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

ANNUAL REPORT

FOR THE PERIOD
1 JULY 2016 TO 30 JUNE 2017

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open FOR BETTER CARE
Hāpai ake te toiora

Patient story — Kim's story

Kim, a Northland man, has had several operations on his left leg in the past two years. He was recently admitted for a procedure from which he would be discharged in a wheelchair.

After his experience, he sent a letter to his district health board to thank them for the care they provided, and for the communication, which made him feel at ease.

'I am incredibly impressed with all the staff,' he wrote.

'The staff's attitude is brilliant and they were both caring and interested in every way.'

Speaking about the clinicians who cared for him, he noted their friendly approach and communication skills with both him and his family made his time in the ward so much easier.

'After my short stay I could name all of them and their service was really exceptional. They all seemed very knowledgeable and nothing was too much trouble. From the doctors, nurses and pharmacist to the lady that makes coffee and the friendly guy that brings meals, they were really welcoming and seemed to genuinely care about everyone in their care.

'My wife obviously came to visit me and was treated with great respect and friendship by all the staff and all of her questions were answered in a friendly and professional manner.'

Kim said the caring nature of his clinical team continued even after his discharge.

'I left my phone charger in the ward and, instead of a phone call as a reminder, it arrived in the mail a couple of days later at my home. Service beyond the call, I call that.'

Note: The patient's name has been changed to protect privacy.

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

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

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

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

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

Whakataukī

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

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

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

The aim of the Health Quality & Safety Commission is to achieve health quality improvement and equity for all. The principles of the Treaty of Waitangi are a basis upon which we strive to achieve this aspiration.

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

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Foreword

We are very pleased to present the annual report of the Health Quality & Safety Commission (the Commission) for 2016/17.

In the past year we have continued to build on the successes of our previous work to improve the quality and safety of the New Zealand health system, and to secure greater value for existing health resources. The enduring focus of our work is to unlock the potential of the system to learn smarter ways of working, safer methods of care and more consumer-focused approaches to service design.

This has been the first full year in which the updated New Zealand Health Strategy has been operating, and we have advanced its key themes in our work in 2016/17. We have fulfilled our mandate to improve the health system's quality and safety, and to implement Government policy across the system. That has involved changing practices to adopt the best ideas from New Zealand and overseas, and using our finite resources intelligently to transform health care in the most sustainable ways.

We are pleased with the results in our key work programmes, which we achieved with baseline funding that has been fixed since 2012/13.

- Our quality improvement programmes focused on reducing harm and waste in many areas, including preventing infections, making surgery and the use of medicines safer, and working to improve primary care through innovative approaches designed in partnership with the sector.
- Our mortality review committees published reports that advance the understanding of mortality and morbidity, and made a compelling case for systemic change to save more lives. Among other achievements, our Child and Youth Mortality Review Committee's efforts, combined with the work of other agencies, contributed to a 24 percent reduction in the number of deaths of children and youth between 2002 and 2014, despite a substantial increase in New Zealand's population over the same period.
- We have used our expertise and sector connections to continue to build quality improvement capability and leadership across New Zealand, laying the groundwork for grassroots, locally driven change.
- Through our measurement and evaluation reporting we are able to understand the influences and outcomes of quality improvement, track performance towards system goals, start conversations about the effectiveness of care, and improve the recommendations for change that both we and our partner agencies offer.
- Our ambition to bring about more equitable care and fair health outcomes for all has gained particular momentum this year from Te Whai Oranga, our Māori advancement framework.
- The Partners in Care consumer engagement programme has helped raise awareness of the benefits of and the need for change and implementation expertise. It has also provided guidance on how to monitor and sustain change.

Without the hard work and dedication of the Commission's staff, and the cooperation of our vital partners throughout New Zealand, none of this would be possible. Our consumer representatives, clinical leads and regional quality improvement champions all deserve our gratitude for their tireless efforts.

We welcome the opportunity to reflect on our successful year in 2016/17, and look forward to the Commission's continued success and achievement in the year ahead.

Prof Alan Merry ONZM FRSNZ
Chair
30 October 2017

Dr Janice Wilson
Chief Executive
30 October 2017

Part one

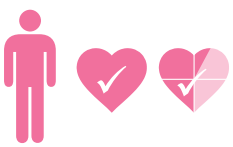
1.0 Achievements

Our work prevents harm and improves the quality of experience of health care for all New Zealanders. As a result, it prevents human suffering and the costs of harm, and reduces ineffective spending, with benefits for both individuals and the whole health care system. In addition, a healthier population is valuable to society, which we can measure using economic methodologies that the public sector in general tends to follow but the health sector in particular does not. This section highlights examples of avoidable harm and costs the health and disability sector has prevented. These are some of the areas we focus on or raise awareness about; the successes are a result of the work and commitment of the whole sector to improve patient safety and save lives.

Falls are the most common cause of serious injury, and occasionally death, in our public hospitals. The Commission's programme to reduce harm from falls has introduced a number of simple interventions to help address falls-related harm. This programme works alongside and supports existing programmes in the sector. Every week in 2010–12, on average two patients fell and broke their hips in New Zealand hospitals. Having a fall can add a month to someone's hospital stay and is very costly. **The rate of broken hips has almost halved**.

Since June 2013, there were 85 fewer falls resulting in a broken hip

An estimated $3.5 million saved



On average, an avoided broken hip gives an extra 1.6 years of healthy life[1]

Value $23 million

1 The infographics in this section use a measure of the value of a year of healthy life. Having people who live longer and healthier lives provides value for the individual and for society. Based on what New Zealanders say they are willing to spend to save a life, we can calculate the value of a life at $4 million. This can be adjusted to give a value for a year of life in good health, which is estimated at $180,000. The underlying data for each infographic is obtained from: the National Minimum Dataset (NMDS) for the falls, DVT/PE and occupied bed-days diagrams; the Surgical Site Infection National Monitor for the infections diagram; and the Child and Youth Mortality Review database for the child deaths diagram. The data is from a third party. The Commission relies on this data and the amounts saved are based on estimates and assumptions.

Deep vein thrombosis (DVT) describes a range of blood clots. These usually start in the leg, but can travel to the lungs to become a pulmonary embolism (PE) and cause serious damage to the lungs and other organs. Since 2013 the Commission has worked with district health boards (DHBs) to implement the Safe Surgery NZ programme, and a number of **DVT/PE cases have been avoided**.

Since January 2013, 378 DVT/PE cases have been avoided

$7.9 million saved

Each DVT/PE case avoided gives 0.6 additional years of healthy life

Value $40 million

Since 2012 the Commission has run its surgical site infection improvement programme, concentrating on hip and knee replacements (and more recently cardiac surgery). Good practice in **avoiding infections** through timely use of the right antibiotics and good skin preparation **has increased significantly** since then, reducing the number of infections from hip and knee replacements.

Since August 2015, reduction in infection rate from 1.3% of operations to 0.9% of operations

This equates to 51 fewer infections between August 2015 and June 2016, saving up to $1.9 million

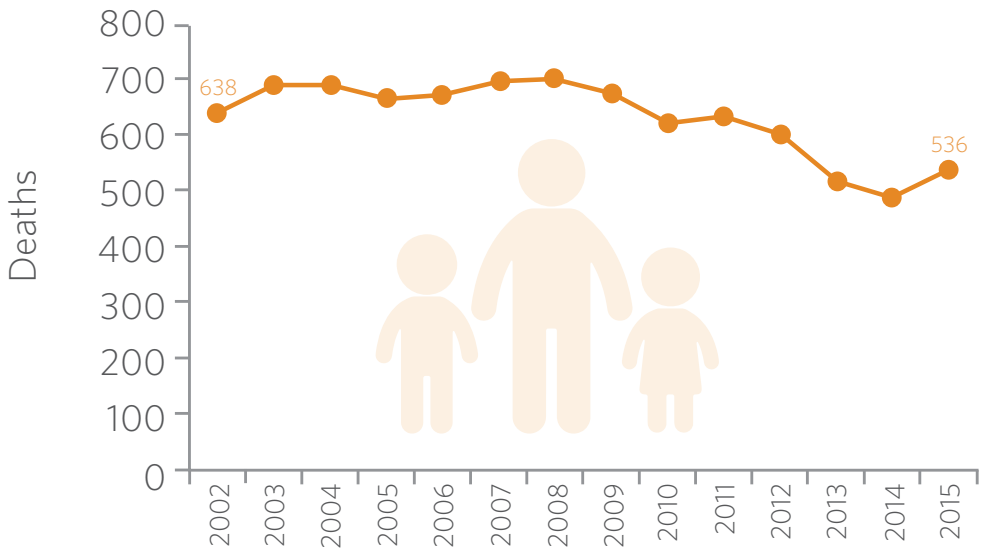
On average, an avoided infection gives an extra 0.5 years of healthy life

Value $4.3 million

Since 2010 **the rate of deaths of children and young people** aged between 28 days and 24 years **has fallen significantly**. Major reasons for this reduction have been work to reduce sudden unexpected death in infancy (SUDI), and fewer road traffic crashes involving young people. Our Child and Youth Mortality Review Committee (CYMRC) has recommended putting babies to sleep on their backs, and this practice has been instrumental in reducing SUDI. In addition, the CYMRC has emphasised the need for safe sleep spaces for babies. For adolescents, the largest reductions in deaths have come from fewer road traffic crashes – probably a combined result of raising the driving age, and introducing graduated licences and a zero-alcohol policy for under-20s.

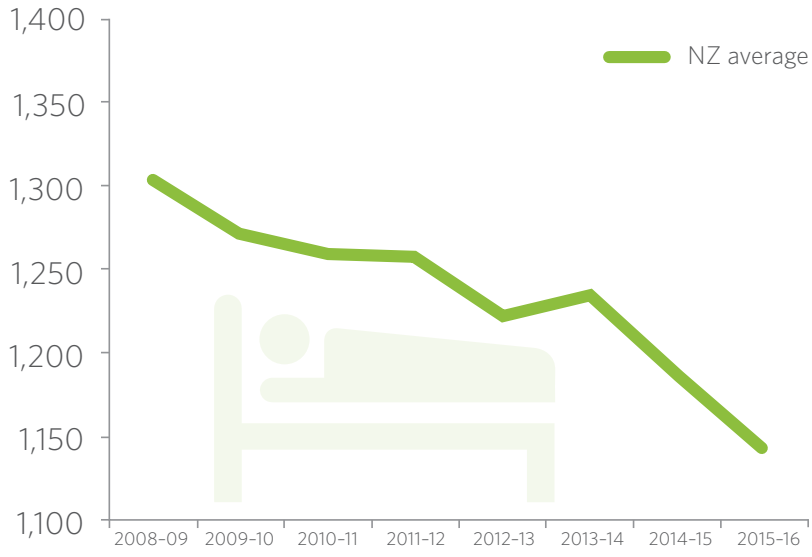
Since 2010, 695 fewer deaths of children
aged between 28 days and 24 years

Value of these early deaths avoided, $271 million



The Commission's health quality and safety indicators have highlighted the number of older people who are admitted to hospital as an emergency more than once. When older people are repeatedly admitted to hospital, it can indicate they are not receiving the right care. The **fall in the number of admissions** is a result of the interventions that many DHBs have put in place.

