.2).

Quality and safety markers (QSMs) – Each QSM is a targeted set of process and outcome measures designed to track progress in uptake of interventions supporting the Commission's key priority programmes, measure their effect on the outcomes desired and, through public reporting, stimulate further improvement. The QSMs report on falls, infection prevention and control (hand hygiene and SSI), perioperative harm and medicine reconciliation. Four

national QSM progress reports were published in 2015/16. There have been significant improvements across most of the process markers and improvements for some outcomes (see Appendix 2).

The New Zealand Atlas of Healthcare Variation – The Atlas measures variation by geographic area in the provision and use of specific health services and outcomes. Presented as an interactive web tool with easy-to-use maps, graphs, tables and commentary, the Atlas is designed to stimulate improvement by prompting debate and raising questions among clinicians, users and providers of health services about why regional differences in health service use and provision are occurring.

In 2015/16 two new Atlas domains were published: an 'equity explorer' and a domain on bowel cancer. Seven domains were also updated with more recent data: polypharmacy, maternity, diabetes, trauma, gout, surgical procedures and falls.

*General practitioner **Dr Rawiri Jansen** chaired the advisory group for the Atlas of Healthcare Variation's new equity domain, known as the equity explorer. 'The explorer allows us to test a new way of showing inequity more clearly, illustrating socioeconomic differences with age-standardised data sets to allow comparisons between ethnic groups,' Dr Jansen says. 'Questions that might be prompted by this information include:*

- *Why are there differences in health outcomes for different groups of people?*
- *Does everyone in the DHB have the same access to health care? Within my DHB area, which indicators have the biggest differences? Why?*
- *Which DHBs seem to be doing better in reducing health inequity and why might that be?*
- *Are there patterns across indicators, within my DHB?'*

The equity explorer and instructions on using it are at: www.hqsc.govt.nz/atlas/equity-explorer.

3.2 Measuring patient experience

Patient experience in hospitals

The patient experience survey is a set of measures used to understand patients' views of the care they receive in DHB hospitals, and to make health care more responsive to their needs. The Commission has run a 20-question survey for hospital inpatients in all DHBs since August 2014. In 2015/16 the Commission published four quarterly reports on the survey, which have shown consistently positive results across the four survey categories. The national weighted average score in each of the four survey categories ranges from 8.2 to 8.7 out of 10. This year we also investigated views of non-respondents, and found their views of the hospital experience were similar to those who responded to the survey.

One patient story we received at a recent Board meeting illustrates the importance of considering the broad determinants of health and wellbeing when patients are hospitalised.

*Following a fall and an unplanned hip replacement operation, **Rose** received good medical treatment but had some complications. She was away from home.*

'Only my daughter could visit me, so I felt very isolated, vulnerable. Very uncertain about my future too, but there was no one there to give me any reassurance. The treatment was very much about medical matters. I was there for nine nights and not one person asked me, "How has this affected you – are you okay?" One thing that was really unsettling was that three times I was told I was going to be discharged, so my daughter came twice – she lived quite a long way from the city. Then suddenly, "You're not going home today," and I wasn't given any reason. I found that really upsetting. Why was I still there?'

On returning to her home city, Rose discovered she had contracted two infections. 'I was rushed into an isolation ward and spent the next five nights there, and it was such a different experience. I was immediately struck by the friendliness and warmth of the nursing staff. They were treating me as a whole person, not just looking after my physical needs. I was always kept informed about what was happening. For me, there's a need to recognise that people in hospitals lose a lot of themselves, particularly if they're not used to being in hospital. Somebody needs to be responsible for checking on the psychological wellbeing of the patient, and that was a huge difference I noticed between the two hospitals. Small talk, a sense of humour, knowing a patient's first name, giving a patient the chance to ask questions.'

Patient experience in primary care

Following the success of the inpatient survey, the Commission and the Ministry of Health developed a second survey to find out what patients' experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists and/or hospital staff. The information is used to improve the quality of service delivery and patient safety. The first online survey began in 46 general practices on 24 February 2016 and 70 practices from six primary health organisations (PHOs) completed the May 2016 survey. Public reporting of results is expected in 2017/18.

Patient experience in aged residential care

In 2015/16 the Commission developed a costed proposal to Associate Minister of Health Hon Peter Dunne, setting out options to measure patient experience in aged residential care. The proposal, which was delivered on 30 June 2016, recommends developing a survey tool administered via a one-to-one interview with trained interviewers in places of residence. Relatives would have the option to participate, but the survey would be primarily administered with residents themselves. The Commission will continue to work with the Ministry of Health in 2016/17 on options to implement the survey via the review of the Health of Older People Strategy.

3.3 Adverse events

Most patients are treated safely and successfully, but some still suffer serious harm or even die from preventable adverse events in our hospitals. In New Zealand we have reported these adverse events in DHBs since 2006 and in other providers since 2013. The reporting process includes analysing the causes of events so we can learn from them and identify opportunities to reduce the chances of the events recurring. By reporting adverse events we promote a culture of openness, transparency and trust, focused on improvement. This in turn helps to build public confidence that such events are learned from and used to improve services.

In 2015/16 we continued to work with the health sector to increase expertise in learning from adverse events. This included providing event review training. There was also a greater emphasis on sharing lessons from adverse events reviews, with the continuation of monthly Open Book reports.[2] These alert providers to the key findings of adverse event reviews and emphasise the changes implemented to prevent the event from happening again.

The Commission published *Learning from adverse events*, its annual adverse events report, in December 2015 (section 8.7), which covered events reported in 2014/15.

Adverse events lead coordinator ***Sarah Upston*** *has been pleased to see the difference the programme's 12 Open Book reports have made this year.*

'These short, accessible case studies are about prompting discussions and considering how other organisations are facing the same situations as them, and coming up with innovative solutions. It's a very collaborative process, and I think increasingly so. For the Open Books to work well, it takes cooperation and a bit of bravery to change the culture. They demonstrate the sector is willing to change, share and learn. It's a robust process looking at the systems behind the events. The value of it is that it allows us to share ideas to reduce the chance of similar events occurring in other organisations.'

Crucial to the success of the Open Books are the positive contributions of providers who volunteer to share their stories, and the peers and experts who advise us on best practice. 'We couldn't do it without them,' Ms Upston says.

3.4 Mortality review[3]

Mortality review committees are statutory bodies appointed by our Board. Committees are empowered by legislation to review and analyse the circumstances resulting in preventable deaths, to provide evidence-based advice on how these deaths can be avoided. There are four permanent mortality review committees and one time-limited committee.

2 These are online at: www.hqsc.govt.nz/our-programmes/adverse-events/projects/open-book.

3 Section 50D(3b) of the New Zealand Public Health and Disability Act 2000 requires the Commission to, at least annually, provide the Minister of Health with a report on the progress of mortality review committees, and include each such report in the Commission's next annual report. This section of the annual report, along with section 8.8, fulfils that obligation.

*Mortality review manager **Shelley Hanifan** is proud of the progress the Commission's mortality review committees have made in the past year.*

'A real effort has been made to cooperate across committees and for them to learn from each other, to strengthen our ability to save more lives. As a result, we've had a stronger focus on working with the sector earlier, as the committees form their recommendations – and a greater focus on supporting recommendations to be implemented after a report is published. This, along with the active support of the Commission's Board, has meant our reports and findings are getting greater traction.

'The mortality review Māori Caucus, a team of Māori mortality review committee members, has been a particular success of the year. They've developed a set of expectations to guide our committees as they interpret and report on Māori mortality. This is such an important responsibility, and it's vital we get it right to make a difference for our high Māori mortality rates. I'm confident that with the support of the Caucus our understanding of and expertise in Māori mortality will continue to grow.'

Child and Youth Mortality Review Committee (CYMRC)

The CYMRC reviews the deaths of children and young people aged 28 days to the day before their 25th birthday, and advises on how to reduce such deaths. It published *Mortality and morbidity of pertussis in children and young people in New Zealand* in December 2015. The report showed there were just under 13,000 cases of confirmed, probable or suspected whooping cough (pertussis) – an average of 992 cases per year. There were 1515 hospital admissions for whooping cough. Over three-quarters were for infants under six months old who had either no or inadequate protection against whooping cough. Māori and Pacific infants, children and young people were significantly more likely to be hospitalised with whooping cough than non-Māori/non-Pacific infants.

The CYMRC also published its *11th Data Report* in June 2016, which mostly covers data from 2010 to 2014. Overall, the number of deaths reduced over this period: in 2010 there were 620 deaths and in 2014 there were 488. This reduction has, in part, been driven by a reduction in the number of deaths due to motor vehicle crashes in young people aged between 15 and 24 years. However, there were fewer deaths from nearly all causes in 2014.

Perinatal and Maternal Mortality Review Committee (PMMRC)

The PMMRC reviews deaths of babies and mothers, and advises on how to reduce such deaths. It published its *Tenth Annual Report* in June 2016. The report considers perinatal and maternal mortality and morbidity from January to December 2014, perinatal mortality from 2007 to 2014, maternal mortality from 2006 to 2014, and babies with neonatal encephalopathy (a disorder or disease of the brain) from 2010 to 2014. It also includes special topics on two causes of maternal mortality: suicide and amniotic fluid embolism.

Family Violence Death Review Committee (FVDRC)

The FVDRC reviews deaths from family violence in New Zealand and provides advice on how to reduce such deaths. FVDRC published its *Fifth Report* in February 2016. The report recommends establishing an integrated system of safety responses to family violence to address the problems caused by the current fragmented approach. It contains detailed recommendations for legislative change, investment in family violence expertise to encourage more effective interventions, better workforce infrastructure and strengthening organisational responsiveness to family violence.

In 2015/16 the FVDRC also wrote multiple briefing papers and discussion documents to inform the cross-government family violence and sexual violence work programme. It has participated in multiple working groups, such as the Police Family Violence Change Programme and the Institute of Judicial Studies Board domestic violence and sexual violence working group. The committee chair was a member of the Law Commission's reference groups on strangulation and victims of family violence who commit homicide. The chair has also met with the Minister of Justice several times to discuss the Law Commission's reports and the opportunities presented by the current reform of family violence legislation.

Perioperative Mortality Review Committee (POMRC)

The POMRC reviews deaths relating to surgery and anaesthesia occurring within 30 days of an operative procedure and provides advice on how to reduce such deaths. In June 2016 it published its *Fifth Report*. The report examined perioperative mortality in New Zealand from 2009 to 2013 for two new clinical areas

of interest: 30-day mortality following operations and procedures under general anaesthesia, and day-of-the-week mortality. The report recommends hospitals investigate all weekend surgery deaths to find out whether the timing of the operation had an impact on the outcome.

Suicide Mortality Review Committee (SuMRC)

As part of implementing the New Zealand Suicide Prevention Action Plan 2013–2016, the Ministry of Health funded the Commission to trial a suicide mortality review mechanism. Its purpose was to find out whether mortality review methods are able to improve knowledge of contributing factors and patterns of suicidal behaviour, which would help to identify key intervention points. The SuMRC has reviewed deaths relating to suicide in three sub-groups: rangatahi (young) Māori, users of mental health and addictions services, and men aged 25–64 years.

The final SuMRC report was provided to the Ministry of Health in October 2015, and published on the Commission's website in May 2016. The trial was successful and illustrated the potential benefits of the mortality review approach to this work. The trial has also demonstrated the feasibility of collecting and using data across multiple agencies and using several different mortality review methods. Much of the progress was derived from work to better integrate information sources, breaking down 'silos' to enable information-sharing and creating a single source of information that had previously been more widely scattered.

*Public health physician **Dr Maria Poynter** says the Commission learned a lot from the suicide mortality review trial. 'The trial met its stated aims. More than that, though, it taught us a great deal about cultural aspects of mortality review. Mortality review is about the people behind the numbers. We have a better understanding of how to balance our responsibilities: holding and using information responsibly; upholding the dignity and mana of deceased people and that of their family/whānau; and working to decrease death rates. It's more than just data for us,' she says.*

*The SuMRC Chair **Prof Rob Kydd** from the University of Auckland School of Medicine says the suicide mortality review trial has shed new light on the complex nature of suicide in New Zealand. 'Our research shows that people who commit suicide aren't just engaging with mental health services – there's often engagement with a wide range of other agencies too, which we can learn from.' Conversely, he adds, 'Some of the group we studied had limited or no mental health service contact. In future we'd welcome the opportunity to investigate their links with other services, such as primary care.'*

A decision is awaited on the future of the suicide review function.