Occupied bed-days associated with 75s and over admitted twice or more as an emergency per 1,000 people



Since January 2013, 95,000 fewer bed-days

$72 million saved

2.0 Who we are and what we do

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,[2] 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 New Zealand Health Strategy 2016 sets out the strategy and outlook of the sector, which it summarises in its motto, 'All New Zealanders live well, stay well, get well'. Within this framework, we define our quality improvement agenda using the New Zealand Triple Aim, which simultaneously addresses quality improvement for individuals, populations and the system.

2 A Crown agent is required to give effect to government policy when directed by the responsible Minister.

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

3.0 Strategy

Our statement of intent for 2014–18, agreed in June 2014, set our strategic direction in 2016/17.[3] 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.

The New Zealand Health Strategy has also guided all work across the health sector since it was published in April 2016. It has informed the Commission's strategy development at all levels. Section 8.0 highlights the aspects of the Health Strategy each of our outputs contributes to.

The Minister of Health's December 2015 letter of expectations stated the following key priorities for the Commission in 2016/17:

Priority	Progress
Expand and embed the use of the patient experience survey tool, as a matter of priority during the year, into the aged care sector.	We progressed this work in 2016/17 through the Ministry of Health's Health of Older People Strategy. We agreed on a way forward in March 2017 and are agreeing on a revised work programme and delivery timeframe for 2017/18.
Support and contribute to the Ministry of Health's work to better capture performance information about the quality and safety of New Zealand's health services, including work on the eventual publication of health data (transparency of health information).	See section 5.1 for further details of this transparency work.
Working jointly with the Ministry to ensure publications reflect a comprehensive, contextualised and joined-up picture of the New Zealand health system.	We consult with relevant Ministry of Health stakeholders on all publications of joint interest, and often invite them to participate directly in steering committees to keep up close communications.
Continue to strongly develop greater sector capability in quality improvement.	See section 6.3, 'Building sector capability'.

3 A new Statement of Intent covering 2017–21 came into effect on 1 July 2017 and will guide our next three years.

The year in review

The Commission worked in a wide range of programmes in 2016/17, including:

- mortality review (involving deaths related to child and youth, family violence, perinatal and maternal, perioperative, suicide), to identify patterns in certain types of deaths and make recommendations to agencies to prevent similar types of deaths from recurring
- infection prevention and control (hand hygiene, preventing central line associated bacteraemia (CLAB), reducing surgical site infections), to reduce harm and waste from preventable infections
- health quality evaluation (Atlas of Healthcare Variation, health quality and safety indicators, quality and safety markers), to measure the quality of the health and disability system and, in so doing, promote ways of improving it
- adverse events learning programme, to improve consumer safety by supporting organisations to report, review and learn from adverse events that occur in health and disability services
- reducing the harm and waste across the health and disability system that occurs due to:
  - medication errors
  - surgery (surgical safety checklist, improving teamwork and communications)
  - falls
  - patient deterioration
- primary care improvement initiatives
- Partners in Care (consumer engagement, health literacy, leadership capability), to promote consumers' active involvement in decision-making about health and disability services at every level
- other areas such as electronic medicines management, reducing harm from falls, preventing pressure injuries and improving aged residential care.

Our reported activities are grouped into three output classes to explain our 2016/17 Statement of Performance Expectations deliverables:

Output class 1: Measurement and evaluation (section 4.0)
Output class 2: Advice and comment (section 5.0)
Output class 3: Assistance to the sector to effect change (section 6.0).

4.0 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, measuring and reporting on quality and safety engages clinicians, managers and consumers, generates informed discussion and improves the efficiency of the sector.

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

Information plays a central role in the ability of a health system to secure improved health effectively and efficiently for its population. It can be used in many diverse ways, such as tracking public health, monitoring health care safety, determining appropriate treatment paths for patients, promoting professional improvement, ensuring managerial control and promoting the accountability of the health system to the public. Underlying all of these efforts is the role performance measurement plays in guiding the decisions that various stakeholders – such as patients, clinicians, managers, governments and the public – make in steering the health system towards better outcomes.

Peter C Smith et al, ***Performance measurement for health system improvement: experiences, challenges and prospects***, World Health Organization, 2008.

4.1 Measuring quality and safety

In 2016/17 our measurement and evaluation activities helped us define the current parameters of quality and safety in the sector, and identify opportunities for further improvements. Our work in this area included:

Overview of quality and safety – Our report, *A Window on the Quality of New Zealand's Health Care*, uses currently available measures to understand quality and safety, and to ask, 'How good is New Zealand's health care?' In our third *Window*, published in June 2017, we reported that fewer New Zealanders are dying from treatable conditions, and fewer are experiencing premature deaths and disability due to ill health. Our health system is relatively inexpensive compared with other English-speaking and western European countries. Our ultimate outcomes of care, such as reducing death and disability, are improving and are in line with other countries similar to New Zealand. However, inequities in health outcomes remain for Māori, Pacific peoples and New Zealanders in the most deprived populations.

Report on the value of the Commission's work – We issued two reports in 2016/17 setting out the value of our work. The *Open4Results* reports combine data on avoided costs of harm, associated value of quality adjusted life years (QALYs) gained, and value of statistical lives for avoided deaths associated with the work of the mortality review committees. The reports also considered avoided expenditure associated with reduced variation. The most recent report was published in June 2017; see section 1.0 for a summary of its collected findings.

Quality and safety markers (QSMs) – Each QSM is a targeted set of process and outcome measures designed to: track how the sector is progressing in adopting 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 surgical site infection), perioperative harm and medicines reconciliation. Four national QSM progress reports were published in 2016/17. The most recent reports revealed the following:

- Ninety-two percent of older patients were assessed for their falls risk in the first three months of 2017 (target 90 percent). The achievement rate has been at the expected rate since October–December 2013. Of those patients assessed as being at risk of falling, about 95 percent had an individualised care plan completed.
- There were 77 falls in hospitals resulting in a broken hip in the 12 months ending March 2017. The median of monthly falls has reduced from eight to six since December 2014. The reduction is estimated to have saved $1.5 million in the year ending March 2017.
- The median surgical site infection rate has improved significantly, dropping to 0.84 percent since June 2015, compared with 1.36 percent during the baseline period of April 2013 to March 2014.
- National compliance with the 'five moments for hand hygiene' remains high. DHBs achieved an average of 84 percent compliance in the quarter to March 2017, the highest rate since the baseline in the third quarter of 2012.

Most of the process markers have improved significantly. Some outcomes have also improved (see Appendix 1).

The New Zealand Atlas of Healthcare Variation – The Atlas measures how geographical areas differ in the way they provide and use specific health services and outcomes. Presented as a web tool using maps, graphs, tables and commentary, the Atlas stimulates improvement by prompting debate and raising questions among clinicians, users and providers of health services about why regions differ in their use and provision of health services. In 2016/17 we updated the data of seven Atlas domains, held two *Open Forum* sessions to stimulate discussion on unwarranted variation, and completed a review of how the Atlas has operated since it was established in 2012.

Two of our Commission senior analysts have built on their measurement and evaluation work in previous years to reveal new insights into health quality and safety in 2016/17.

***Ying Li** says she is particularly pleased with improvements to QSM reporting: 'It's now more user-friendly and interactive. There's more information and the webpage is more interactive, which helps users navigate more quickly to the data they want, and to see the trends they want to investigate over time. We've also published new DHB quality dashboards since early 2017, which helps users to see all the QSM and patient experience survey data for a DHB on a single page. Comparing this data with DHB baselines and the national average helps DHBs understand how well they're performing, which stimulates improvement.'*

***Nikolai Minko** admits his work is often 'under the radar' as he develops and tests the data architecture that underpins Commission reporting, and draws together sources from multiple agencies. 'I do data management for national health care data collections. I also worked on new indicators this year, like adapting a US model of prevention quality indicators for New Zealand. They examine conditions in DHB hospitals that may be amenable to primary care treatment, and include 14 factors such as the rate of diabetes or pneumonia. Having more information in different areas will help us and the sector understand aspects of clinical services and how to improve them, by looking at performance from a different perspective.'*

4.2 Mortality review

Mortality review committees are statutory bodies appointed by our Board.[4] Legislation empowers these committees to review and analyse the circumstances resulting in preventable deaths, so they can provide evidence-based advice on how to avoid these deaths. Four permanent mortality review committees were active in 2016/17, investigating deaths and developing practical solutions for practice change, in consultation with the affected agencies.

Perinatal and Maternal Mortality Review Committee

The Perinatal and Maternal Mortality Review Committee (PMMRC) reviews deaths of babies and mothers. It published its 11th annual report in June 2017, corresponding with its annual national conference. The perinatal related mortality rate in 2015 (the most recent year of reported data) is the lowest rate reported since the PMMRC began collecting data in 2007 and is significantly lower than the rate for the years 2007–14 combined.

The maternal mortality ratio for Māori mothers is significantly higher than – almost double – the ratio for New Zealand European mothers. Māori women are also over-represented in maternal suicides. The main factors contributing to these deaths continue to be barriers to accessing and/or engaging with care. The PMMRC will work with the sector to address these concerns.

Neonatal mortality has fallen significantly in the United Kingdom since 2007, as well as in Australia and Scandinavia, but has remained the same in New Zealand. PMMRC will investigate this disparity in future reports.

Since May 2016 the PMMRC has also hosted the work of the Maternal Morbidity Working Group (MMWG), which the Ministry of Health supports with funding. The MMWG has four regional panels that review incidents where women were pregnant or within 42 days after delivery and were also very ill, and uses the findings to inform quality improvement initiatives alongside maternal health services. In 2016/17 the MMWG established and tested its review methodology and conducted two review panels on sepsis and hysterectomy around the time of childbirth. It also surveyed DHBs and established the need for a standard maternal morbidity review toolkit to support and promote local review. The toolkit will be delivered in 2017/18.

Perioperative Mortality Review Committee

The Perioperative Mortality Review Committee (POMRC) reviews deaths relating to surgery and anaesthesia occurring within 30 days after an operative procedure. In June 2017 the POMRC published its sixth annual report. In this report the POMRC identifies the discrepancies it finds unacceptable in the mortality rates for New Zealand's most deprived populations compared with other population groups. A special chapter focuses on perioperative mortality and socioeconomic deprivation.

Among its findings are that people living in the most deprived areas (areas with greatest poverty) had a higher rate of perioperative mortality (0.63 percent) than people living in the least deprived areas (0.39 percent). The poorest patients were almost twice as likely as the other groups to have emergency surgery, and also had 14 percent more elective (waiting list) operations.

The report recommended conducting research on socioeconomic and ethnic inequity in rates of perioperative mortality, as well as rates of emergency versus elective surgery. It also recommended that DHBs, with the support of the Ministry of Health, investigate programmes to increase access to both primary care and medical and surgical specialists.

The POMRC's sixth annual report identified disparities in surgical outcomes for both those living in deprived areas, and those who identify as Māori. 'Whenever we see a death after surgery it represents a tragic loss of life,' says POMRC Chair ***Dr Leona Wilson****. 'But this disparity in mortality rates and number of emergency admissions is glaring and we need to look into why it exists, as every person in New Zealand has the right to expect the same standard of health care regardless of their socioeconomic situation.*

'There are a number of reasons this may be occurring, including difficulty accessing or affording health care – it may be more difficult for those in the most deprived areas to travel to the doctor or get leave for the care they need for example. However, the POMRC believes there is no reason these disparities should exist and work needs to be done urgently in the sector to reduce them.'

4 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 to include each of these reports in our next annual report. This section, along with section 8.2, meets that requirement.

Family Violence Death Review Committee

The Family Violence Death Review Committee (FVDRC) reviews deaths from family violence in New Zealand. In February 2017 the FVDRC held its first national conference, 'Shifting the paradigm – a child-centred, perpetrator pattern and survivor strengths-based care and protection approach'. Minister for Social Development and for Children, Hon Anne Tolley, opened the conference. David Mandel, the executive director of the Safe and Together Institute, gave the keynote address; he has over 25 years' experience in improving how care and protection systems respond to family violence.

At the conference the FVDRC launched its first position brief, 'Six reasons why you cannot be effective with either intimate partner violence or child abuse and neglect unless we address both together'. The Children's Commissioner also announced that 2018 will see a thematic monitoring review of Oranga Tamariki's child and family assessments where family violence was a presenting issue.

In June 2017 the FVDRC released *Fifth Report Data: January 2009 to December 2015*. The following were key messages from its analysis of family violence deaths:

- Intimate partner violence is a pattern of harm related to gender.
- To keep victims safe, we must improve our responses to abusive men.
- To prevent family violence, we have to respond to child abuse and neglect and intimate partner violence together.
- To deal with intergenerational violence, we have to make an intergenerational response.
- Kaupapa Māori responses to preventing violence are essential.

In 2016/17 the FVDRC also wrote a range of briefing papers and discussion documents to inform the cross-government family violence and sexual violence work programme. It informed the development of the Family and Whānau Violence Legislation Bill. The Bill includes strangulation as an offence, as the FVDRC recommended in its fourth annual report.

The FVDRC has participated in several working groups, such as the Institute of Judicial Studies Board domestic violence and sexual violence working group and the Integrated Safety Response implementation training team for the Christchurch and Waikato pilots. It was also an Expert Design Group member of the Family Violence, Sexual Violence and Violence within Whānau Framework, which Hon Anne Tolley launched on 7 June 2017.

Child and Youth Mortality Review Committee

The Child and Youth Mortality Review Committee (CYMRC) reviews the deaths of children and young people, covering those aged 28 days to those on the day before their 25th birthday. The CYMRC published its seventh activities report in January 2017, highlighting its work since its last activities report in 2012. Activities reports do not make substantive recommendations to the sector. Instead, the 2017 report summarised the current state of child mortality in New Zealand and the reduction in mortality rates since 2002. It also outlined national and local work, types of recorded deaths and inequity in mortality rates. The report noted that the number of child and youth deaths fell from 638 in 2002 to 488 in 2014, while New Zealand's population increased substantially over the same period.

Suicide Mortality Review Committee

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. The aim was to find out whether mortality review methods can improve knowledge of contributing factors and patterns of suicidal behaviour, to better identify key intervention points. The Suicide Mortality Review Committee (SuMRC) 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 SuMRC gave its final report to the Ministry of Health in October 2015, and the Commission published it on its website in May 2016. The trial was successful and illustrated the potential benefits of the mortality review approach to this work.

The SuMRC did not meet in 2016/17 because the Ministry of Health had not confirmed its funding. In July 2017 the Commission welcomed the Ministry of Health's extension of funding to restart the SuMRC's work in 2017/18.

4.3 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 of hospital inpatients in all DHBs since August 2014. In 2016/17 we published four quarterly reports on the survey, which have shown consistently positive results across the four survey categories. The final quarterly survey results update for 2016/17, published on 28 April 2017, highlights scores from 8.3 to 8.6 out of 10 across the four survey categories.

Survey results did not change in 2016/17. Results between DHBs did not vary greatly, and the national response rate remained at around 28 percent. We continue to monitor the qualitative feedback patients provide in a free text field, which patients generally use to expand on their comments in other parts of the survey. (We published an analysis of this qualitative feedback in 2015/16.)[5]

Patient experience in primary care

Following the success of the hospital inpatient survey, the Commission and the Ministry of Health developed a second survey to capture patients' experience in primary care 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. It is not currently published, but may be released in 2017/18.

In all, 155 primary health organisation (PHO) practices are now participating in the pilot. We made good progress in 2016/17 in promoting the survey to PHOs and practices, with a series of workshops we held around the country. We also developed resources to support the survey, including a guide for the reporting portal, a comprehensive booklet for providers and a video for practices to play during survey week that promoted the survey to patients.

Patient experience in aged residential care

In 2015/16 the Commission developed a costed proposal to the Associate Minister of Health, Hon Peter Dunne, setting out options to measure patient experience in aged residential care. The proposal, which we delivered on 30 June 2016, recommended 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.

On 10 August 2016 Hon Peter Dunne indicated his preferred option for this work. This preference was to go ahead with the aged residential care survey by making it part of the Ministry of Health's review of the Health of Older People Strategy, to allow wider consultation. We have since agreed next steps with the Ministry of Health and developed proposals for a programme expert advisory group to guide development work in 2017/18.

4.4 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 similar 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 hospitals learn from such events and use that learning to improve services.

We released this year's adverse events report in November 2016. It shows a small reduction in the total number of events reported, and a more substantial reduction in the number of reports of falls causing serious harm.

Providers reported 44 events relating to ophthalmology. These included delays in people getting follow-up appointments to see ophthalmologists, during which time eye conditions deteriorated in some of these cases. DHBs are examining their ophthalmology services closely and we anticipate the number of reported events in this category will increase as reporting improves.

The report also shows that the number of falls reported in public hospitals decreased by 14 percent, from 277 in 2014/15 to 237 in 2015/16.[6] The National Minimum Dataset shows a decline, so the figures are likely to show an actual reduction in falls, rather than only a reduction in reporting.

5 Health Quality & Safety Commission. 2015. *Qualitative analysis of patient experience survey results*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/Qualitative-analysis-PES-Aug-Nov-2015.pdf (accessed 20 September 2017).

6 We will release the 2016/17 adverse events total in late November in a separate Commission report.

Most consumers/patients are treated safely and successfully, but some still suffer serious harm or even die from potentially preventable adverse events. I especially would like to acknowledge the people affected by the tragic events outlined in this report. We are looking at better ways to involve consumers/patients and their families/whānau in the process of analysing and learning from adverse events. It is important for the voice of the consumer to be heard as we grapple with the challenge of making our already excellent services safer.

Prof Alan Merry, Commission Chair, foreword to *Learning from adverse events: Adverse events reported to the Health Quality & Safety Commission* (2015/16), November 2016, p 1

5.0 Output class 2: Advice and comment

With the specialised knowledge we gain through our programmes, measurement and evaluation functions, and local and international networks, we can provide expert advice and commentary on quality and safety, alongside that of the Ministry of Health. We are also well placed to provide informed comment. As the Ministry of Health states:

In New Zealand, we have a strong and growing knowledge base, developed from research, about what contributes to good health, from birth into adulthood. This knowledge will be an ongoing resource to guide policies that help children to start out on pathways for healthy growth and development. Early intervention can help prevent some health conditions that can occur later in life.

Ministry of Health, *New Zealand Health Strategy: Future direction*, April 2016, p 12

During 2016/17 this work included:

- publishing evidence-based reports and discussion/opinion papers on health quality and safety in peer-reviewed journals, on our website and via other media
- organising successful workshops featuring influential international and New Zealand expert speakers
- holding three mortality review committee conferences to encourage the sector to share information and implement recommendations.

5.1 Journal articles and opinion papers

One of the Commission's roles is sharing knowledge about and advocating for health quality and safety. Publishing articles in peer-reviewed journals helps to build expertise and drive the national quality and safety agenda. In 2016/17 we published, among other work, *New Zealand Medical Journal* articles on 'Reducing harm from falls' and 'Falls prevention as everyday heroism'.

In addition, we also seek to influence the national quality and safety agenda through opinion papers. In 2016/17 we published *New Zealand Medical Journal* opinion papers 'Opioid rain: opioid prescribing is growing and practice is diverging' and 'Progress in public reporting in New Zealand since the Ombudsman's ruling, and an invitation'.

In 2016/17 we continued cooperating with the Ministry of Health and the Accident Compensation Corporation (ACC) to improve the transparency of public reporting on New Zealand health care, in light of an Ombudsman's ruling in June 2016. Our published opinion paper summarises the current situation and offers suggestions to the sector on how to continue to improve in its openness:

There is huge potential to develop processes to report a greater number of tailored measures at the appropriate level of unit or institution in cooperation between clinicians and consumers to increase transparency and continue to drive improvement in our already high-performing health services.

New Zealand has robust national data collections and a number of registries at different stages of sophistication and maturity, and all are rich sources of potential measures that consumers may value in their quest to understand their care and that providers can use to report upon the quality and safety of their services to drive continuous improvement. There are opportunities for further measures to be developed.