3.5 Surveying safety culture

In October 2015 we reported on the safety culture of DHBs in our *Surgical Culture Safety Survey* report. This drew on nearly 850 survey responses to provide baseline data on attitudes and perceptions of surgical team members at DHBs. The culture survey results show that, in most instances, team members work relatively well together. The findings are generally positive, although particular areas identified for improvement include communication between surgical team members, and clinical leadership. On several measures New Zealand seems to be doing better than the United States of America.

4.0 Output class 2: Advice and comment

The specialised knowledge gained through our programmes, measurement and evaluation functions, and local and international networks, enables the Commission to provide expert advice and commentary on quality and safety, alongside that of the Ministry of Health.

> *... [W]e need to get better and faster at sharing the best new ideas and evidence and putting them to work throughout the system. Such improvements will help us avoid unwarranted variations in the quality, safety and sustainability of services, and will also mean that effort is not wasted when regions or organisations independently develop solutions to common problems.*
>
> Ministry of Health (2016), *New Zealand Health Strategy: Future direction*, p 27

4.1 Strategic advice to Government and government agencies

The Commission's legislative responsibilities, as set out in section 59C(1) of the Act, include several aspects with a strategic advice function.

- Advise the Minister of Health on how quality and safety in health and disability services may be improved.
- Advise the Minister on any matters relating to 1) health epidemiology and quality assurance, and 2) mortality.

During the year we provided strategic advice in areas such as:

- the update of the New Zealand Health Strategy
- child and youth mortality, family violence deaths, perinatal and maternal mortality, perioperative mortality, and suicide deaths (see section 3.4)
- the quality and safety of the New Zealand health system through findings from our Atlas work and our QSMs and QSIs
- the overall state of health quality in New Zealand, through the *Window on the Quality of New Zealand's Health Care* reports (see section 4.2).

We meet with our partners the Ministry of Health, the ACC and the Health and Disability Commissioner, including through the national Information Sharing Forum, and are increasingly invited to provide input into key strategic issues across government agencies.

During the year we worked with the Ministry of Health and Treasury on a project to explore the links between quality improvement strategies and organisational outcomes. All four case study DHBs (Auckland, Bay of Plenty, Whanganui and Canterbury) showed clear improvements in some patient experience and outcome measures. For some measures the improvement was greater than for DHBs not involved in the project. There was also evidence that quality improvement programmes can lead to operational efficiencies and fiscal savings, contributing to the ongoing sustainability of the DHBs.

Commission staff assisted the Ministry of Health in a range of ways, such as by reviewing DHB annual and regional plans and quality accounts. At a more targeted level, we provided advice and assisted the Ministry of Health and other agencies through working groups and review groups and with issues such as consumer engagement and partnership, collecting and using quality and safety-related data, improvement education and training, family violence, child and youth mortality, methodologies and specific programme areas.

4.2 Providing informed public comment and promoting sector and public debate

During 2015/16, this work included:

- publishing the *Window on the Quality of New Zealand's Health Care* reports
- publishing evidence-based reports and discussion/opinion papers on health quality and safety in peer-reviewed journals, on our website and via other media. We had five articles published in the *New Zealand Medical Journal (NZMJ)*, one in *Health Affairs*, and one in the Royal Australasian College of Surgeons' newsletter *Cutting Edge*
- organising successful workshops featuring two influential international expert speakers, improvement specialist Helen Bevan (July 2015) and neurosurgeon Henry Marsh (March 2016)
- publishing five mortality review committee reports and working across agencies to encourage implementation of recommendations.

Annual overview of quality and safety across the system

In December 2015 we published our first *Window on the Quality of New Zealand's Health Care* report, which used currently available measures to understand quality and safety, and asked, 'how good is New Zealand's health care?' We updated the report in May 2016, and included the welcome news that there was, between December 2014 and March 2015, a reduction in serious in-hospital falls as measured by falls leading to a fractured neck of femur. The reduction avoided $2.5 million in costs. The report also found rates of premature death, and disability caused by ill health, are similar in New Zealand to most other English-speaking and Western European countries, but per-capita expenditure on health care is lower than most.

Journal articles and opinion papers

One of our roles is sharing knowledge about and advocating for safety and quality. Publishing articles in peer-reviewed journals helps to build expertise and drive the national quality and safety agenda. We also seek to influence the national quality and safety agenda by circulating opinion papers. (See sections 8.11 and 8.12 for publication details.)

Workshops featuring international speakers

We arrange visits and forums featuring highly skilled international experts who can contribute their valuable expertise to New Zealand quality and safety discussions. In 2015/16 we:

- held a successful workshop on scaling-up and spreading change, featuring National Health Service (NHS) improvement expert Helen Bevan (Wellington, 28 July 2015)
- co-sponsored a forum with Henry Marsh, leading English neurosurgeon and author of *Do No Harm: Stories of life, death and brain surgery* (Wellington, 9 March 2016), in partnership with the Auckland Writers Festival. Other speakers included Minister of Health Hon Dr Jonathan Coleman, Director-General of Health Chai Chuah and Martin Snedden.

The Henry Marsh forum was a particular success, with around 300 attendees and several memorable speakers on the agenda to discuss clinical leadership in quality and safety.

> *The most difficult thing, Henry Marsh says, is dealing with the human reality of illness, and when things go wrong. 'That's the real difficulty, and you will make mistakes, because you're a human being, and all human beings make mistakes.'*
>
> *The only way doctors can reduce mistakes, Marsh feels, is by admitting them, and being open with one's colleagues. 'I'm not saying we should all be touchy-feely, committee-working, politically correct people, we're not. But you've got to be honest with your colleagues and try to criticise them, and they can criticise you before you make a mistake, rather than after.'*
>
> **Henry Marsh, stuff.co.nz, 7 March 2016**

Mortality review committee conferences

In addition to publishing reports, the PMMRC and the POMRC held annual national conferences in 2015/16 at Te Papa in Wellington. These allowed the committees' findings and recommendations to be discussed and promoted directly to the practitioners who can drive quality and safety improvement in the sector.

- The 2016 POMRC conference (13 June 2016) had 71 attendees. Speakers included Associate Minister of Health Hon Peter Dunne, Prof Paul Myles (Monash University), Prof Peter Zelas (University of Western Sydney) and Teena Robinson (nurse practitioner in adult elective perioperative care).
- The 2016 PMMRC conference (28 June 2016) had 285 attendees. The focus was on the PMMRC's annual report findings, social and economic determinants, the prevalence and effect on Māori, and preventing very pre-term birth. Speakers included Hon Dr Jonathan Coleman, Assoc Prof Vicki Flenady (Mater Research, Queensland), Prof Innes Asher (University of Auckland) and Dr Leonie Pihama (Te Kotahi Research Institute, University of Waikato).

Informing the sector about adverse events

In 2015/16 we published 12 Open Book reports (discussed in section 3.3). The sector has given us positive feedback on the importance of the reports for stimulating quality discussions, and how the reports are used in DHBs and PHOs to frame staff training discussions and examine how local processes would address the issues raised.

5.0 Output class 3: Assisting the sector to effect change

One of the Commission's key roles is to 'lend a helping hand' to enable the sector to improve the quality and safety of services. This includes:

- building leadership capability, including clinical leadership
- building quality and safety capability in the sector
- building the capability of providers and consumers to work as partners in care
- increasing uptake of evidence-based practice by translating evidence into easy-to-use tools and resources for frontline staff
- supporting networks that can build momentum, champion and lead quality improvement, and sustain longer-term change.

5.1 Partners in Care

Partners in Care programme

The Partners in Care framework is the basis of our work to improve health literacy and consumer participation, and develop leadership capability for providers and consumers. We believe consumers and their families/whānau are central to improving the quality and safety of health care. They should be partners in decision-making at all levels about their care.

We delivered a Partners in Care co-design programme in two DHBs (Nelson Marlborough and MidCentral) between October 2015 and May 2016. Examples of successful patient-centred co-design projects funded by the Commission include:

- cooperation by Nelson Marlborough DHB's radiology department with patients to improve care by redesigning services and helping to create a more comfortable and informative environment for patients and their families/whānau
- MidCentral DHB's work with patients on medication planning for discharge, and how patients can communicate their concerns and receive the right information so they feel properly informed about their medication and the next steps for their treatment and recovery.

Five other co-design projects across these two DHBs have also been completed. Here is one example from MidCentral DHB of how co-design can prioritise the patient experience, from their entrance through the hospital front door until they see the first treating clinician.

We all worry about our patients in the waiting room. The 94-year-old man sitting quietly in a wheelchair in the waiting room. He has a rug on his lap because it is a cold morning. He fell overnight, landing beside his bed and couldn't get up. His daughter went to visit and found him on the floor covered in excrement. He managed to pull the bedspread over him to keep warm. She showered him and took him to his GP. The GP referred him to the emergency department for assessment. He was triaged and placed in the waiting room. It won't be long until he gets a bed.

Now four hours later, uncomplaining, there he sits, still in the wheelchair. His daughter had to leave to attend to other tasks. She doesn't complain or enquire either. A different generation. You can see him. He is in your thoughts to bring in but other patients keep trumping him. Government targets, critical patients, departmental red flags. He is slightly slumped forward. He is patiently waiting. Doesn't want to make a fuss. Other people arrive. They must be sicker as they get rushed in. Five hours in the waiting room, he finally gets a bed. His diagnosis is a fractured neck of femur.

There he sat, uncomplaining, for five hours. No one spoke to this man because he was quietly, patiently, waiting. We know what we are doing. Let's change this. Come with us on a journey to listen to the patient's story. Let's change our practice. Let's help our patients.

MidCentral DHB Partners in Care case study

Partners in Care evaluation

We also completed an evaluation of the first three years of the Partners in Care programme. The evaluation report indicates the programme has contributed to a culture change in favour of consumer engagement in health care. The report's findings include the following.

- The Commission's leadership in consumer engagement is well regarded by sector stakeholders.
- The programme's activities are guided by a strong evidence base.
- The sector is aware of the Commission's activities but awareness could be increased.
- The Commission's activities are raising awareness of the need for change and the benefits of change.
- The Commission has increased sector knowledge about how to change.
- The Commission supports consumer engagement in direct care, co-design and governance and leadership.

5.2 Building sector leadership

We work to increase sector capability for quality and safety improvement by helping to provide the skills and training necessary to make this improvement 'business as usual'. We meet regularly with all DHBs at the board and chief executive level, to better coordinate our sector leadership engagement and to find out how we can assist quality improvement initiatives locally. In 2015/16 we worked to provide a quality and safety self-assessment tool for DHB boards, and national guidance on clinical governance for quality and safety.

Quality and safety self-assessment tool

The guide *Governing for Quality* was circulated to DHB chief executives and chairs, plus the Ministry of Health, in December 2015. It helps DHBs put quality and safety at the centre of governance and drive improvement in their organisations. The guide includes an outline of the role of boards as agents for quality and safety improvement, the seven steps boards can take to improve the quality and safety of health care services, and a checklist to guide boards and assess progress.

National guidance on clinical governance for quality and safety

In 2015/16 we circulated draft clinical governance guidance to DHBs for consultation, and received feedback that the proposed approach would benefit from a more tailored approach that takes into account the varying levels of expertise across DHBs. Accordingly, the draft guidance is being revised and will be recirculated to DHBs once it is rebalanced for a wider set of sector audiences.

Clinical leadership for quality improvement

A programme designed to develop clinical leadership for quality improvement and patient safety commenced in April 2016. The programme was offered to people who were identified by their organisations as 'emerging' clinical leaders. The module has three parts: what makes a great clinical leader; using data to support improvement; and leading change within a complex system. Up to June 2016, 250 participants have attended five programmes.