Carl Shuker et al, 'Progress in public reporting in New Zealand since the Ombudsman's ruling, and an invitation', *NZMJ*, 16 June 2017

5.2 Workshops featuring international speakers

We arrange visits and forums featuring highly skilled international experts who contributed their valuable expertise to New Zealand quality and safety discussions. We held four *Open Forums* in 2016/17:

1. A forum on variation with UK National Institute for Health and Care Excellence (NICE) chief executive Sir Andrew Dillon, in Wellington, 30 August 2016. Sir Andrew could not attend in person as planned, so appeared by videoconference. Professor Anne Duggan, senior medical advisor at the Australian Commission on Safety and Quality in Health Care, delivered the keynote in person.
2. 'The journey to high reliability', with Peter Pronovost, director of the Armstrong Institute for Patient Safety and Quality, Johns Hopkins Hospital (Baltimore), in Auckland, 28 October 2016.
3. 'May you never grow old' forum on positive ageing, with Dr Karen Hitchcock, a Melbourne hospital staff physician and writer, in Wellington, 10 April 2017.
4. 'Atlas of Variation: Maps to better care' forum with Dr Thérèse Stukel (Canada) and Dr Dominik Von Stillfried (Germany), in Wellington, 9 May 2017.

'Much of the reason we are not getting the value from health care that we want is down to unwarranted variation. Reducing this variation is a high priority to drive better-value care,' says Prof Anne Duggan, senior medical advisor at the Australian Commission on Safety and Quality in Health Care. Prof Duggan said we need to understand more about the impact of low-value procedures, and the flip side of that, which is a lack of care that would be of benefit. 'We need to look at things differently and to think about care in terms of the value it provides to society.'

An example from Australia of a low-value procedure was arthroscopies for people over 55 with arthritis. 'The first Australian Atlas of Healthcare Variation found large variation and a high rate of arthroscopic procedures in this age group. We know arthroscopies don't benefit the majority of this group. When we provide low value care we expose individuals to greater harm than benefit and deprive the community of resources that could be better used elsewhere.'

Prof Anne Duggan, Commission blog, 13 September 2016

5.3 Mortality review committee conferences

In addition to publishing reports, the mortality review committees PMMRC, POMRC and FVDRC held annual national conferences in 2016/17. The events offered a tremendous opportunity to discuss the committees' findings and recommendations and promote consistent improvement messages directly to the practitioners who can drive quality and safety improvement in the sector.

- FVDRC conference (20 February 2017, 180 attendees): speakers included the Minister for Social Development and for Children, Hon Anne Tolley, and David Mandel, (Executive Director, Safe and Together Institute).
- PMMRC conference (13 June 2017, 290 attendees): speakers included Hon Dr Jonathan Coleman, Dr Lynn Sadler (Auckland DHB), Dr Matire Harwood (University of Auckland), Dr Donna Cormack (University of Auckland) and Dr Rose Elder (Capital & Coast DHB).
- POMRC conference (21 June 2017, 80 attendees), held as a joint workshop with Safe Surgery NZ: speakers included Associate Minister of Health Hon Peter Dunne, Barry Smith (Lakes DHB), Professor David Story (University of Melbourne), Professor Justin Roake (University of Otago) and Professor Ian Civil (Safe Surgery NZ and the Commission).

6.0 Output class 3: Assistance to the sector to effect change

One of the Commission's key roles is to 'lend a helping hand' to the sector so it can improve the quality and safety of health and disability services. This work 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.

6.1 Partners in Care

The Partners in Care framework is the basis of our work to improve health literacy and consumer participation, and to develop leadership capability for providers and consumers. We believe consumers and their families and 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.

In 2016/17 we delivered a Partners in Care co-design programme in Taranaki and Hutt Valley DHBs. Two examples from the eight successful patient-centred co-design projects funded by the Commission are:[7]

- Hutt Valley DHB's work to better understand choice and decision-making in acute care, to inform winter health messaging and the larger redesign process of the Hutt Valley acute care system.
- Taranaki DHB's project to discuss how to improve the repeat prescription process for mental health service users, to encourage greater efficiency and to include more consistent communication with service users.

We also worked to improve communication between providers and families and whānau. In 2016/17 we ran four focus groups in Waikato, Bay of Plenty, Nelson Marlborough and Northland DHBs to improve communication and discharge planning for medication information. The focus groups will inform the development of small-scale interventions to improve medication management.[8]

Through interviews and focus groups with Canterbury and Waitemata DHBs, we piloted the concept of the 'always event', which the Picker Institute and Institute for Healthcare Improvement were the first to develop. We also completed a report to explore how well this concept applies to New Zealand as a whole. A further initiative was developing a resource ('Who to contact') to improve communication between hospital staff and the families and whānau of patients.

Querida Whatiura-Strickland *from Hawke's Bay DHB offers some advice on how health workers can establish rapport with Māori early on: 'I believe it's your first interaction: I always go, "Kia ora" or "Tēnā koe" to the patient, and it's just a natural thing when I see another Māori. So already the "wall" is dropping. There's lots of things that could help. Getting the pronunciation of the name – it does mean a lot to me when someone can pronounce my name correctly, and it makes me feel like a nobody when I'm a patient and a doctor or nurse comes in and can't say my name [properly]. When I see that a nurse has tried really hard it means a lot to me, and I know it means a lot to our whānau too.'*

6.2 Building sector leadership

We work to increase the sector's capability to improve quality and safety 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 find out how we can support quality improvement initiatives locally.

Clinical leadership for quality improvement

In 2016/17 we promoted and encouraged the sector to use a clinical leadership online training module, and built a clinical network of participants in leadership workshops. We developed this work by holding four successful webinars from August to November 2016, along with six face-to-face workshops and six follow-up webinars to continue strengthening the clinical network.

Implementing the capability framework

Following the publication of the *From knowledge to action* capability framework[9] at the Commission scientific symposium in October 2016, we distributed the document to all DHBs and have continued our presentations to senior DHB personnel. Sector feedback has been favourable and we have printed around 800 copies for distribution. DHBs are including the framework in their quality training.

7 For further co-design project case studies, go to www.hqsc.govt.nz/our-programmes/partners-in-care/work-programme/co-design.
8 For the full focus group report, *Raising the bar on the national patient experience survey*, go to www.hqsc.govt.nz/our-programmes/partners-in-care/news-and-events/news/2942.
9 www.hqsc.govt.nz/our-programmes/improving-leadership-and-capability/projects/leadership-and-capability-framework

6.3 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 conferences, workshops and events help the sector to share knowledge, as well as to learn best practice and apply it consistently in the workplace. We completed a wide range of this work on sector capability in 2016/17.

Improvement science

Around 130 attendees participated in our symposium in Auckland in October 2016. Here we launched our new capability framework (see also 'Implementing the capability framework' in section 6.2). Feedback was particularly positive about speaker Jen Morris from the University of Melbourne, who spoke on 'The science behind consumer engagement'.

Infection prevention and control national workshop

We held our national workshop for infection prevention and control in August 2016 in Wellington. It had a full capacity of 120 attendees, who gave positive feedback about the event. This was a valuable opportunity to meet in multidisciplinary teams to discuss regional approaches to infection prevention and control.

Clinical leadership for medication safety

We held meetings with regional patient safety alliances in all four DHB regions, with Midland hosting two. Meetings with the four regional Drugs and Therapeutics Committees also strengthened knowledge of medication safety work and priorities at all levels (local, regional and national). Positive feedback came from all network meetings and the sector has a strong appetite for continued workshops. Local champions are encouraging others to attend these meetings.

Adverse events learning workshops

We held workshops in Auckland, Wellington and Christchurch to support the adverse events learning programme (see section 4.4) by sharing adverse events review methodology with staff from a wide range of providers. Their feedback was used to inform course content and workshops planned for 2017/18.

Safe surgery workshops

In 2016/17 we ran four regional workshops in DHBs, providing support and training to over 180 local safe surgery project leads and team members. We also delivered observational auditor training in how to use the surgical safety checklist to around 90 staff from all 20 DHBs.

Primary care improvement

In July 2016 we called for submissions for Whakakotahi ('to be as one'), our primary care quality improvement challenge. This involves primary care teams working on a quality improvement project of their choice, to address an area of patient care they wish to improve. We asked for expressions of interest for initiatives to drive improvement in three priority areas: equity, consumer engagement and integration. Our first major Whakakotahi learning group event in May 2017 was well attended and received positive feedback. We uploaded learning materials from this event to the Commission's website. Planning is under way for a second learning event for the PHO improvement network in September or October 2017.

*Project manager **John Kristiansen** from our Auckland office has been one of the team working on Whakakotahi in 2016/17. 'The three selected Whakakotahi initiatives this year have made good progress, in part thanks to our sponsoring participants through the PHO Quality Improvement Facilitator Programme at Ko Awatea. We also ran a group learning event to share progress, build networks to encourage cooperation, and provide specific training on our three priority areas, such as equity, and co-design. Next year we plan to build on the successes of 2016/17 by adding at least another six initiatives to the programme, with a further 12 more to come in 2018. Ultimately we may go on to run a national collaborative or similar, to take advantage of the opportunities the expanding primary care improvement network creates.'*

Patient deterioration

We are running a five-year national patient deterioration programme, which began in July 2016. It aims to reduce harm from failures to recognise or respond to acute physical deterioration in adult inpatients (excluding maternity). The team held a national workshop for all DHBs, hosted by the Health Roundtable in October 2016. It also held regional follow-up workshops in the Midland and Northern regions.

6.4 Expert advice, tools and guidance

We seek 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, and help to achieve change that might otherwise not occur.

Teamwork and communication

The programme is rolling out surgical teamwork and communication interventions nationally in a staggered approach between 2015 and 2017. The communication tools (such as ISBAR: identify, situation, background, assessment and recommendation) are well established in most DHBs. The first reports against the QSM began in December 2016 and we are now considering the second round of QSM results. About half of the DHB surgical teams are undertaking briefings and debriefings, but the practice is not consistent in all theatres yet.

Reducing surgical site infections

Project manager ***Maree Meehan-Berge*** *and the safe surgery programme team have worked with the sector to support greater teamwork and communication in operating theatres. 'This year we've been continuing to support and embed the use of the paperless surgical safety checklist and beginning support for the briefing and debriefing interventions that maximise the impact of the checklist,' she says.*

Ms Meehan-Berge says the team's work in 2016/17 is beginning to produce positive results in the sector. 'The evidence is starting to accumulate that team engagement with the checklist is improving, as are perceptions of both teamwork and patient safety. The surgical safety culture survey tool measures surgical team members' perceptions of the impact of the interventions. International studies have shown that about half of all adverse events and postoperative complications will be positively impacted by good teamwork and communication. Other incidental impacts that staff are telling us about are reduced levels of specimen errors and the improvement to job satisfaction levels. We have many reports of people just enjoying working in their surgical teams more than before. A surgeon told us in a public workshop that their quality of life has improved as a result of this work, which is something to be really proud of.'

We have sent our feedback summary and recommended options for an anti-*Staphylococcus aureus* bundle to stakeholders. A call for expressions of interest received nine responses, which we are now considering.

Primary care improvement initiatives

The selection process for the first set of Whakakotahi initiatives was completed in December 2016. From the 16 applications we received from providers, we shortlisted five teams and invited them to submit full proposals. Eventually we chose three projects.

- Hutt Union & Community Health Services/Te Awakairangi will work with the Commission on its diabetes project. The aim of the project is to improve glycaemic control of patients with diabetes.
- National Hauora Coalition – Oranga Rongoa is a project to improve the delivery of best-practice therapy for gout. The project aims to reduce serum uric acid levels in Māori and Pacific patients aged over 20 years who are classified as having gout.
- Nelson Marlborough DHB's initiative based in Mapua Health and Tima Health in Nelson is called 'Live longer & feel better following treatment for a heart attack'. It focuses on reducing preventable deaths and acute re-admissions to hospital following an angioplasty procedure.

We held the first group learning session in May 2017.

Rapid response systems to respond to clinical deterioration

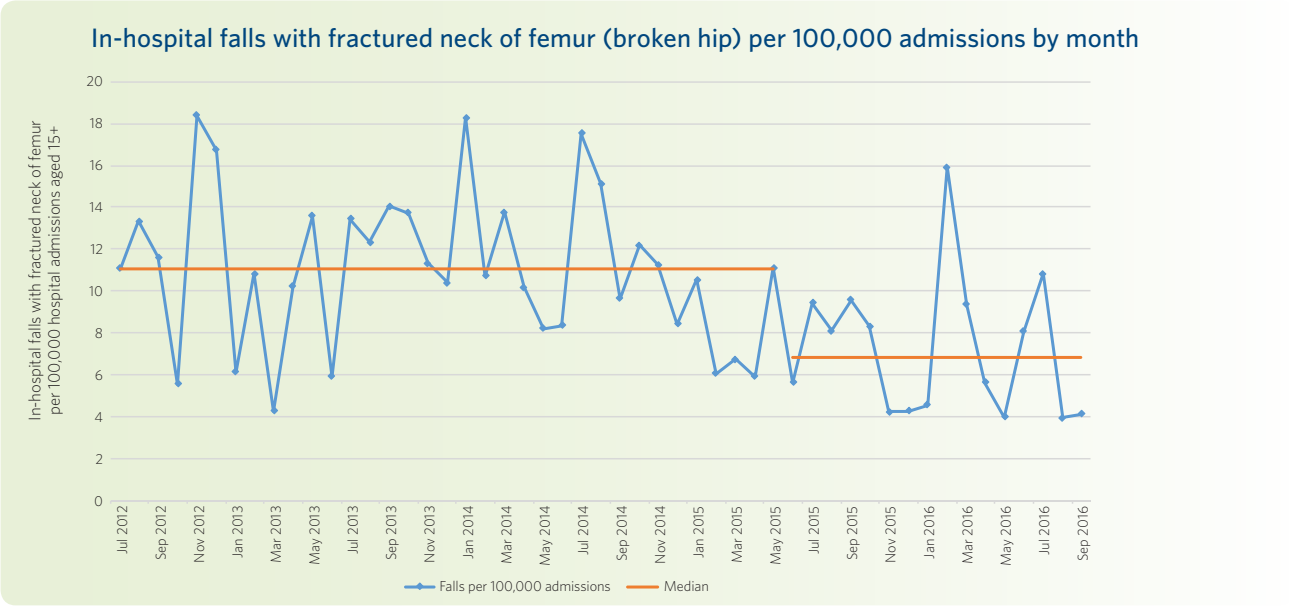
Four of the six sites for rapid response systems have launched: Southern Cross Christchurch, Nelson Marlborough, Auckland and Whanganui. We conducted a sector feedback exercise in April and May 2017, followed by a learning session with the sites in May 2017.

6.5 Other improvement programmes

In 2016/17 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 the number of falls in hospital that led to a broken hip decreased for the first time. This reduction continued, to the extent that since late 2015 the rate has been 30–40 percent lower on average than it was before the falls programme started in 2013 (see figure below).



April 2017 saw another successful annual April Falls promotion, with the theme of 'Stand up to falls'. The theme was part of our efforts to sustain the success of New Zealand public hospitals in reducing the number of in-hospital falls that result in a broken hip. New Zealand appears to be the first country to achieve such a reduction on a national scale – an achievement reported in the *New Zealand Medical Journal* in December 2016.[10] We published new 'Stand up to falls' resources to add to the collection already available. In addition, the annual April Falls quiz 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. Its 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 2016/17 was the clinical leadership for medication safety work (see section 6.3 for details).

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 2017 ePA was operating across all adult wards in four DHBs (Waitemata, Canterbury, South Canterbury and Southern), and roll-out was under way at a further two (Taranaki and Auckland).

Infection prevention and control

The Commission works with ACC and Auckland and Canterbury DHBs to implement evidence-based bundles of interventions to reduce surgical site infections (SSIs) for hip and knee arthroplasty and cardiac surgery. Our SSI improvement programme has developed and implemented a consistent, evidence-based approach to collecting and reporting high-quality data about SSIs. DHBs are encouraged to improve SSIs in line with a bundle of agreed practice interventions. For data on uptake of good practice and results of the SSI improvement programme, see Appendix 1.

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. In June 2017 the percentage of DHB staff complying with the World Health Organization's recommended 'five moments for hand hygiene' reached 83.7 percent (up from 62 percent in October 2012). In the final reporting period for 2016/17, 16 DHBs achieved at or above the national target of 80 percent.

10 S Jones, S Blake, R Hamblin, et al. 2016. Reducing harm from falls. *New Zealand Medical Journal* 129(1446). URL: www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2016/vol-129-no-1446-2-december-2016/7089 (accessed 18 September 2017).

7.0 Organisational capability

7.1 Governance

The Commission is governed by a board of eight members appointed by the Minister of Health, and led by Chair Professor Alan Merry. Two board committees supported the Board's work in 2016/17.

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

Te Roopū Māori provided advice to the Board and Chief Executive of the Commission on strategic issues, priorities and frameworks from a Māori perspective and identified key quality and safety issues for Māori patients and organisations. The Roopū's hui on 16 February 2017 provided valuable input into the Commission's updated Statement of Intent for 2017-21. The Board agreed to consider specific proposals for a Māori improvement programme following Roopū consideration. Other Roopū achievements in 2016/17 include:

- starting and running a quarterly 'equity hub' for agencies to discuss and network on equity in health care
- growing networks with Māori stakeholder groups, such as Te Tumu Whakarae and Ngā Manukura o Āpōpō
- appointing a new kaiwhakahaere for Te Whai Oranga to the Commission executive leadership team
- holding an all-staff marae day at Tapu Te Ranga marae in Island Bay, Wellington
- prompting mortality review committees to strengthen their focus on equity in their reports.

7.2 Equity

Equity is widely accepted as a component of high-quality health care, and the Commission is expanding its work in this area. Our increased attention to equity is in line with international thinking; for example, in 2016 the Institute for Healthcare Improvement called equity the 'forgotten aim' of health care improvement. Health equity also features strongly in the priorities of the New Zealand Health Strategy and under Te Tiriti o Waitangi.

In 2016/17 the Commission examined the relationship between health quality improvement and health equity, specifically addressing potential tensions between the two approaches. We will shortly publish our literature and stakeholder findings in the form of a 'think piece' article that sets the scene for equity as one of our new strategic priorities.

Other work to improve equity included:

- launching a monthly equity interest group to build staff capability
- aligning equity and Māori advancement work
- considering the equity impacts of data analysis on equity (for example, stratification of data, age-standardisation and modelling)
- raising the profile of equity within all quality improvement programmes (for example, equity impact assessment of key decisions in our new patient deterioration workstream, and including equity as a key assessment criterion in the Whakakotahi primary care improvement programme).

7.3 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.

We have a dedicated staff training budget and encourage staff to identify future education and training needs and undertake relevant programmes. The Commission arranged regular education and training opportunities for staff in 2016/17. This included a marae day to discuss progress on Te Whai Oranga, our Māori advancement framework, and making available an online tool for quality improvement methodology training.

We also actively fulfilled our obligations under the 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 responsibilities set out in the Act. The following are some of our health and safety initiatives.

- Over the first six months of 2017 the Safety and Wellness Committee worked to give new staff an initial health and safety induction and complete the online induction questionnaire.

- To help staff with combating flu and colds this winter, we arranged for a nurse to give flu vaccinations in-house, provided antibacterial wipes in locations around the office and arranged for a complete sanitised clean of computer and phone equipment.
- Mindfulness May activities for staff in Wellington and Auckland included in-house yoga sessions, meditation sessions and massage. These activities were overwhelmingly the most popular according to a staff survey.

Flexibility and work design

We 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. Flexible work 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. Being flexible in these ways helps us maintain the skills set among our staff that we need and encourage a working environment adaptable to the needs of our employees.

Support and culture

Staff hold weekly meetings in Wellington (with staff in the Auckland office and elsewhere videoconferencing in) to talk about work and current issues, recognise staff and team successes and hear from external speakers.

Following on from the discussion that our Performance Improvement Framework (PIF) report began in December 2015, 'Ask Your Team' surveys consulted Commission staff on workplace issues. Management has responded to the survey results. We are now considering a PIF update for late 2018.

The Board takes a close interest in the Commission's health and safety performance. Our active Safety and Wellness Committee 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 and whānau with work or personal issues.

As an employer, we will not tolerate harassment or bullying in the workplace. We also take all practical steps to manage hazards and avoid exposing employees to unnecessary risk.

7.4 Staff profile

Workplace profile as at 30 June 2017

As at 30 June 2017 the Commission had 66 staff members (62.2 full-time equivalents). Fifty-two were full time (46 in 2016) and 15 part time (12 in 2016). Fifty-nine percent had more than two years of service with the Commission (34 percent in 2016).

Female	71%
Male	29%
Māori	7%
Pacific	0%
Asian	4%
NZ European	81%
Other ethnicity	8%
Not declared	0%
Age 20–29 years	7
Age 30–39 years	14
Age 40–49 years	22
Age 50–59 years	16
60+	7
People with disabilities (injury, illness or disability)	7.5%

Equal employment opportunity policies

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

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

Equal employment opportunity and diversity practices include hiring on merit, fairness at work, flexible working options and promotion based on talent. 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 equal employment opportunity policy. We actively seek and target diversity as we recruit for current vacancies. We use Māori recruiters to actively increase our potential pool of Māori applicants. We also 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 reach agreement around annual remuneration levels. We do not discriminate based on age, disability, gender, sexual identity, religious beliefs or ethnicity.