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5.3 Building sector capability

Clinical leadership is fundamental to improving patient safety and service quality, workforce satisfaction and effectiveness, and, ultimately, clinical and financial sustainability. All key Commission programmes have clinical leads that are well respected in their fields. Our quality and safety improvement events help the sector to share knowledge, and learn and apply best practice consistently in the workplace. We completed a wide range of this sector capability work in 2015/16.

Infection prevention and control national and regional workshops

In September 2015 we held a national hand hygiene improvement workshop with Canadian expert Dr Michael Gardam. There were 42 participants from DHBs and private surgical hospitals. Regional infection prevention and control meetings were also held in the Northern (August and November 2015), South Island (December 2015) and Midland (February 2016) regions. Regional meetings transitioned in the last quarter of the year to being regionally led, which shows DHBs are receiving high-level support from their senior management. Increased medical attendance also reflected higher interest in the Commission's hand hygiene and SSI improvement programmes and in nationally and regionally focused multidisciplinary approaches to infection prevention and control.

Transparency and outcomes data

In 2015/16 we led the sector discussion over transparency and the public reporting of outcomes data, in the context of a complaint to the Ombudsman regarding availability of data on the mortality and complications rates of individual surgeons. This work involved wide sector consultation, and consumer and clinician workshops co-sponsored by the Ministry of Health. It resulted in a large position paper and evidence review published alongside an editorial in the *NZMJ* and comment in *Health Affairs*. This work led public and sector debates, contributed to the Ombudsman's final decision, and forms the foundation for ongoing work among the central agencies on transparency of clinical outcomes.

Safe use of opioids national collaborative learning session

The Commission ran an 'all share/all learn' learning session for the safe use of opioids national collaborative in Auckland in November 2015, with 73 attendees from 19 sites. Three 'care bundles' with five or six interventions each to reduce opioid-related harm

have since been agreed, addressing constipation caused by opioid use, dangerously low breathing rates caused by opioids, and uncontrolled pain. A 'composite care bundle' with elements of all the individual harm care bundles is being taken to DHBs for further testing in 2016/17.

Improvement science

In November 2015 we held a clinical leads workshop with American transformational leadership expert Paul Plsek. Subjects discussed included adaptive systems science, leading large-scale organisational change, and combining innovation and standardisation.

Adverse events learning pilot workshops

We held learning workshops in Auckland, Wellington and Christchurch to share adverse events review methodology with staff from a wide range of providers. Their feedback was used to inform course content in 2015/16 and workshops planned for 2016/17.

Safe surgery workshops

We delivered learning sessions to three cohorts of DHBs, providing support and training to local safe surgery project leads and team members. Observational auditor training in how to use the surgical safety checklist was also delivered to staff from all DHBs.

National quality accounts workshop

Our national workshop in Wellington in March 2016 focused on sharing best practice for preparing effective quality accounts. DHB participants also heard presentations on the pilot testing of the NHS Safety Thermometer dashboard approach in New Zealand.

5.4 Quality and safety in the kaiāwhina workforce

The non-regulated health care workforce (kaiāwhina) has just as great a need to include quality and safety thinking in its training as the rest of the health workforce. In 2015/16 the Commission contributed its quality improvement expertise to Health Workforce New Zealand's Health and Disability Kaiāwhina Workforce Action Plan. We also helped to promote the 'Improving Together' online quality improvement learning resource to kaiāwhina.

5.5 Expert advice, tools and guidance

We aim to act as an intelligent commentator and advocate for positive change in the sector. Our advice, tools and guidance to the sector build on existing skills in several areas.

Safe use of opioids in hospitals

The opioids collaborative tested ideas for reducing opioid-related harm, with the goal of producing an agreed 'bundle' of evidence-informed interventions. From April 2016 the focus shifted to testing the bundles using the Institute for Healthcare Improvement's (IHI's) 'model for improvement', which focuses on small-scale testing and fine-tuning improvements. DHBs were also coached in the plan–do–study–act (PDSA) cycle to help tailor the bundles to their local needs and resources.

Teamwork and communication

Work to make DHB operating theatre teamwork and communication more effective has included providing resources to all DHBs and members of the Association for Private Surgical Hospitals and Southern Cross Hospitals. Intervention training has also been delivered in DHB cohorts. Workshop participants were provided with evidence of drivers of change, implementation guides and information posters for operating theatres. With Quality Hub NZ we also developed a web-based auditing tool to capture compliance and engagement using a validated rating tool.

Reducing SSIs

To reduce SSIs in people undergoing hip and knee surgery and cardiac surgery, we implemented the recommendations of the SSI expert faculty group. These included adding cefuroxime as an acceptable alternative to cefazolin, combining deep and organ space SSIs for orthopaedic procedures for reporting purposes, and excluding revision procedures for infection. We also established an expert faculty group for cardiac-related SSIs in April 2016.

5.6 *Open for better care*

The Commission led and coordinated *Open for better care*, the national patient safety campaign, from its origins in March 2013 until it concluded on 30 June 2016. The campaign's aims were 'to inform and mobilise the New Zealand population to ensure safety and quality improvement in health care by preventing harm, avoiding waste and getting better value from resources'.

The campaign focused on one topic at a time. In 2015/16 the two final topics were completed: reducing harm from

falls (for a second time) and leadership for quality and safety. Each topic identified simple changes in practice that make a difference to patient safety. Tools, interventions, collaborations, promotions, resources and workforce development opportunities were provided to help people do the right thing.

A highlight of the campaign was the annual Patient Safety Week, held for the second time in the first week of November 2015. The focus for 2015 was on good communication with patients and their families/whānau, and the theme was 'Let's talk'. We introduced a new airline-style safety card for patients with easy-to-understand advice on how to stay safe in hospitals.

Victoria University of Wellington and the University of Otago research centres jointly evaluated *Open for better care*. The final evaluation report was published in April 2016.

For more information about the campaign topic, see section 8.22.

Director of communications ***Liz Price*** *was involved in the* Open for better care *campaign throughout its three years, and thinks it made a real difference in that time. 'It gave a focus to specific topics and encouraged people to work together in fun and innovative ways,' she says. 'This year, that continued with our second* Open *falls topic. It was community-focused, to target a major source of falls, and it encouraged a lot of new ways of working with different stakeholders in primary care. And there was definitely a need in the sector for our final* Open *topic, which focused on supporting and encouraging emerging clinical leaders. Just being selected to attend the workshop is recognition for clinicians that they are seen as "emerging leaders", which is a really positive message. People found the training very useful – it was a great opportunity for them to learn, network with peers and reflect on characteristics of leaders and their own ways of working.'*

The campaign evolved over the three years, changing in response to sector feedback. 'The final clinical leadership topic is very different to the approach of the first topic in 2013, and that's because we learned and tried to be responsive to our audience,' Ms Price says.

Open *couldn't have succeeded without the hard work of many in the sector, and in particular by DHB quality and risk managers. 'They've been fantastic champions of* Open*,' says Ms Price. 'Without them, we couldn't have driven the campaign locally and reached so many parts of the health system. We're looking forward to continuing our work with them each year in Patient Safety Week, which is another one of the legacies of the campaign.'*

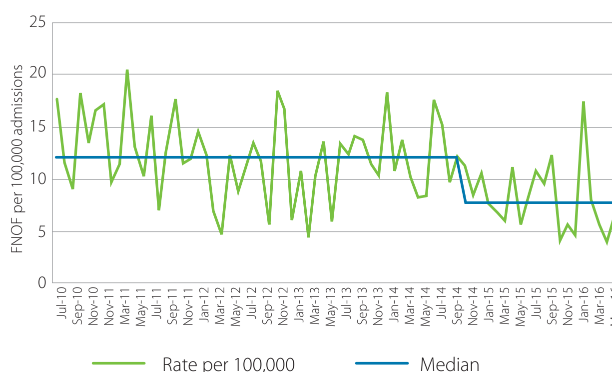
5.7 Other improvement programmes

In 2015/16 the Commission also made impressive progress on its health quality and safety improvement programme work outside the Statement of Performance Expectations.

Reducing harm from falls

The Commission has run its programme to reduce harm from falls in our hospitals since 2013. In 2015 there was for the first time a reduction in the number of falls in hospital that led to a broken hip. This reduction appears to have been sustained (see figure below and section 2.1).

Outcome marker: In-hospital falls with fractured neck of femur (FNOF) per 100,000 admissions by month



April 2016 saw another highly successful April Falls promotion, which focused on the themes of preventing, reviewing and learning from falls. The underlying message encouraged health professionals to engage with consumers and families/whānau early in all settings, with the theme 'falls prevention is everyone's business'. A range of updated and new falls resources was promoted and made available on the Commission's website. The annual April Falls quiz also provided a fun and informative focus for the promotion.

Medication safety

The medication safety programme aims to reduce the number of New Zealanders harmed by medication errors and adverse drug events across the health and disability sector. The goal is to ensure 'the right patient gets the right medicine, in the right dose, at the right time, by the right route and correctly recorded'.

A key medication safety focus in 2015/16 was the safe use of opioids national collaborative (described in section 5.3).

The Commission also works in partnership with the Ministry of Health to lead the national Hospital eMedicines Management (eMM) programme. The programme focuses on electronic prescribing and administration (ePA), electronic medicines reconciliation (eMR) and electronic pharmacy (ePx) systems. These systems allow health care providers better access to a person's medication information, enabling more effective clinical decision support and medicines management. By June 2016, ePA was rolled out across all adult wards in two DHBs, and rollout was underway at a further three.

Infection prevention and control

The Commission works with Auckland and Canterbury DHBs to implement evidence-based bundles of interventions to reduce SSIs for hip and knee arthroplasty and cardiac surgery. The SSI improvement programme has developed and implemented a consistent, evidence-based approach for collecting and reporting high-quality data about SSIs. DHBs are encouraged to drive SSI improvement against a bundle of agreed practice interventions. For uptake of good practice and results of the SSI improvement programme, see Appendix 2.

Since 2011 we have worked in partnership with Auckland DHB to improve hand hygiene among health care workers via the Hand Hygiene New Zealand quality improvement programme. Hand hygiene compliance in DHBs with the recommended World Health Organization (WHO) 'five moments for hand hygiene' reached 82.5 percent in June 2016 (62 percent in October 2012). In the final reporting period for 2015/16, 14 DHBs achieved at or above the national target of 80 percent.

Safe surgery

In 2015/16 we worked to improve surgical safety by promoting more effective teamwork and communications, and providing training to all DHBs (see section 5.5).

Pressure injuries

This year the Ministry of Health and the ACC agreed to work with us to prepare a cross-agency programme charter to reduce pressure injuries. An investment case report was released and is informing emerging work.

6.0 Organisational capability

6.1 Governance

The Commission is governed by a Board of eight members appointed by the Minister of Health. Full Board and committee membership is detailed in Appendix 1.

Commission Board as at 30 June 2016. Back row: Shelley Frost (Deputy Chair), Gwendoline Tepania-Palmer, Prof Alan Merry (Chair), Heather Shotter, Dame Alison Paterson. Front row: Dr Bev O'Keefe, Robert Henderson, Dr Dale Bramley. (Photographed by Falyn Cranston, September 2016)

Three board committees supported the Board's work in 2015/16.

The Finance and Audit Committee (which includes an independent member, Andrew Boyd from St John) provided assurance and assistance to the Board on the Commission's financial statements and adequacy of systems of internal controls.

Following a terms of reference change to focus only on audit and risk, the Board decided on 19 May 2016 to change the name of this group to the Audit Committee.

Te Roopū Māori provided advice to the Board and Chief Executive of the Commission on strategic issues, priorities and frameworks from a Māori world view and identified key quality and safety issues for Māori patients and organisations.

The Communications and Engagement Committee remained on call to provide strategic advice on the Commission's communications and stakeholder engagement, but this was not required in 2015/16.

6.2 Staff

At 30 June 2016 we had 55 staff (full-time equivalent (FTE)). Seventy-four percent of our staff is female. This staff total was in addition to our sector-based clinical leaders for each programme area, and a number of expert committees.

6.3 Good employer obligations

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

The Commission wants to attract and retain productive, talented staff. All positions have competency requirements, and all staff have an annually reviewed personal development plan. We use an online performance review and development system, which includes competencies, goals and objectives for all staff.

The Commission has a dedicated staff training budget and staff are encouraged to identify future education and training needs and undertake relevant programmes. The Commission arranged regular education and training opportunities for staff in 2015/16. These included:

- a workshop with Helen Bevan (July 2015) on spreading, 'up-scaling' and sustaining change
- a marae focus day to discuss progress on Te Whai Oranga, our Māori advancement framework.

We also actively fulfilled our obligations under the new Health and Safety at Work Act 2015, which came into effect on 4 April 2016. All relevant management and staff teams have been trained in the new responsibilities.

Flexibility and work design

Our policy is to support flexible work arrangements for employees who have carer responsibilities, under the provisions of Part 6AA of the Employment Relations Act 2000, and also for employees who require flexible work opportunities for a variety of other reasons, including further study and career development. Such arrangements include:

- changes to hours of work
- part-time work (for example, to accommodate partial retirement or further study)
- working from home.

Some staff work shorter days to accommodate school hours and some work from home when necessary, with technology to support this.

Support and culture

Weekly staff meetings are held in Wellington (with Auckland staff videoconferencing in) for staff to talk about their work and current issues, to recognise staff and team successes and, from time to time, to hear from external speakers.

We have a very active health, safety and wellness committee, which manages areas such as workplace hazards and other safety issues, and arranges activities to promote a healthy and joined-up workplace.

The Commission funds an Employment Assistance Programme, a professional counselling service to help staff and/or their families/whānau with work or personal issues.

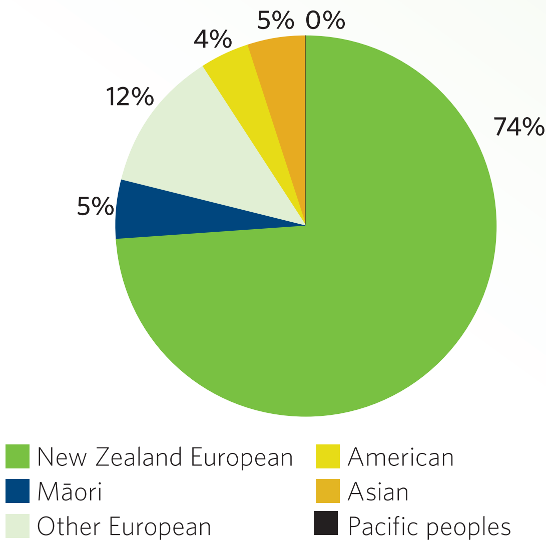
As an employer the Commission will not tolerate harassment or bullying in the workplace and takes all practical steps to manage hazards and avoid exposing employees to unnecessary risk.

6.4 Equal employment opportunities (EEO)

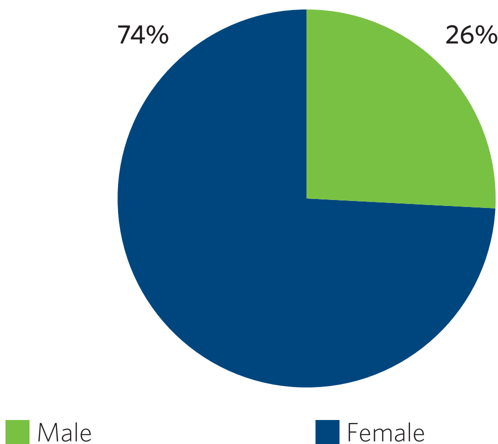
Workplace profile as at 30 June 2016

As at 30 June 2016 there were 58 staff members (55 FTE). Forty-six were full time (38 in 2015) and 12 part time (9 in 2015). Thirty-four percent had more than two years of service (47 percent in 2015).

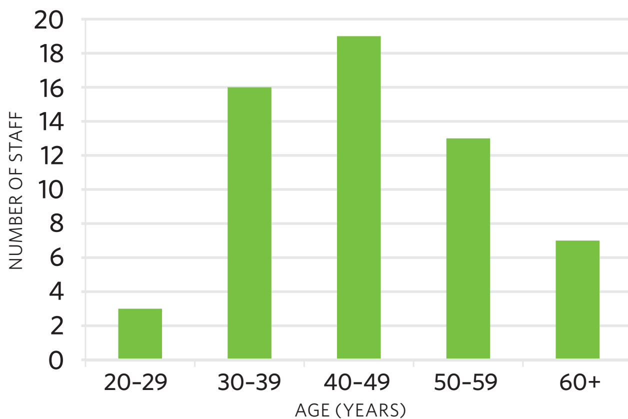
Breakdown of staff by ethnicity



Breakdown of staff by gender



Staff age bands



Five percent of staff identify as having a disability.

EEO policies

We have a specific policy on equality and diversity, which includes a firm commitment to the principles of EEO and ensures no discriminatory policies or practices exist in any aspect of employment, including harassment and bullying.

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

EEO/diversity practices include hiring on merit, fairness at work, flexible working options and promotion based on talent. They relate to all aspects of employment including recruitment, pay and other rewards, career development and work conditions. All staff involved in recruiting and managing staff are made aware of the requirements of the Commission's EEO policy. The Commission actively seeks and targets diversity as it recruits for current vacancies. We participate in the Highly Skilled Migrant mentoring programme to offer migrants experience in the public sector.

Remuneration

We work closely with the Ministry of Health as our monitoring agency and to obtain agreement around annual remuneration levels. We do not discriminate based on age, disability, gender, sexual identity, religious beliefs or ethnicity.

6.5 External relationships

Engagement with the Minister(s) and Ministry of Health

In 2015/16 the Commission provided monthly update reports to the Minister with delegated responsibility for the Commission and provided quarterly update reports on performance against the Statement of Performance Expectations. We met with the Minister with delegated responsibility for the Commission regularly, and kept both the Minister and Ministry of Health informed of any potentially contentious events or issues in a timely manner.

Collaboration and partnerships with stakeholders

Partners are vital to a small agency like the Commission and we tap into the considerable expertise in the sector and overseas, and identify and learn from existing innovative quality and safety practice. Of particular importance are our partnerships

with DHBs, the Ministry of Health, the Health and Disability Commissioner, the ACC, professional colleges and associations, clinical leaders, consumers and consumer groups, and our developing partnership with Māori. We also continue to develop strong international links, so we are well connected to innovation, evidence and advice from our colleagues overseas.

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

In 2015/16 we routinely engaged with the Ministry of Health in joint strategic planning and cooperation on joint work programmes. In particular, we provided advice on the revision of the New Zealand Health Strategy. The Commission, the Ministry of Health, the Health and Disability Commissioner and the ACC meet to support collaboration and joint planning. The four agencies work collaboratively to share and use the different information received by each agency more effectively.

We also worked with Treasury and the Ministry of Health to investigate the effectiveness of quality improvement initiatives in four DHBs, which illustrated some common success factors across case study DHBs (see section 4.1).

Communication with stakeholders and the public

During 2015/16, our communications team continued to:

- keep our website up-to-date and useful
- ensure our publications were of a high standard and easy to understand
- circulate widely read e-newsletters
- help us contribute visibly to conferences and events promoting quality and safety
- successfully complete the final topics of the *Open for better care* campaign
- proactively manage interaction with the media to promote our key messages effectively
- identify and manage communications risks.

Having an effective website is an important communications tool for the Commission. It provides a cost-effective way to communicate health quality and safety improvement information, projects and contacts, and offers opportunities for direct dialogue and engagement with stakeholders. During 2015/16 we had 76,207 unique visits to our website and 494,550 page views, compared with 78,311 unique visits and 526,992 page views in 2014/15.

6.6 Financial and resource management

Financial management

Maintaining financial sustainability is a critical part of the Commission's strategy and we have continued our record of remaining within budget.

We maintain sound management of public funding through our compliance with relevant requirements under the State Sector and Public Finance Acts and applicable Crown entity legislation.

The audit results for 2015/16 are in section 12.0 of this report.

Improving internal efficiency

The Commission uses the All-of-Government procurement processes and contracting unless there is compelling reason not to. All-of-Government processes are used for most of our office and IT purchases, data storage, communications, print services and travel. We continue to tender for services on GETS, the Government Electronic Tenders Service. We have implemented the *ComplyWith* legislative compliance information, monitoring and reporting programme, which is used by over 60 Crown-owned or funded entities, departments, companies and by the Office of the Auditor-General. Financial services remain in-house. We are also actively participating in the Wellington Accommodation Project (WAP2).

Payroll functions and payments to committee members have been outsourced to a third-party specialist payroll provider able to provide services more economically than the Commission could provide in-house.

Improving effectiveness of our work

Every Commission improvement project has a clear focus on its value proposition, both human and economic. There is now a clear life-cycle for projects to ensure they are designed to become sustainable and 'business as usual' in the sector, allowing the Commission to redirect investment to emerging priorities. We also find willing partners to help increase our relatively small investment capability.

In September 2015 the Commission's Performance Improvement Framework (PIF) was completed,

incorporating a range of potential improvements and feedback from staff and senior stakeholders. The senior leadership team and Board are continuing to implement changes to respond to the PIF's suggestions.

In April 2016 the Commission published a joint study by Victoria University of Wellington and the University of Otago research centres evaluating our national *Open for better care* campaign, the overall impact of the Commission's work and the improvement advisor development programme. Our response to the study included the following:

We are pleased to note that overall, the Commission's leadership and facilitation role appears to be very well understood and its work seen as important. The independence of the Commission is well supported, enabling its focus on improvement rather than compliance. The evaluation found that, while it is too early to be certain, there are positive signs the approach adopted by the Commission may result in sustainable improvement.

Meeting our legal responsibilities

We ensure we meet our good employer requirements as set out in the Public Finance Act 1989, the Public Records Act 2005, the State Sector Act 1988, the Crown Entities Act 2004 and other applicable Crown entity legislation.

We undertake regular *ComplyWith* surveys (six-monthly for staff and annually for Board members). These continue to show a high level of overall legislative compliance with no material breaches.

Risk management

The Commission maintains a risk management register, which is a regular item on the Board meeting agenda.

6.7 Permission to act despite being interested in a matter

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

Part two

7.0 Reporting

The Commission provided the Ministry of Health and the Minister of Health (through the Ministry) with information to enable monitoring of our performance including:

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

Section 50D(3b) of the New Zealand Public Health and Disability Act 2000 requires the Commission to, at least annually, provide the Minister of Health with a report on the progress of mortality review committees, and must include each such report in the Commission's next annual report. The report on progress of mortality review committees is included in this report in sections 3.4 and 8.8.

8.0 Report against the Statement of Performance Expectations

This Statement of Performance Expectations has been prepared in accordance with generally accepted accounting practice. It describes each reportable class of outputs supplied by the Commission during 2015/16 and includes, for each class of outputs:

- the standards of delivery performance achieved by the Commission, as compared with the forecast standards included in the Commission's statement of forecast performance for 2015/16
- the actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the Commission's statement of forecast performance for 2015/16.

Output class 1: Measurement and evaluation

8.1 Progress reports to the Ministry of Health and DHBs against markers for patient falls, healthcare associated infections, surgical harm and medicine reconciliation – achieved

Measure	2015/16 performance
Deliverable dates: Reports due 30 September 2015, 31 December 2015, 31 March 2016 and 30 June 2016	
Four QSM reports published	Four national progress reports were published, on 30 September 2015, 18 December 2015, 31 March 2016 and 30 June 2016. For results, see Appendix 2.
Reports and data are subject to expert clinical and technical peer review	Expert advisory groups developed the QSMs and review reports and data related to their particular area. These expert advisory groups include clinical expertise and some technical expertise. Additional technical peer review was provided by the Commission's internal technical expertise and by DHB review of all data and reports.

2014/15 performance: Four QSM reports published

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

Measure	2015/16 performance
Deliverable date: 30 June 2016	
At least one report published	The national QSI report annual update was published on the Commission's website on 29 June 2016.
Report and data are subject to expert clinical and technical peer review	A QSI expert advisory group provided expert clinical and technical peer review of all reports and data. Additional technical peer review is provided by the Commission's internal technical expertise and by DHB review of all data and reports.