Statistics New Zealand provides three measures of gender equity for employers, which are appearing in our annual report for the first time in 2016/17. Our gender pay gap for 2016/17 is calculated at 4 percent. This is lower than the last reported public service average pay gap, which was 13.5 percent at 30 June 2016.[11] If the calculation takes median hourly earnings into account, the gap is 7 percent. We are unable to calculate a 'motherhood penalty' total because we do not collect this level of personal detail from staff.

7.5 External relationships

Engagement with the Minister(s) and Ministry of Health

In 2016/17 we provided regular update reports to the Minister with delegated responsibility for the Commission, and provided quarterly update reports on performance against our Statement of Performance Expectations. We met regularly with the Minister with delegated responsibility for the Commission, 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. 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, 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 investments other agencies have made. For example, with our work on reducing harm from falls, neonatal encephalopathy and pressure injuries, ACC provided additional resources.

In 2016/17 we routinely engaged with the Ministry of Health in strategic planning and cooperation on joint work programmes. The Commission, the Ministry of Health, the Health and Disability Commissioner and ACC meet to support collaboration and joint planning. The four agencies work collaboratively to share and more effectively use the different information each agency receives.

Strategic advice to Government and government agencies

The Commission's legislative responsibilities, as set out in section 59C(1) of the New Zealand Public Health and Disability Act 2000, 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 including:

- child and youth mortality, family violence deaths, perinatal and maternal mortality and perioperative mortality (see section 4.2)
- the quality and safety of the New Zealand health system through findings from our Atlas of Healthcare Variation work and our QSMs
- the overall state of health quality in New Zealand, through the reports *A Window on the Quality of New Zealand's Health Care* and *Open4Results* (see section 4.1).

We meet regularly with our partners the Ministry of Health, ACC and the Health and Disability Commissioner, as noted above. We were also invited to provide input into key strategic issues across government agencies.

Commission staff helped the Ministry of Health in a range of ways, such as with reviews of DHB annual

11 State Services Commission. 2016. *Human Resource Capability in the New Zealand State Sector.* Wellington: State Services Commission. URL: www.ssc.govt.nz/sites/all/files/HRCReport-2016_0.pdf (accessed 18 September 2017).

and regional plans and quality accounts. At a more targeted level, we provided advice and helped 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 data related to quality and safety, improvement education and training, family violence, child and youth mortality, methodologies and specific programme areas.

Communication with stakeholders and the public

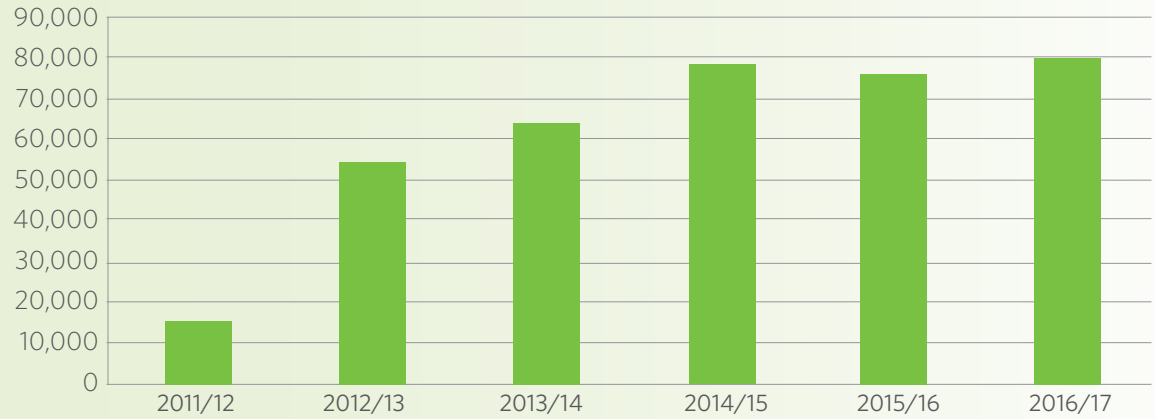
During 2016/17 our communications team continued to:

- keep our website up to date and useful
- produce publications that were of a high standard and easy to understand
- circulate widely read e-newsletters
- help us contribute visibly to conferences and events that promote health quality and safety
- proactively manage interaction with the media to promote our key messages effectively
- identify and manage communications risks.

The team also led the development of a stronger Commission presence on social media, encouraging programme teams to contribute material that is useful to the sector. Our profile has been expanding, including with over 1,200 followers on Twitter.

Having an effective website is an important communications tool for the Commission. It provides a cost-effective way to communicate information on health quality and safety improvement, projects and contacts, as well as offering opportunities for direct dialogue and engagement with stakeholders. During 2016/17 we had 80,625 users on our website and 499,120 page views, compared with 76,207 users and 494,550 page views in 2015/16. Our website traffic has been growing in recent years, as the following figure shows.

Number of users of the Commission's website, 2011/12–2016/17



7.6 Financial and resource management

Financial management

Maintaining financial sustainability is a critical part of the Commission's strategy. In 2016/17 we continued our record of remaining within budget.

We maintain sound management of public funding through our compliance with relevant requirements under the State Sector Act 1988, the Public Finance Act 1989 and applicable Crown entity legislation.

Section 12 sets out the audit results for 2016/17.

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 information technology purchases, data storage, communications, print services and travel. We continue to tender for services on the Government Electronic Tenders Service (GETS). We have implemented the *ComplyWith* legislative compliance information, monitoring and reporting programme, which is used by over 60 Crown-owned or funded entities, departments, companies and by the Office of the Auditor-General. Financial services remain in-house.

ComplyWith legislative compliance is an outsourced process. Payroll functions and payments to committee members are also 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. Projects now have a clear life-cycle to ensure they are designed to become sustainable and 'business as usual' in the sector, allowing us to redirect investment to emerging priorities. We also find willing partners to help increase our relatively small investment capability.

In September 2015 we completed the Commission's PIF, taking account of a range of potential improvements and feedback from staff and senior stakeholders. The senior leadership team and Board continue to implement changes to respond to the PIF's suggestions, and we are likely to schedule a PIF update in 2018. Our 'Ask Your Team' process also included a survey of staff opinions on a range of organisational issues, and management responded to the feedback.

Meeting our legal responsibilities

Through our governance, operational and business rules, we ensure we meet our good employer requirements and our obligations under the Public Finance Act 1989, the Public Records Act 2005, the State Sector Act 1988, the Crown Entities Acts 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.

In line with the whole-of-government approach agreed by Cabinet, we are required to report on our progress with implementing the New Zealand Business Number (NZBN). In 2016/17 we were not provided an NZBN, but we raised staff awareness of the NZBN and considered opportunities for its use in our business interactions.

Risk management

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

7.7 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**

8.0 Reporting

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

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

Section 50D(3b) of the New Zealand Public Health and Disability Act 2000 requires the Commission to, at least annually, provide the Minister of Health with a report on the progress of mortality review committees. It must also include each such report in the Commission's next annual report. Sections 4.2 and 8.2 provide this report on progress of mortality review committees.

8.1 Report against the Statement of Performance Expectations

The 2016/17 Statement of Performance Expectations was prepared in line with generally accepted accounting practice. It describes each reportable class of outputs the Commission supplied during 2016/17. For each class of outputs, it includes:

- the standards of delivery performance the Commission achieved, as compared with the forecast standards included in the Commission's statement of forecast performance for 2016/17
- 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 2016/17.

The following sections report on the output classes, using the following keys for each output class and each theme of the New Zealand Health Strategy.

Key: Output classes

ME	1. Measurement and evaluation
AC	2. Advice and comment
AS	3. Assistance to the sector to effect change

Key: New Zealand Health Strategy themes

S	Smart system
PP	People powered
CH	Closer to home
VH	Value and high performance
OT	One team

8.2 Output class 1: Measurement and evaluation

ACTIVITY	OC	HS	PERFORMANCE MEASURES	RESULTS
1. Report against the full set of national and international measures of quality and safety	ME	S	Publish one 'Window on quality' report *(due 30 April 2017. 2015/16 performance: One report published)*	**Substantially achieved** – We completed the report before the 30 April deadline but publication was delayed until 1 June 2017 so senior Commission spokespeople could be present to address any enquiries on its release.
2. Patient experience indicators for hospital services	ME	PP	Publish four reports on patient experience of hospital services *(due August and November 2016, and February and May 2017. 2015/16 performance: Four survey reports published)*	**Achieved** – We published the final quarterly survey results update for 2016/17 on 28 April 2017. Results remained consistently positive, with scores from 8.3 to 8.6 out of 10 across the four survey categories. The experience survey results in 2016/17 did not change from the previous financial year. Results between DHBs were also generally consistent, and the national response rate remained at around 28%.
3. Patient experience indicators for primary care services	ME	PP	Roll out and publish the primary care survey in four quarterly instalments conducted privately *(due August and November 2016, and February and May 2017. 2015/16 performance: Survey rollout approved December 2015)*	**Achieved** – The number of pilot PHO practices participating increased from 147 in February 2017 to 155 in May 2017. The response rate (21% of those invited) and completion rate (16%) for May were consistent with other rounds. The goal for the primary care survey for 2016/17 was to transition the survey to business as usual using the National Enrolment Service (NES) as the source of patient contact details. NES implementation has taken longer than anticipated and has delayed the implementation of the survey in PHOs and practices outside of the pilot group. It is hoped that the November 2017 survey round will switch to the NES as the data source. In 2016/17 we made good progress with promoting the survey to PHOs and practices, through a series of workshops around the country.
4. Patient experience indicators for aged care	ME	PP	Develop and implement a phased rollout of the chosen option for the aged residential care survey *(due 30 June 2017. 2015/16 performance: Minister provided with costed proposal 30 June 2016)*	**Substantially achieved** – On 10 August 2016 Hon Peter Dunne indicated his preferred option for this work. That preference was to go ahead with the aged residential care survey by making it part of the Ministry of Health's review of the Health of Older People Strategy, to allow wider consultation. The Ministry of Health provided guidance at a meeting on 23 March 2017 to discuss next steps, which are likely to include establishing a cross-agency advisory group. We sent proposals for an expert advisory group to the Ministry on 28 June 2017. We will continue to work with partner agencies to implement the survey within the Health of Older People Strategy process in 2017/18.

ACTIVITY	OC	HS	PERFORMANCE MEASURES	RESULTS
5. Updated Atlas of Healthcare Variation domains	ME	CH S	Update at least six domains *(due 30 June 2017. 2015/16 performance: Two new domains published and seven domains updated)*	**Achieved** – The domains updated are: opioids (19 August 2016), asthma (19 August 2016), diabetes (28 November 2016), mental health (12 December 2016), falls (3 April 2017), maternity (21 June 2017) and Well Child/Tamariki Ora (23 June 2017).
6. Report on the value of the Commission's work	ME	VH	Publish two reports on the value of Commission work *(VoSL/QALY) (due January and June 2017. New deliverable for 2016/17)*	**Achieved** – We released the first *Open4Results* report on 31 October 2016 to tie into the annual Patient Safety Week promotions. On 21 June 2017, we published the second *Open4Results* report. It included the following key findings: • The rate of patients falling and breaking their hip in public hospitals has almost halved. Since June 2013 New Zealand hospitals have had 85 fewer falls resulting in a broken hip, saving an estimated $3.5m. • Since January 2013, 378 cases of deep vein thrombosis/ pulmonary embolism (DVT/PE) – or blood clots – have been avoided, a $7.9m saving. • Since August 2015 the rate of SSIs related to hip and knee replacements has fallen from 1.3% to 0.9% of operations, saving up to $1.9m between August 2015 and June 2016. • Since August 2015 fewer older people have been admitted to hospital as an emergency more than once – amounting to 95,000 fewer bed-days in total. This saved $72m that can be redirected to patients who otherwise could not have been treated.
7. Adverse events	ME	S OT	Public reporting on serious adverse events *(due 30 March 2017. 2015/16 performance: One report published)*	**Achieved** – We released this year's adverse events report on 10 November 2016. It showed a small reduction in the total number of events reported, and a more substantial reduction in the number of reports of falls causing serious harm. Providers reported 44 events relating to ophthalmology. These included delays in people getting follow-up appointments to see ophthalmologists, during which time eye conditions deteriorated in some of these cases. DHBs are examining their ophthalmology services closely and we anticipate the number of reported events in this category will increase as reporting improves. The report also showed the number of serious falls in public hospitals decreased by 14 percent from 277 in 2014/15 to 237 in 2015/16. The decline is also reflected in the National Minimum Dataset, so the figures are likely to show an actual reduction in falls, rather than only a reduction in reporting.

ACTIVITY	OC	HS	PERFORMANCE MEASURES	RESULTS
8. Progress reports to the Ministry of Health and DHBs against QSMs for: • falls • infection prevention – hand hygiene – surgical site infection • safe surgery • medicine reconcilitation	ME	S	Publish four QSM reports including process and/or outcome information *(due September and December 2016, and March and June 2017. 2015/16 performance: Four QSM reports published)*	**Achieved** – We published four QSM reports in 2016/17: on 30 September 2016, 19 December 2016, 31 March 2017 and 30 June 2017.
9. MRC reports	ME	S OT	At least one report on child and youth mortality published *(due 31 January 2017. 2015/16 performance: One report published)* At least one report on perinatal and maternal mortality published *(due 30 June 2017. 2015/16 performance: One report published)* At least one report on perioperative deaths published *(due 30 June 2017. 2015/16 performance: One report published)*	**Achieved** – The CYMRC published its seventh activities report on 31 January 2017. The report summarised the current state of child mortality in New Zealand and the reduction in mortality rates since 2002. It also outlined national and local work, types of recorded deaths, and inequity in mortality rates. The PMMRC published its 11th annual report on 13 June 2017, timed with its annual national conference. The perinatal related mortality rate in 2015 (the most recent year of reported data) was the lowest reported since the PMMRC began collecting data in 2007 and significantly lower than the rate for the years 2007–14 combined. The POMRC published its sixth annual report on 16 June 2017. It identified what the committee says are unacceptable discrepancies in the mortality rates for New Zealand's most deprived populations. The report contained a special chapter on perioperative mortality and socioeconomic deprivation.

8.3 Output class 2: Advice and comment

ACTIVITY	OC	HS	PERFORMANCE MEASURES	RESULTS
10. Articles in peer-reviewed journals	AC	S	At least two articles published *(due 30 June 2017. 2015/16 performance: Four articles published)*	**Achieved** – The first published article was 'Reducing harm from falls' (*New Zealand Medical Journal*, 2 December 2016). It concluded that 'effective, carefully targeted falls prevention strategies – starting with a heightened awareness of the importance of falls and simply asking older people about falls – are a relatively low cost investment that returns potentially substantial savings, both financial and in terms of human suffering'. The second published article was 'Falls prevention as everyday heroism' (*New Zealand Medical Journal*, 2 December 2016). In it, author Frances Healy of NHS Improvement noted that the Commission's falls initiative is 'the first in the world to describe credible reductions on a national scale in the most serious type of harm – the fractured hips from falls in hospitals that lead to long-term loss of independence for most patients who experience them, and are followed by death within weeks or months for too many'.
11. Opinion papers	AC	S	At least two opinion papers disseminated *(due 30 June 2017. 2015/16 performance: Three articles published)*	**Achieved** – The first published article was 'Opioid rain: opioid prescribing is growing and practice is diverging' *(New Zealand Medical Journal*, 19 August 2016). It noted that our Atlas of Healthcare Variation has shown significant reductions in oxycodone dispensing with a rate of 5.4 people per 1,000 receiving the opioid in 2015, down from 7.3 per 1,000 in 2011, representing 7,800 fewer people. In DHBs that have had dedicated campaigns aiming to reduce prescribing rates, the outcomes have been particularly positive. Nelson Marlborough and Wairarapa DHBs have reduced their dispensing of oxycodone by 60–70% and fallen below the national average. The second published article was 'Progress in public reporting in New Zealand since the Ombudsman's ruling, and an invitation' (*New Zealand Medical Journal*, 16 June 2017). It updates developments since an Ombudsman's ruling in June 2016 on a journalist's request for data on volumes and types of operations, and mortality and complications rates, for individual surgeons. The Ombudsman ruled that DHBs were not obliged to release individualised data of this sort. The article summarises developments in public reporting and calls on the profession to engage with the Commission and the Ministry of Health to pursue informed and effective reporting of outcome data at all levels.

ACTIVITY	OC	HS	PERFORMANCE MEASURES	RESULTS
12. Workshops featuring international speakers	AC	OT	At least two workshops featuring international speakers held *(due 30 June 2017. 2015/16 performance: Two workshops held)*	**Achieved** – The Commission held four *Open Forums* in 2016/17: • A forum on variation with Sir Andrew Dillon, Wellington, 30 August 2016. • 'The journey to high reliability' with Peter Pronovost, Auckland, 28 October 2016. • 'May you never grow old' forum on positive ageing, with Dr Karen Hitchcock, Wellington, 10 April 2017. • 'Atlas of Variation: Maps to better care' forum with Dr Thérèse Stukel (Canada) and Dr Dominik Von Stillfried (Germany), Wellington, 9 May 2017. (See section 5.2 for event details.)
13. MRC conferences	AC AC	S S	FVDRC conference, PMMRC conference and POMRC conference/safe surgery workshop held *(all due 30 June 2017. 2015/16 performance: Two conferences held)*	**Achieved** – The FVDRC held its first national family violence prevention workshop in Wellington on 20 February 2017. The PMMRC held its 2017 conference on 13 June at Te Papa and the Minister of Health Hon Dr Jonathan Coleman opened it. The POMRC held its 2017 conference on 21 June at Te Papa and Hon Peter Dunne opened it. The event was held as a joint workshop with Safe Surgery NZ. (See section 5.3 for event details.)

8.4 Output class 3: Assistance to the sector to effect change

ACTIVITY	OC	HS	PERFORMANCE MEASURES	RESULTS
14. Engage consumers and providers as partners in care	AS	PP	Deliver a co-design programme for consumer/provider teams focused on key DHBs *(due 30 June 2017. 2015/16 performance: Co-design programme delivered in two DHBs)*	**Achieved** – Co-design workshops in Taranaki and Hutt Valley DHBs have finished, and teams have been working on individual co-design projects covering a range of DHB services.
15. Build communication between providers and families/whānau	AS	PP	Hold at least two workshops to explore issues in communication between providers and families/whānau Develop a resource based on information from the workshops to guide providers and families/whānau in approaches to communication *(both due 30 June 2017. New deliverables for 2016/17)*	**Achieved** – Four focus groups workshopped how to improve communication and discharge planning as it relates to medication information in Waikato, Bay of Plenty, Nelson Marlborough and Northland DHBs. These focus groups will inform the development of small-scale interventions to improve medication management. Through interviews and focus groups with Canterbury and Waitemata DHBs, we piloted the concept of the 'always event', which the Picker Institute and Institute for Healthcare Improvement were the first to develop. We completed a resource to explore how well this concept applies to New Zealand as a whole. A further initiative was developing a resource ('Who to contact') to improve communication between hospital staff and the families and whānau of patients.
16. Build sector leadership	AS	OT S	Promote and encourage the use of the clinical leadership online training module, and build a clinical network of participants in leadership workshops Implement the capability framework across providers *(both due 30 June 2017. New deliverables for 2016/17)*	**Achieved** – We built a network of clinical leaders through holding four successful webinars from August to November 2016. In six further face-to-face workshops and six follow-up webinars since then, we have continued to strengthen the clinical network. We launched the *From knowledge to action* capability framework at the Commission's scientific symposium on 18 October 2016. We distributed it to all DHBs and continue to make presentations to senior DHB personnel. Sector feedback has been favourable and we have printed around 800 copies for distribution. DHBs are including the framework in their quality training.