2014/15 performance: Indicators report updated

8.3 New and updated Atlas domains – achieved

Measure	2015/16 performance
Deliverable date: 30 June 2016	
At least two new domains completed (including an equity domain) and four domains updated	Two new domains were published: • Equity explorer (20 June 2016) • Bowel cancer (30 June 2016). Seven domains were updated: • Polypharmacy (9 July 2015) • Maternity (10 September 2015) • Diabetes (15 December 2015) • Trauma (20 January 2016) • Gout (19 February 2016) • Selected surgical procedures (5 April 2016) • Falls in people aged 50 and over (6 May 2016).
Reports and data are subject to expert clinical and technical peer review	An Atlas steering group provides advice on topic selection, presentation and data matters. For each Atlas domain an expert advisory sub-group is established. Additional technical peer review is provided by the Commission's internal technical expertise and by DHB review of all data and reports.

2014/15 performance: Four Atlas domains published

8.4 Patient experience indicators (hospital services)* – achieved

Measure	2015/16 performance
Deliverable dates: 31 August 2015, 30 November 2015, 29 February 2016, 31 May 2016	
Four reports on patient experience in-hospital services published	Four quarterly inpatient experience survey reports published: • 29 July 2015 • 24 November 2015 • 29 February 2016 • 4 May 2016. Results have remained positive and consistent across the previous surveys, with weighted averages of 8.2 to 8.7 out of 10 over the four categories measured.
Reports and data are subject to expert clinical and technical peer review	The patient experience tool was developed after extensive consultation and testing with the sector and service users, and following rigorous analysis of international trends in measuring patient experience. We studied non-responder rates and learned that their views of hospital services are similar to those who participated in the survey.

*Deliverable name changed from 2014/15 'Delivery of patient experience indicators'

2014/15 performance: First three quarterly inpatient surveys published

8.5 Patient experience indicators (primary care) – achieved

Measure	2015/16 performance
Deliverable date: 31 January 2016	
Deliver to the Ministry of Health a system for collecting patient experiences in primary care services	After a survey pilot in 16 general practices, a multi-agency governance group (including the Ministry of Health) approved the rollout of the survey, which was then provided to PHOs in December 2015. The first online survey began in 46 general practices on 24 February 2016, and by May 2016 it had expanded to 70 practices from six PHOs.
Delivery meets Ministry of Health contract expectations	The Commission's deliverables were all met.

New deliverable for 2015/16

8.6 Patient experience indicators (aged care) – achieved

Measure	2015/16 performance
Deliverable date: 30 June 2016	
Provide the Minister of Health with a costed proposal for measuring patient experience in aged residential care	On 30 June 2016 the Commission provided the Minister with a proposal including options for consideration, with an outline of potential costs.
Proposed solution is based on best available evidence	A full literature review of experience survey methods used in different jurisdictions was the starting point for this work.

New deliverable for 2015/16

8.7 Adverse events* – achieved

Measure	2015/16 performance
Deliverable date: 30 December 2015	
Public reporting on serious adverse events	*Learning from adverse events: Adverse events reported to the Health Quality & Safety Commission, 1 July 2014 to 30 June 2015*, was published on 4 December 2015. The report details 525 adverse events in 2014/15, up from 454 adverse events in 2013/14.
Reports and data are subject to expert clinical and technical peer review	The adverse events learning programme expert advisory group provides expert clinical and technical peer review of all reports and data.

*Deliverable name changed from 2014/15 'Reportable events'

2014/15 performance: One report published

8.8 Mortality review committee reports – achieved

Child and youth mortality review

Measure	2015/16 performance
Deliverable date: 31 January 2016	
At least one report published	Published *Mortality and morbidity of pertussis in children and young people in New Zealand: Special report 2002–14* (16 December 2015).
Any advice or recommendations made in the reports will be consulted on with parties that may be involved in their implementation	The report's recommendations were the subject of consultation with all affected parties.
An annual analysis will be undertaken by each committee of implementation of previous recommendations	Analysis of how previous recommendations have been implemented is included in the report.

2014/15 performance: One report published

Perinatal and maternal mortality review

Measure	2015/16 performance
Deliverable date: 30 June 2016	
At least one report published	Published *Tenth Annual Report of the Perinatal and Maternal Mortality Review Committee* (28 June 2016).
Any advice or recommendations made in the reports will be consulted on with parties that may be involved in their implementation	The report's recommendations were the subject of consultation with all affected parties.
An annual analysis will be undertaken by each committee of implementation of previous recommendations	Analysis of how previous recommendations have been implemented is included in the report.

2014/15 performance: One report published

Family violence death review

Measure	2015/16 performance
Deliverable date: 30 June 2016	
At least one report published	Published *Fifth Report: January 2014 to December 2015* (25 February 2016).
Any advice or recommendations made in the reports will be consulted on with parties that may be involved in their implementation	The report's recommendations were the subject of consultation with all affected parties.
An annual analysis will be undertaken by each committee of implementation of previous recommendations	Analysis of how previous recommendations have been implemented is included in the report.

2014/15 performance: One report published

Perioperative mortality review

Measure	2015/16 performance
Deliverable date: 30 June 2016	
At least one report published	Published *Perioperative Mortality in New Zealand: Fifth report of the Perioperative Mortality Review Committee* (9 June 2016).
Any advice or recommendations made in the reports will be consulted on with parties that may be involved in their implementation	The report's recommendations were the subject of consultation with all affected parties.
An annual analysis will be undertaken by each committee of implementation of previous recommendations	Analysis of how previous recommendations have been implemented is included in the report.

2014/15 performance: One report published

8.9 Survey of safety culture in DHBs – substantially achieved

Measure	2015/16 performance
Deliverable date: 30 September 2015	
Report on a survey of the safety culture in DHBs published	Published DHB surgical safety culture section of the report on the Commission's website (30 October 2016). This was updated with the full report (18 December 2015).
The survey will provide baselines against which to measure improvement in safety culture in a repeat survey in 3–5 years	The survey provides baselines against which to measure improvements. Planning for the repeat survey will commence in due course.

New deliverable for 2015/16

Output class 2: Advice and comment

8.10 Overview of quality and safety across the system – achieved

Measure	2015/16 performance
Deliverable date: 30 April 2016	
One 'Window on quality' report published	Second *Window on the Quality of New Zealand's Health Care* report published (6 May 2016).
Report includes comment and discusses process improvements and reduction in harm and cost	The report includes informed commentary on its findings and notes the tangible benefits of quality improvement initiatives.

New deliverable for 2015/16

8.11 Articles in peer-reviewed journals – achieved

Measure	2015/16 performance
Deliverable date: 30 June 2016	
At least two articles published	Four articles published: • 'Partnership and rigor in improving patient care' (*NZMJ*, 4 September 2015). • 'Health literacy: from the patient to the professional to the system' (*NZMJ*, 16 October 2015). • 'Reducing perioperative harm in New Zealand: the WHO surgical safety checklist, briefings and debriefings, and venous thromboembolism prophylaxis' (*NZMJ*, 30 October 2015). • 'Transparency and public reporting of quality data: lessons from New Zealand' (*Health Affairs*, 19 April 2016).
Acceptance of an article for a peer-reviewed journal is evidence of quality	The *NZMJ* and *Health Affairs* are peer-reviewed journals of high standing.

2014/15 performance: Four articles published

8.12 Opinion papers – achieved

Measure	2015/16 performance
Deliverable date: 30 June 2016	
At least two opinion papers disseminated	Three articles published: • Editorial opinion on gout (*NZMJ*, 29 January 2016). • Editorial opinion on the publication of health care performance data (*NZMJ*, 11 March 2016). (Detailed position paper and evidence review published on Commission website, also 11 March.) • 'Quality, quantity and communication – a new survey finds out what surgical teams really think' (*Cutting Edge*, March 2016).
Publication stimulates debate as measured by uptake by print, broadcast and social media	Uptake has been monitored following publication. The publication of health care information paper was reported by Radio New Zealand, *New Zealand Doctor*, the *Dominion Post*, NZ Newswire/Yahoo News, Newshub and *Pharmacy Today*.

2014/15 performance: Two articles published

8.13 Workshops featuring international speakers – achieved

Measure	2015/16 performance
Deliverable date: 30 June 2016	
At least two workshops featuring international speakers held	Workshops with international speakers held: • Held successful workshop on scaling-up and spreading change, featuring NHS improvement expert Helen Bevan, in Wellington, 28 July 2015. • Co-sponsored Henry Marsh, leading English neurosurgeon and author of *Do No Harm*, in a forum on 9 March 2016, in partnership with the Auckland Writers Festival.
An evaluation of speaking engagements is undertaken to inform future choice of speakers. This will include analysis of stakeholders represented and the key lessons	Evaluation responses to the Helen Bevan workshop were positive, with qualitative feedback citing the useful knowledge and ideas communicated, and how to apply these in practice. The evaluation of the Henry Marsh forum revealed a positive response from attendees, with average ratings for the nine workshop segments ranging from 3.20 to 3.99 on a five-point scale with five being the highest rating.
A survey undertaken no later than three months after each speaking engagement to analyse application of key learnings to practice	Surveys were undertaken as outlined.

2014/15 performance: Two workshops held

8.14 Annual mortality review conferences – achieved

Measure	2015/16 performance
Deliverable date: 30 June 2016	
Perioperative and perinatal and maternal mortality review conferences held	The 2016 POMRC conference was held at Te Papa in Wellington on 13 June. There were 71 attendees. The 2016 PMMRC conference was held at Te Papa in Wellington on 28 June. There were 285 attendees.
The conferences are approved for credit towards relevant professional college and society continuing professional development programmes	The conferences were approved for accreditation.

2014/15 performance: Two workshops held

8.15 Informing the sector about adverse events – achieved

Measure	2015/16 performance
Deliverable date: Monthly, to 30 June 2016	
Monthly 'Open Book' reports published, providing learning from adverse events for the sector	12 Open Book reports published: • 'CVC removal', 12 August 2015. • 'Safe discharge processes – norovirus', 31 August 2015. • 'Epidural medicines through intravenous lines', 30 September 2015. • 'Surgery abandoned due to unavailable instruments', 16 December 2015. • 'Retained vaginal swabs following childbirth', 17 December 2015. • 'Delay due to the use of an unfamiliar acronym', 25 February 2016. • 'Ensuring referrals happen', 25 February 2016. • 'Reviewing trigger tool notes to uncover harm', 12 April 2016. • 'Bloodstream infection related to peripheral intravenous cannula', 20 May 2016. • 'Transmission of "super-bug" in hospital', 20 May 2016. • 'Red reflex assessment in newborns', 16 June 2016. • 'Incorrect assembly of surgical equipment', 30 June 2016.
Oversight by the adverse events learning programme expert advisory group, subject matter experts and expert input from an editorial committee of senior Commission staff	The adverse events learning programme expert advisory group provided expert clinical and technical peer review of all reports and data.

New deliverable for 2015/16

Output class 3: Assistance to the sector to effect change

8.16 Partners in Care – achieved

Measure	2015/16 performance
Deliverable date: 30 June 2016	
A nine-month co-design programme for consumer/ provider teams is delivered	The 2015/16 co-design programme was delivered in two DHBs between October 2015 and May 2016. The evaluation report, interviews and case studies from the programme are all available on the Commission's website: www.hqsc.govt.nz/our-programmes/partners-in-care.
Summaries of each completed co-design project published on the Commission's website	Summaries are available on the Commission's website: www.hqsc.govt.nz/our-programmes/partners-in-care/publications-and-resources/publication/2574.

New deliverable for 2015/16

8.17 Evaluate Partners in Care – achieved

Measure	2015/16 performance
Deliverable date: 30 June 2016	
Complete an evaluation of the previous three years of the Partners in Care programme	The evaluation report has been received and indicates that the Partners in Care programme has contributed to a culture change in favour of consumer engagement in health care. The report's findings are described in section 5.1.
Draft report is reviewed by the consumer network and a selection of providers	The draft report was reviewed as outlined.

New deliverable for 2015/16

8.18 Build sector leadership – self-assessment tool – achieved; clinical governance guidance – partially achieved

Measure	2015/16 performance
Deliverable date (1): quality and safety self-assessment tool – 31 December 2015 Deliverable date (2): national guidance on clinical governance – 31 March 2016	
(1) Quality and safety self-assessment tool for DHB boards completed	Updated information has been prepared to support the existing two-page DHB self-assessment tool published in July 2013. The guide *Governing for quality* was circulated to key stakeholders on 10 December 2015.
(2) National guidance provided on clinical governance for quality and safety in the sector	In response to feedback from DHBs on the first draft, the guidance is being revised to take into account different levels of expertise in the sector. A revised draft was considered by the expert advisory group on 9 June 2016 and will be developed further to meet the needs of a wider set of sector audiences.
Senior clinicians, managers and board members are involved in development	Clinicians, managers and other sector stakeholders were consulted during the development of both sets of guidance.

New deliverable for 2015/16

8.19 Build sector capability – achieved

Measure	2015/16 performance
Annual conferences, workshops and events to share good practice and innovation Deliverable dates: see below	
(1) Improvement science symposium (due 30 April 2016)	Held clinical leads workshop with US transformational leadership expert Paul Plsek (9 November 2015). Topics included adaptive systems science, leading large-scale organisational change, and combining innovation and standardisation.
(2) Infection prevention national and regional workshops (due 30 June 2016)	A hand hygiene national improvement workshop with Canadian expert Dr Michael Gardam was held on 1 September 2015, with 42 participants from DHBs and private surgical hospitals. Infection prevention control regional meetings were held in the Northern region (13 August 2015; 26 November 2015) and South Island region (14 December 2015). During this quarter regional meetings transitioned from Commission-led to regionally led, with high-level support evident from senior management.
(3) Safe use of opioids national collaborative learning session (due 30 November 2015)	An 'all share/all learn' safe use of opioids national collaborative learning session was held in Auckland, 10–11 November, with 73 attendees from 19 sites.
(4) Adverse events learning pilot workshops (due 30 June 2016)	Workshops were held in Auckland (10–11 August 2015), Wellington (14–15 September 2015) and Christchurch (11–12 April 2016) to share adverse events review methodology with staff from a wide range of providers. Their feedback was used to inform course content in 2015/16 and future workshops.
(5) Safe surgery workshops for three DHB cohorts (due 30 June 2016)	We delivered learning sessions to three cohorts of DHBs, providing support and training to local safe surgery project leads and team members. Observational auditor training in how to use the surgical safety checklist was also delivered to staff from all DHBs.
(6) National quality accounts workshop (due 30 June 2016)	A successful national workshop was held in Wellington on 10 March 2016. It focused on quality accounts best practice and ideas sharing, and the pilot results of testing the NHS Safety Thermometer dashboard.
For each event, a survey is undertaken including an analysis of stakeholders represented and the key lessons they take from the event	Surveys were planned and undertaken for each programme, apart from the quality accounts workshop. No formal survey was conducted because after three years of workshops and with quality accounts becoming business as usual, it is unlikely to be staged in the same form next year.

New deliverable group for 2015/16

8.20 Quality and safety in the kaiāwhina workforce – achieved

Measure	2015/16 performance
Deliverable date: 30 June 2016	
The quality and safety component of the Health Workforce New Zealand five-year kaiāwhina workforce work programme delivered	We delivered quality and safety aspects of the five-year workforce action plan (August 2015). Then we implemented the actions associated with the quality and safety sections of the plan and promoting the 'Improving Together' online quality improvement learning resource to kaiāwhina (January–June 2016).
Health Workforce New Zealand, the Ministry of Health and the broader disability, aged care, mental health community and home support sector are engaged in the development process	An advisory panel that included consumers, Health Workforce New Zealand, the Ministry of Health and the broader disability, aged care, mental health community and home support sector met four times to assist with the drafting of the sections.

New deliverable for 2015/16

8.21 Expert advice, tools and guidance – achieved

Measure	2015/16 performance
Expert advice, tools and guidance provided to the sector Deliverable dates: all 30 June 2016	
(1) Safe use of opioids in hospitals	DHBs participating in the safe use of opioids national collaborative developed and tested ideas for inclusion in a care 'bundle', and from April 2016 the interventions were selected. We provided quality improvement tools to support DHBs' testing using the IHI's Model for Improvement and the PDSA cycle, to tailor the testing to local needs and resources.
(2) Implementing teamwork and communication in DHB operating theatres	Resources were provided to all DHBs and members of the Private Surgical Hospitals Association and Southern Cross Hospitals. Intervention training for DHBs was provided in cohorts, as were auditor training workshops. The Commission and Quality Hub NZ also developed a web-based auditing tool to capture compliance and engagement based on a validated rating tool.
(3) Reducing SSI for people undergoing knee and hip surgery and cardiac surgery	On the advice of the expert faculty for orthopaedic surgery SSI, the QSM for dosage was expanded to include cefuroxime alongside cefazolin, although the latter remains the preferred agent. In addition, deep and organ space SSIs for the orthopaedic programme are to be combined for reporting purposes, and revision procedures for infection are no longer included. The orthopaedic manual was updated to reflect this. National and DHB-specific reporting was released for hip and knee arthroplasty (4 March 2016). An expert faculty group for cardiac SSI was established (April 2016).
Resources and tools are based on evidence and developed in partnership with consumers	All resources and tools have been developed according to international and national best practice and in partnership with consumers.

New deliverable group for 2015/16

8.22 *Open for better care* national patient safety campaign – achieved

Measure	2015/16 performance
Deliverable dates: *Open* topic launched (30 June 2016), Patient Safety Week held (30 November 2015)	
(1) At least one topic launched	Seven leadership for quality and safety modules were delivered from March to June 2016, focusing on educating emerging clinical leaders. Over 280 attended. The workshops covered the characteristics of a good clinical leader, where patient harm is occurring and what leaders can do about it, leading change in a complex system, quality improvement knowledge and skills, and measuring and evaluating quality. Topic workshops were held across the country to achieve maximum reach. The campaign concluded on 30 June 2016.
(2) Patient Safety Week 2015 held	Patient Safety Week 2015 was held on 1–7 November, focusing on consumer engagement and communication. A key element of the week was launching the Commission's new patient safety card and discharge sheet to help consumers engage in hospital admission and discharge processes.

New deliverable for 2015/16

9.0 Revenue/expenses for output classes

	Output class 1 Measurement and evaluation		Output class 2 Advice and comment		Output class 3 Assistance to the sector to effect change		Total	
	Actual $000	Budget $000	Actual $000	Budget $000	Actual $000	Budget $000	Actual $000	Budget $000
Revenue								
Crown revenue	6,803	6,342	650	650	6,464	6,639	13,917	13,632
Interest revenue	23	37	3	4	25	39	51	80
Other revenue	176	0	194	50	550	0	920	50
Total revenue	**7,002**	**6,379**	**847**	**704**	**7,039**	**6,678**	**14,888**	**13,762**
Expenditure								
Operational and internal programme cost	4,719	3,904	583	584	3,865	3,723	9,167	8,211
External programme cost	2,691	2,475	251	120	2,883	3,045	5,825	5,641
Total expenditure	**7,410**	**6,379**	**834**	**704**	**6,748**	**6,768**	**14,992**	**13,852**
Surplus/(deficit)	**(408)**	**0**	**13**	**0**	**291**	**(90)**	**(104)**	**(90)**

10.0 Financial statements

10.1 Statement of comprehensive revenue and expenses for the year ended 30 June 2016

Actual 2015 $000		Notes	Actual 2016 $000	Budget 2016 $000
	Revenue			
13,456	Revenue from Crown	2	13,917	13,632
105	Interest revenue		51	80
902	Other revenue	3	920	50
14,463	**Total revenue**		**14,888**	**13,762**
	Expenditure			
5,680	Personnel costs	4	6,747	6,015
106	Depreciation and amortisation	12,13	116	114
2,647	Other expenses	6	2,304	2,082
4,028	External quality and safety programmes		3,991	3,721
2,039	External mortality programmes		1,834	1,920
14,500	Total expenditure		**14,992**	**13,852**
(37)	**Surplus/(deficit)**		**(104)**	**(90)**
0	Other comprehensive revenue		0	0
37	**Total comprehensive revenue**		**(104)**	**(90)**

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

10.2 Statement of financial position as at 30 June 2016

Actual 2015 $000		Notes	Actual 2016 $000	Budget 2016 $000
	Assets			
	Current assets			
2,170	Cash and cash equivalents	7	1,677	2,084
262	GST receivable		215	294
306	Debtors and other receivables	8	306	0
68	Prepayments		53	52
2,806	**Total current assets**		**2,251**	**2,430**
	Non-current assets			
202	Property, plant and equipment	12	283	143
15	Intangible assets	13	66	71
217	**Total non-current assets**		**349**	**214**
3,023	**Total assets**		**2,600**	**2,644**
	Liabilities			
	Current liabilities			
1,476	Creditors and other payables	14	1,058	1,116
273	Employee entitlements	16	372	347
1,749	**Total current liabilities**		**1,430**	**1,463**
1,749	**Total liabilities**		**1,430**	**1,463**
1,274	**Net assets**		**1,170**	**1,181**
	Equity			
1,311	General funds July		1,274	1,271
0	Contributed capital	17	0	
(37)	Surplus/(deficit)		(104)	(90)
1,274	**Total equity**		**1,170**	**1,181**

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

10.3 Statement of changes in equity for the year ended 30 June 2016

Actual 2015 $000		Notes	Actual 2016 $000	Budget 2016 $000
1,311	Balance at 1 July		1,274	1,271
	Comprehensive revenue and expenses for the year			
(37)	Surplus/(deficit)		(104)	(90)
	Owner transactions		0	0
0	Capital contribution		0	0
1,274	**Balance at 30 June**	**17**	**1,170**	**1,181**

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

10.4 Statement of cash flows for the year ended 30 June 2016

Actual 2015 $000		Notes	Actual 2016 $000	Budget 2016 $000
	Cash flows from operating activities			
13,456	Receipts from Crown		13,917	13,632
721	Other revenue		920	110
105	Interest received		51	80
(8,486)	Payments to suppliers		(8,532)	(7,880)
(5,695)	Payments to employees		(6,649)	(5,873)
119	Goods and services tax (net)		47	39
220	Net cash flow from operating activities	18	(246)	108
	Cash flows from investing activities			
(185)	Purchase of property, plant and equipment		(186)	(130)
(16)	Purchase of intangible assets		(61)	0
(201)	Net cash flow from investing activities		(247)	(130)
	Capital flows from financing activities			
0	Capital contribution		0	0
0	Net cash flow from financing activities	17	0	0
(19)	**Net (decrease)/increase in cash and cash equivalents**		**(493)**	**(22)**
2,151	Cash and cash equivalents at the beginning of the year		2,170	2,107
2,170	**Cash and cash equivalents at the end of the year**	7	**1,677**	**2,084**

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

10.5 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 2016, and were approved by the Board on 28 October 2016.

BASIS OF PREPARATION

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

Statement of compliance

The financial statements of the Commission 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 PBE accounting standards.

Measurement base

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

Changes in accounting policies

There have been no changes in accounting policies.

Standards, amendments and interpretations issued that are not yet effective and have not been early adopted

In May 2013 the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. The Commission has applied these standards in preparing the 30 June 2016 financial statements.

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 the Commission meeting its objectives as specified in its Statement of Intent. The Commission considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement. The fair value of revenue from the Crown Revenue has been determined to be equivalent to the amounts due in the funding arrangements.

Grants received

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

Interest

Interest income is recognised using the effective interest method.

Foreign currency transactions

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

Operating leases

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

Cash and cash equivalents

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

Debtors and other receivables

Debtors and other receivables are measured at face value less any provision for impairment. There are no provisions for impairment in 2015/16.

Bank deposits

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

Inventories

Inventories held for sale are measured at the lower of cost (calculated using the first-in, first-out basis) and net realisable value. There are no inventories held for sale in 2015/16.

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 of deficit.

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

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

Depreciation

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

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

Intangibles

Software acquisition

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

Amortisation

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

The useful life and associated amortisation rate of a major class of intangible assets have been estimated as follows:

Acquired computer software	3 years	33% SL

Impairment of property, plant and equipment, and intangible assets

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

Non-cash-generating assets

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

amount is the higher of an asset's fair value less costs to sell and value in use.

Goods and services tax

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

The net amount of GST recoverable from, or payable to, 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 face value.

Employee entitlements

Short-term employee entitlements

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

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Note 2: Revenue from the Crown

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

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

Note 3: Other income

An additional $0.920 million ($0.902 million 2015) was received from:

- the National Health IT Board's contribution to the eMM programme
- the ACC for SSI improvement programme
- DHB contributions to the national data warehouse for SSI
- Henry Marsh forum
- the ACC for safe surgery evaluation
- adverse event workshops
- the PMMRC and POMRC annual conferences.

Note 4: Personnel costs

	Actual 2015 $000	Actual 2016 $000
Salaries and wages	5,286	6,069
Recruitment	101	167
Temporary personnel	50	179
Membership, professional fees and staff	76	111
Training and development		
Defined contribution plan employer contributions	120	149
Increase/(decrease) in employee entitlements	47	72
Total personnel costs	**5,680**	**6,747**

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

Note 5: Capital charge

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

Note 6: Other expenses

	Actual 2015 $000	Actual 2016 $000
Audit fees to Audit NZ for financial audit	30	31
Staff travel and accommodation	394	378
Printing/communications	203	218
Consultants and contractors	627	235
Board costs/mortality review committees	618	553
Outsourced corporate services and overhead	766	882
Loss on property, plant and equipment	0	0
Other expenses	9	7
Total other expenses	**2,647**	**2,304**

Note 7: Cash and equivalents

	Actual 2015 $000	Actual 2016 $000
Cash at bank and on hand	2,170	1,677
Total cash and cash equivalents	**2,170**	**1,677**

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 2015 $000	Actual 2016 $000
Debtors and other receivables	306	306
Less: provision for impairment	0	0
Total debtors and other receivables	**306**	**306**

FAIR VALUE

The carrying value of receivables approximates their fair value.

IMPAIRMENT

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

Note 9: Investments

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

Note 10: Inventories

The Commission has no inventories for sale in 2015/16.

Note 11: Non-current assets held for sale

The Commission has no current or non-current assets held for sale in 2015/16.

Note 12: Property, plant and equipment

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

	Computer $000	Furniture and office equipment $000	Leasehold improvements $000	Total $000
Cost or valuation				
Balance at 1 July 2014	178	157	36	371
Additions	113	74	0	187
Disposals	(102)	(4)	(36)	(142)
Balance at 30 June 2015/1 July 2015	189	227	0	416
Additions	69	81	37	187
Disposals	0	0	0	0
Balance at 30 June 2016	258	308	37	603
Accumulated depreciation and impairment losses				
Balance at 1 July 2014	144	92	35	271
Depreciation expense	48	34	0	82
Elimination on disposal	(101)	(3)	(35)	(139)
Balance at 30 June 2015/1 July 2015	91	123	0	214
Depreciation expense	55	47	4	106
Elimination on disposal	0	0	0	0
Balance at 30 June 2016	146	170	4	320
Carrying amounts				
At 1 July 2014	34	64	1	99
At 30 June and 1 July 2015	98	104	0	202
At 30 June 2016	112	138	33	283

The Commission does not own any buildings or motor vehicles.

Note 13: Intangible assets

Movements for each class of intangible asset are as follows.

	Acquired software $000
Cost	
Balance at 1 July 2014	132
Additions	15
Balance at 30 June 2015/1 July 2015	147
Additions	61
Balance at 30 June 2016	208
Accumulated amortisation and impairment losses	
Balance at 1 July 2014	108
Amortisation expenses	24
Balance at 30 June 2015/1 July 2015	132
Amortisation expenses	10
Balance at 30 June 2016	142
Carrying amounts	
At 1 July 2014	24
At 30 June and 1 July 2015	15
At 30 June 2016	66

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 2015 $000	Actual 2016 $000
Creditors	794	833
Accrued expenses	682	225
Other payables	0	
Total creditors and other payables	**1,476**	**1,058**

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. The Commission has a non-cancellable lease for office space previously occupied.

Note 15: Borrowings (NZ IAS 1.77)

The Commission does not have any borrowings.

Note 16: Employee entitlements

	Actual 2015 $000	Actual 2016 $000
Current portion		
Accrued salaries and wages	30	57
Annual leave and long service	234	272
Total current portion	264	329
Non-current portion long service leave	9	43
Total employee entitlements	**273**	**372**

No provisions for sick leave or retirement leave have been made in 2015/16.

Provisions for long service leave have been made in 2015/16.

Note 17: Equity

	Actual 2015 $000	Actual 2016 $000
General funds		
Balance at 1 July	1,311	1,274
Surplus/(deficit) for the year	(37)	(104)
Capital contributions	0	0
Balance at 30 June	**1,274**	**1,170**

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

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

	Actual 2015 $000	Actual 2016 $000
Net surplus/(deficit)	(37)	(104)
Add/(less) movements in statement of financial position items		
Debtors and other receivables	(62)	47
Creditors and other payables	136	(418)
Depreciation	106	116
Prepayments	91	15
Employee entitlements	(14)	98
Net movements in working capital		
Net cash flow from operating activities	220	(246)

Note 19: Capital commitments and operating leases

CAPITAL COMMITMENTS

There were no capital commitments at balance date.

OPERATING LEASES AS LESSEE

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

	Actual 2015 $000	Actual 2016 $000
Not later than one year	192	353
Later than one year and not later than five years	0	608
Later than five years	0	0
Total non-cancellable operating leases	**192**	**961**

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 2019 with three one-year rights of renewal. The value of the lease to March 2019 is $0.864 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 six staff. The sub-lease expires in December 2018.

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

Note 20: Contingencies

CONTINGENT LIABILITIES

The Commission has no contingent liabilities.

CONTINGENT ASSETS

The Commission has no contingent assets.

Note 21: Related party transactions

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

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

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

KEY MANAGEMENT PERSONNEL

Salaries and other short-term employee benefits to key management personnel[4] totalled $1.09 million ($1.07 million 2015).

4 Key management personnel for 2015/16 include the Chief Executive, General Manager, Director of Measurement and Evaluation and Chief Financial Officer. Board members have been reported separately.

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

The total value of remuneration paid or payable to each Board member (or their employing organisation*) during the full 2015/16 year was as follows.

	Actual 2015 $000	Actual 2016 $000
Prof Alan Merry* (Chair)	29	29
Shelley Frost* (Deputy Chair)	18	18
Dr David Galler*	15	0
Dr Bev O'Keefe*	0	10
Dame Alison Paterson	15	15
Dr Dale Bramley*	15	15
Robert Henderson*	17	19
Heather Shotter	15	15
Gwendoline Tepania-Palmer	15	15
Total Board member remuneration	**139**	**136**

Fees were in accordance with the Cabinet Fees Framework.

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

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

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

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

Note 23: Employee remuneration

Total remuneration paid or payable to employees is as follows.

	Employees 2015	Employees 2016
$100,000–$109,999	6	2
$110,000–$119,999	4	10
$120,000–$129,999	0	3
$130,000–$139,999	2	1
$140,000–$149,999	3	2
$150,000–$159,999	1	2
$160,000–$169,999	1	2
$200,000–$209,999	2	1
$210,000–$219,999	0	1
$220,000–$229,999	1	0
$230,000–$239,999	0	1
$240,000–$249,999	0	1
$250,000–$259,999	1	0
$320,000–$329,999	0	1
$380,000–$389,999	1	0
$390,000–$399,999	0	1
Total employees	**22**	**28**

During the year ended 30 June 2016 no employees received compensation and 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 2015/16 Statement of Service Expectations follow.

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSES

The year-end result for the year to 30 June 2016 is a $0.104 million deficit against a planned Statement of Performance Expectations deficit of $0.090 million.

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

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

Increased overhead and other occupancy costs are associated with the leasing of an additional half floor in the Whitmore Street offices, insurance, IT support, and software licensing for the staff required to deliver on the additional revenue during 2015/16.

STATEMENT OF FINANCIAL POSITION

Cash and cash equivalents were lower than budgeted as debtors of $0.3 million associated with additional third party revenue were not budgeted for in June 2016.

Debtors are higher than budgeted due to invoices being raised in quarter 4 for the additional unbudgeted revenue streams (including eMM, Australian and New Zealand Intensive Care Society database and the primary care experience survey).

Property, plant and equipment are higher than planned as the Commission's laptop fleet was upgraded during the period and new office furniture was purchased for the additional half floor in the Whitmore Street offices.

STATEMENT OF CHANGES IN CASH FLOW

Because the Commission received an additional $1.1 million in revenue during the period, both revenue received and 'payment to suppliers and employees' are higher than budgeted figures.

Payments to suppliers are also higher because fewer creditors were outstanding at year end.

Note 28: Acquisition of shares

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

Note 29: Responsibilities under the Public Finance Act

To comply with our responsibilities under the Public Finance Act 1989, here we report the activities funded through the Crown Vote Health and how performance is measured against the forecast information contained in the Estimates of Appropriations 2015/16 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 2015/16 $000	Budget 2015/16 $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 as reported in the Statement of Performance

The Commission also received Crown funding of:

- $0.325 million from Vote Health – Monitoring and Protection of Health Consumer Interests
- $0.258 million from Vote Health – Primary Health Care Strategy (M36) appropriation
- $0.169 million from Vote Health – National Personal Health Services
- $0.156 million from Vote Health – National Mental Health Services (M36) appropriation.

11.0 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 2016.

Signed on behalf of the Board:

Prof Alan Merry ONZM FRSNZ
Chair
28 October 2016

Shelley Frost
Deputy Chair
28 October 2016

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Health Quality and Safety Commission's financial statements and performance information for the year ended 30 June 2016

The Auditor-General is the auditor of Health Quality and Safety Commission (the Commission). The Auditor-General has appointed me, Andy Burns, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Commission on her behalf.

Opinion on the financial statements and the performance information

We have audited:

- the financial statements of the Commission on pages 37 to 51, that comprise the statement of financial position as at 30 June 2016, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Commission on pages 8 to 19, 24 to 36, and 58 to 62.

In our opinion:

- The financial statements of the Commission:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2016; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Accounting Standards.
- The performance information:
  - presents fairly, in all material respects, the Commission's performance for the year ended 30 June 2016, including:
    - for each class of reportable outputs:
      - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;

- what has been achieved with the appropriation; 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 28 October 2016. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and the performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and the performance information. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Commission's financial statements and performance information 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.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Commission's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and the performance information. Also, we did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

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

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information that:

- comply with generally accepted accounting practice in New Zealand and Public Benefit Entity Accounting Standards;
- present fairly the Commission's financial position, financial performance and cash flows; and
- present fairly the Commission's performance.

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

The Board is responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and the performance information, whether in printed or electronic form.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

Other than the audit, we have no relationship with or interests in the Commission.

Andy Burns
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Appendix 1: Board and committee membership

Board members

Dr Dale Bramley (*Ngā Puhi*)

Shelley Frost (Deputy Chair)

Robert Henderson

Prof Alan Merry (Chair)

Dr Bev O'Keefe (from 1 August 2015, replacing Dr David Galler)

Dame Alison Paterson

Heather Shotter

Gwendoline Tepania-Palmer (*Te Aupōuri, Ngāti Kahu, Ngāti Pāoa Tainui*)

Board committees

Finance and Audit Committee*

Andrew Boyd

Dr Dale Bramley

Prof Alan Merry

Dame Alison Paterson (Chair)

Heather Shotter

* From 19 May 2016 renamed the Audit Committee

Communication and Engagement Committee:

Shelley Frost

Heather Shotter (Chair)

Gwendoline Tepania-Palmer

Roopū Māori members

Dr Peter Jansen (*Ngāti Raukawa*)

Dr George Laking (*Te Whakatōhea*)

Marama Parore (*Ngāti Whātua, Ngāti Kahu, Ngāpuhi*)

Leanne Te Karu (*Muaūpoko/Whanganui*)

Tuwhakairiora (Tu) Williams (Chair) (*Ngāti Porou, Whakatōhea, Ngāi Tai*)

Prof Denise Wilson (*Ngāti Tahinga (Tainui)*)

Consumer network members

Martine Abel

James Ahipene (*Ngāti Tūwharetoa*)

Kula Alapaki

Marj Allan

Mary Campbell

Vicki Culling

Renee Greaves

Shaun McNeil

Shreya Rao

Ezekiel Robson

Te Rina Ruru (*Ngāti Kahu ki Whāingaroa/Te-Aitanga-a-Māhaki*)

Traci Stanbury

Courtenay Thrupp

Mortality review committee members at 30 June 2016

Perinatal and Maternal Mortality Review Committee	Perioperative Mortality Review Committee	Child and Youth Mortality Review Committee	Family Violence Death Review Committee	Suicide Mortality Review Committee
Dr Sue Belgrave (Chair)	Prof Ian Civil	Prof Shanthi Ameratunga	Dr Fiona Cram	Maria Baker
Dr Max Berry	Dr Catherine Ferguson (Deputy Chair)	Dr Terryann Clark	Paul von Dadelszen	Dr Sarah Fortune (Deputy Chair)
Dr Sue Crengle	Dr Michal Kluger	Dr Arran Culver	Prof Dawn Elder (Deputy Chair)	Prof Robb Kydd (Chair)
Alison Eddy (Deputy Chair)	Dr Jonathan Koea	Dr Stuart Dalziel (Deputy Chair)	Pamela Jensen	Prof Roger Mulder
Dr Rose Elder	Keri Parata-Pearse	Dr Felicity Dumble (Chair)	Prof Jane Koziol-McLain	Dr Deborah Peterson
Gail McIver	Robert Vigor-Brown	Dr Paula King	Assoc Prof Julia Tolmie (Chair)	Dr Jemima Tiatia-Seath
Linda Penlington	Dr Anthony Williams	Fale Lesa	Prof Denise Wilson (Deputy Chair)	David White
	Dr Leona Wilson (Chair)	Prof Ed Mitchell		

The Suicide Mortality Review Committee last met on 12 November 2015 and currently has no meetings planned while its future status is decided.

Clinical leads

Dr John Barnard	Medication safety
Sandy Blake	Reducing harm from falls
Prof Ian Civil	Reducing perioperative harm
Avril Lee	Safe use of opioids
Dr Arthur Morris	Infection prevention and control
Dr Alex Psirides	Deteriorating patient
Gillian Robb	Global trigger tool
Dr Sally Roberts	Infection prevention and control
Dr Iwona Stolarek	Reportable events
Dr John Wellingham (Chair)	Primary care

Postal address

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Fax: 04 901 6079
Email: info@hqsc.govt.nz
Web: www.hqsc.govt.nz

Auditor

Audit New Zealand on behalf of the Auditor-General

Appendix 2: Measuring progress against the quality and safety markers

The QSMs measure changes in practice and outcomes for priority programmes. Baselines against which progress is being measured are highlighted in bold.

Table 1: Reducing harm from healthcare associated infections

Measure	Actual 2011/12	Actual 2012/13	Actual 2013/14	Actual 2014/15	Target 2015/16	Actual 2015/16	Data source
Process measures							
Percentage observed compliance with all 'five moments for hand hygiene'	**62.1%** **(October 2012)**	70.5% (June 2013)	73%	80% with 12 out of 20 DHBs meeting the target	80%	82% (June 2016) with 14 out of 20 DHBs meeting the target	Hand Hygiene New Zealand programme
Compliance with bundle of procedures for inserting central line catheters in intensive care units	**77%** **(April 2012)**	82% (whole year)	95%	90% (July to December 2014)	Not applicable	Not measured – CLAB marker retired December 2014	*Target CLAB Zero* programme
Outcome measures							
Rate of healthcare associated *Staphylococcus aureus* bacteraemia[5] per 1000 inpatient days	0.14	**0.11**	0.12	0.12 (July 2014 to March 2015)	Maintenance of rate between 0.07 infections and 0.11 per 1000 bed-days	0.14	Hand Hygiene New Zealand programme
Rate of central line associated bacteraemia (CLAB) per 1000 line days	**3.5**[6]	0.49	0.52	0.42 (July to December 2014)	Not applicable	Not measured – CLAB marker retired December 2014	*Target CLAB Zero* programme (data not collected since Dec 2014)
Rate of SSI per 100 procedures for total hip and knee joint replacements		**1.9** (based on the initial four months from the eight pilot sites)	1.2 (July 2013 to June 2014)	1.2 (July 2014 to June 2015)		1.0 (July 2015 to March 2016, full-year data not available)	National monitor system (ICNet)

5 A bacterial infection, which can result from poor hand hygiene practices.
6 *Target CLAB Zero* final report.

Table 2: Reducing perioperative harm

Marker	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14[7]	Actual 2014/15	Target 2015/16	Actual 2015/16	Data source
Process measures								
Percentage of operations where all three parts of the WHO surgical safety checklist are used			**71.2%**	95% (April to June 2014)	93% (January to March 2015)	Not specified	Not measured – (a new QSM aimed at measuring levels of teamwork and communication was rolled out. The first public reporting will be in the December 2016 QSM update)	Chart reviews[8]
Outcome measures								
Postoperative sepsis rate[9] per 1000 surgical episodes	8.37[10]	8.9	**10.77**	12.3 (see note 1)	12.9[11]	Reduction of around 30% over three years	13.1	National Minimum Dataset (NMDS)
Postoperative sepsis rate (elective) per 1000 surgical episodes	3.68[12]	4.08	**3.66**	5.89	6.6 (July 2014 to December 2014)		All postoperative only now reported	NMDS
Postoperative DVT/PE rate per 1000 surgical episodes	3.94[13]	3.97	**3.81**	4.18[14]	4.18[15]		4.3	NMDS

Note 1: A significant driver of the increased sepsis rate is that more complex cases (thus at greater risk of sepsis) are being undertaken more frequently.

Note 2: Eight reducing perioperative harm outcome measures listed in our Statement of Intent for 2014–18 (Appendix 2, p 37) are no longer included in our annual reports. Changes in reporting the safe surgery QSMs since 2015/16 have led us to reduce the number of outcome measures reported while the safe surgery QSM is being revised. The following statement of intent outcome measures are no longer part of our QSM reporting and are therefore not reported here: Additional OBDs associated with postoperative sepsis (elective); Additional OBDs associated with postoperative DVT/PE; Additional cost associated with postoperative sepsis; Additional cost associated with postoperative sepsis (elective); Additional cost associated with postoperative DVT/PE; Excess number of in-hospital deaths associated with sepsis; Excess number of in-hospital deaths associated with sepsis (elective); Excess number of in-hospital deaths associated with DVT/PE.

7 The estimates based on the NMDS use actual data for a calendar year. Validated NMDS data for the full year are not available until at least three months after the end of the period.

8 Based on chart reviews – we are working towards observer-based data in future.

9 Calculated as the number of surgical admissions where postoperative sepsis and postoperative deep vein thrombosis/pulmonary embolism (DVT/PE) was recorded within the initial surgical episode or where a readmission was associated with postoperative sepsis and DVT/PE occurred within 28 days of discharge from an initial surgical episode per 1000 surgical episodes.

10 The numbers for 2010/11 to 2012/13 differ from those previously reported due to an improved definition of readmission being used in the context of the markers. The new definition has been used to recalculate the numbers for those years.

11 The reported total in 2014/15 was 13.3 for the nine months from July 2014 to March 2015. The figure now reported is for the full 2014/15 year.

12 Haynes AB, Weiser TG, Berry WR, et al. 2008. A surgical safety checklist to reduce morbidity and mortality in a global population. *New England Journal of Medicine* 360(5): 491–9.

13 *Ibid.*

14 Across the four years, there has been no statistically significant change.

15 The reported total in 2014/15 was 4.1 for the nine months from July 2014 to March 2015. The figure now reported is for the full 2014/15 year.

Table 3: Reducing harm from falls

Marker	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14	Actual 2014/15	Target 2015/16	Actual 2015/16	Data source
	Process measures							
Percentage of older patients given a falls risk assessment			**77%**	90%	90%	No target identified	91% (June 2016)	DHB audits of patients aged 75+
Percentage of older patients assessed as at risk of falling who received an individualised care plan that addressed these risks			**80%**	90%	90%	No target identified	95% (June 2016)	DHB audits of patients aged 75+
	Outcome measures							
In-hospital fractured neck of femur (FNOF)	111	91	**97**	92	88 (April 2014 to March 2015)	Reduction of falls with FNOF of 10–30% over three years	70	NMDS
Additional occupied bed-days (OBDs) following in-hospital FNOF	4124	3944	**2677**	513[16]	3204 (April 2014 to March 2015)	Measurement of associated reduction in additional OBDs and cost	See note 1	NMDS
Cost of additional OBDs associated with FNOF			**$2.06 million**	$0.4 million	$2.4 million		See note 1	NMDS/cost data from New Zealand Institute of Economic Research (NZIER)[17]

Note 1: This measurement is no longer provided. Now we use the number of falls reduced to calculate the total saving, given the falls rate observed in the period July 2010–June 2012.

Note 2: One reducing harm from falls outcome measure listed in our Statement of Intent for 2014–18 (Appendix 2 p 38) is no longer included in our annual reports. The measure, Mortality following in-hospital FNOF, is noted in the Statement of Intent as exhibiting numbers that are too small to be reliable. This is still the case, and this measure is no longer included in our annual reports.

16 The large reduction in additional OBDs (and cost of additional OBDs) was caused by a small number of very long stay patients present in 2012/13, but not in 2013/14, so should not be seen as a genuine reduction of this magnitude.

17 De Raad JP. 2012. *Towards a value proposition... scoping the cost of falls. NZIER scoping report to Health Quality and Safety Commission NZ*. Wellington: NZIER.

Table 4: Reducing surgical site infections

Marker	Baseline Jul-Sept 2013	Actual Jan-Mar 2014	Actual 2014/15 (Jan-Mar 2015)	Target 2015/16	Actual 2015/16 (Jan-Mar 2016)	Data source
Process measures						
Antibiotic given at right time	**85%**	92%	94%	No annual target identified	97%	ICNet
Right antibiotic and right dose (2 g cefazolin)	**55%**	78%	90%		96% see note 1	
Right skin preparation	**91%**	98%	98%		99% see note 2	
Outcome measures						
SSIs (total across period)	**30**	24	25	No annual target identified	31	ICNet
Infections per 1000 hip and knee operations (rate in the final quarter)	**13**	10	10		12	
Sum of estimated incident cost ($)	**$0.53 million**	$0.425 million	$0.44 million		$0.71 million	

Note 1: Fourteen DHBs have reached the 95 percent threshold compared with only three at 2013 baseline.
Note 2: The 100 percent target was met by 13 DHBs. Six more DHBs are achieving 99 percent.

Table 5: Reducing medication errors

Marker	Baseline 30 June 2015	June 2016	Expected outcome over the next four years (target)	Data source
Structural measure				
eMM implemented anywhere in the DHB	5 DHBs	5 DHBs (2 DHBs are able to report all markers, 2 DHBs are only able to report structural marker, 1 DHB is unable to provide report yet as reporting system is still being tested)	All DHBs	DHB eMR system
Number and percentage of relevant wards with eMR implemented	Ranging between 50% and 91% for the four DHBs reporting	Ranging between 50% and 97% for the four DHBs reporting	All relevant wards	DHB eMR system
Process measures				
Percentage of relevant patients aged 65 and over (55 years for Māori and Pacific patients) where eMR was undertaken within 72 hours of admission	Ranging between 49% and 58% for the two DHBs reporting	43–62%	Not specified	DHB eMR system
Number and percentage of relevant patients aged 65 and over (55 years for Māori and Pacific patients) where eMR was undertaken within 24 hours of admission	Ranging between 19% and 51% for the two DHBs reporting	14–56%	Not specified	DHB eMR system
Percentage of patients aged 65 and over (55 years for Māori and Pacific patients) discharged where eMR was included as part of the discharge summary	Ranging between 55% and 65% for the two DHBs reporting	50–67%	Not specified	DHB eMR system

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