ACTIVITY	OC	HS	PERFORMANCE MEASURES	RESULTS
17. Build sector capability	AS	VH OT S	Annual conferences, workshops and events to share good practice and innovation:	**Achieved**
			1. Scientific symposium on improvement science *(due 31 April 2017. 2015/16 performance: One workshop held)*	Around 130 attendees participated in the symposium at Novotel Auckland Airport, 18 October 2016. Here we launched the new capability framework (see also activity 16 above). Feedback was particularly positive about speaker Jen Morris from the University of Melbourne, who spoke on 'The science behind consumer engagement'. This year's event will be held in Auckland on 14 November 2017.
			2. National workshops for infection prevention *(due 30 June 2017. 2015/16 performance: National and regional workshops held)*	We held our national workshop on infection protection and control on 9 August 2016 in Wellington. It had 120 attendees (full capacity), who gave positive feedback about the event. This was a valuable opportunity to meet in multidisciplinary teams to discuss regional approaches to infection prevention and control. The next multidisciplinary event is being planned for early or mid 2018.
			3. Build regional networks to support clinical leadership for medication safety *(due 30 June 2017. 2015/16 performance: One national collaborative learning session held)*	We held meetings with regional patient safety alliances: Northern (30 March 2017), Midland (3 April and 22 June 2017), South Island (16 May 2017) and Central (22 June 2017). We held meetings with regional drugs and therapeutics committees to strengthen knowledge of medication safety work and priorities at all levels (local, regional and national): Northern (24 May 2017), South Island (29 May 2017), Midland (12 June 2017) and Central (15 June 2017). Participants gave positive feedback on all network meetings and the sector has a strong appetite for continued workshops. Local champions are encouraging others to attend meetings.
			4. Workshops to support learning from adverse events *(due 30 June 2017. 2015/16 performance: Four regional workshops held)*	We held workshops in Auckland (4–5 August 2016 and 30–31 March 2017), Dunedin (31 August to 1 September 2016) and Rotorua (11–12 May 2017).
			5. Safe surgery regional workshops *(due 30 June 2017. 2015/16 performance: Delivered learning sessions to three cohorts of DHBs)*	We delivered workshops in Auckland, Wellington, Christchurch and Hamilton (4–7 October 2016), with international speaker Professor Cliff Hughes. Over 180 surgical team members attended. Workshop evaluation was extremely positive.

ACTIVITY	OC	HS	PERFORMANCE MEASURES	RESULTS
			6. Supporting primary care improvement network *(due 30 June 2017. New deliverable for 2016/17)*	The first Whakakotahi learning group event (23 May 2017) was well attended and received positive feedback. We uploaded learning materials from the event to our website. We are planning the second learning event for the PHO improvement network in September–October 2017.
			7. Deteriorating patient regional and national workshops *(due 30 June 2017. New deliverable for 2016/17)*	The Health Roundtable hosted a national workshop for all DHBs (October 2016). Midland (videoconference, 25 May 2017) and Northern (meeting, 6 June 2017) had regional workshops.

ACTIVITY	OC	HS	PERFORMANCE MEASURES	RESULTS
18. Expert advice, tools and guidance	AS	VH OT S	Expert advice, tools and guidance provided to the sector on:	**Achieved**
			1. Implementing teamwork and communication in DHB operating theatres *(due 30 June 2017 2015/16 performance: Resources provided to all DHBs and some private hospitals)*	The communication tools are well established in most DHBs. The first reports against the QSM began in December 2016 and we are now considering the second round of QSM results. About half of the DHB surgical teams are undertaking briefings and debriefings, but the practice is not consistent in all theatres yet.
			2. Reducing surgical site infections for people undergoing knee and hip surgery and cardiac surgery *(due 30 June 2017. New deliverable for 2016/17)*	We sent the feedback summary and recommended options for an anti-staphylococcal bundle to stakeholders. Our call for expressions of interest received nine responses, which we are now considering.
			3. Primary care improvement initiatives selected through an expressions of interest process *(due 30 June 2017. New deliverable for 2016/17)*	The selection process for the first set of initiatives ended in December 2016. From the 16 applications we received from providers, we shortlisted five teams and invited them to submit full proposals. Eventually we chose three projects. We held the first group learning session on 23 May 2017.
			4. Develop and pilot national rapid response systems to ensure timely, patient-specific responses to clinical deterioration for adult inpatients *(due 30 June 2017. New deliverable for 2016/17)*	Four of the six sites have launched: Southern Cross Christchurch (7 February 2017), Nelson Marlborough and Auckland (both 20 February 2017) and Whanganui (27 February 2017). We have conducted a sector feedback exercise (April–May 2017), as well as a learning session with sites (24 May 2017).

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	6,772	6,738	636	636	6,831	6,777	14,239	14,151
Interest revenue	8	36	1	3	9	41	18	80
Other revenue	255	50	9	50	2,272	735	2,536	835
Total revenue	**7,035**	**6,824**	**646**	**689**	**9,112**	**7,553**	**16,793**	**15,066**
Expenditure								
Operational and internal programme costs	4,496	4,166	694	569	5,456	4,409	10,646	9,144
External programme cost	2,548	2,658	154	120	3,561	3,394	6,263	6,172
Total expenditure	**7,044**	**6,824**	**848**	**689**	**9,017**	**7,803**	**16,909**	**15,316**
Surplus/(deficit)	**(9)**	**0**	**(202)**	**0**	**95**	**(250)**	**(116)**	**(250)**

10.0 Financial statements

10.1 Statement of comprehensive revenue and expenses for the year ended 30 June 2017

Actual 2016 $000		Notes	Actual 2017 $000	Budget 2017 $000
	Revenue			
13,917	Revenue from Crown	2	14,239	14,151
51	Interest revenue		18	80
920	Other revenue	3	2,536	835
14,888	**Total revenue**		**16,793**	**15,066**
	Expenditure			
6,747	Personnel costs	4	7,856	6,824
116	Depreciation and amortisation	12,13	147	140
2,304	Other expenses	6	2,643	2,180
3,991	External quality and safety programmes		4,493	4,252
1,834	External mortality programmes		1,770	1,918
14,992	Total expenditure		**16,909**	**15,316**
(104)	**Surplus/(deficit)**		**(116)**	**(250)**
0	Other comprehensive revenue		0	0
(104)	**Total comprehensive revenue**		**(116)**	**(250)**

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 2017

Actual 2016 $000		Notes	Actual 2017 $000	Budget 2017 $000
	Assets			
	Current assets			
1,677	Cash and cash equivalents	7	1,789	2,020
215	GST receivable		205	209
306	Debtors and other receivables	8	220	209
53	Prepayments		109	52
2,251	**Total current assets**		**2,323**	**2,600**
	Non-current assets			
283	Property, plant and equipment	12	250	138
66	Intangible assets	13	43	65
349	**Total non-current assets**		**293**	**203**
2,600	**Total assets**		**2,616**	**2,803**
	Liabilities			
	Current liabilities			
1,058	Creditors and other payables	14	1,087	1,176
329	Employee entitlements	16	430	394
1,387	**Total current liabilities**		**1,517**	**1,569**
	Non-current liabilities			
43	Employee entitlements	16	45	0
43	**Total Non-current liabilities**		**45**	**0**
1,430	**Total liabilities**		**1,562**	**1,569**
1,170	**Net assets**		**1,054**	**1,234**
	Equity			
1,274	General funds July		1,170	1,484
0	Contributed capital	17	0	0
(104)	Surplus/(deficit)		(116)	(250)
1,170	**Total equity**		**1,054**	**1,234**

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 2017

Actual 2016 $000		Notes	Actual 2017 $000	Budget 2017 $000
1,274	Balance at 1 July		1,170	1,484
	Comprehensive revenue and expenses for the year			
(104)	Surplus/(deficit)		(116)	(250)
0	Owner transactions		0	0
0	Capital contribution		0	0
1,170	**Balance at 30 June**	**17**	**1,054**	**1,234**

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 2017

Actual 2016 $000		Notes	Actual 2017 $000	Budget 2017 $000
	Cash flows from operating activities			
13,917	Receipts from Crown		14,239	14,151
920	Other revenue		2,622	835
51	Interest received		18	80
(8,532)	Payments to suppliers		(8,933)	(8,325)
(6,649)	Payments to employees		(7,753)	(6,690)
47	Goods and services tax (net)		10	(16)
(246)	Net cash flow from operating activities	18	203	35
	Cash flows from investing activities			
(186)	Purchase of property, plant and equipment		(87)	(190)
(61)	Purchase of intangible assets		(4)	0
(247)	Net cash flow from investing activities		(91)	(190)
	Cash flows from financing activities			
0	Capital contribution		0	0
0	Net cash flow from financing activities	17	0	0
(493)	**Net (decrease)/increase in cash and cash equivalents**		**112**	**(155)**
2,170	Cash and cash equivalents at the beginning of the year		1,677	2,175
1,677	**Cash and cash equivalents at the end of the year**	7	**1,789**	**2,020**

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 2017, and were approved by the Board on 30 October 2017.

BASIS OF PREPARATION

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

Statement of compliance

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

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

Measurement base

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

Changes in accounting policies

There have been no changes in accounting policies.

SIGNIFICANT ACCOUNTING POLICIES

Revenue

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

Revenue from the Crown

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

Grants received

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

Interest

Interest income is recognised using the effective interest method.

Foreign currency transactions

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

Operating leases

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

Cash and cash equivalents

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

Debtors and other receivables

Debtors and other receivables are measured at face value less any provision for impairment. There are no provisions for impairment in 2016/17.

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 2016/17.

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

Acquired computer software	3 years	33% SL

Impairment of property, plant and equipment, and intangible assets

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

Non-cash-generating assets

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

Goods and services tax

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

The net amount of GST recoverable from, or payable to, 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 $1.7 million ($0.920 million 2016) was received, consisting of:

- $1.36 million from DHB and Ministry of Health contributions towards advance care planning
- $0.215 million towards costs associated with the Australian and New Zealand Intensive Care Society database
- $0.100 million for mental health quality improvement training
- $0.052 million from DHBs towards patient experience survey questions re-charged to the sector
- $0.060 million toward Medication Error Reporting System.

Note 4: Personnel costs

	Actual 2016 $000	Actual 2017 $000
Salaries and wages	6,069	7,125
Recruitment	167	144
Temporary personnel	179	242
Membership, professional fees and staff	111	122
Training and development		
Defined contribution plan employer contributions	149	148
Increase/(decrease) in employee entitlements	72	75
Total personnel costs	**6,747**	**7,856**

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 2016 $000	Actual 2017 $000
Audit fees to Audit NZ for financial audit	31	32
Staff travel and accommodation	378	459
Printing/communications	218	260
Consultants and contractors	235	350
Board costs/mortality review committees	553	557
Outsourced corporate services and overhead	882	976
Loss on property, plant and equipment	0	4
Other expenses	7	5
Total other expenses	**2,304**	**2,643**

Note 7: Cash and equivalents

	Actual 2016 $000	Actual 2017 $000
Cash at bank and on hand	1,677	1,789
Total cash and cash equivalents	**1,677**	**1,789**

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 2016 $000	Actual 2017 $000
Debtors and other receivables	306	220
Less: provision for impairment	0	0
Total debtors and other receivables	**306**	**220**

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 2016/17.

Note 11: Non-current assets held for sale

The Commission has no current or non-current assets held for sale in 2016/17.

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 2015	189	227	0	416
Additions	69	81	37	187
Disposals	0	0	0	0
Balance at 30 June 2016/1 July 2016	258	308	37	603
Additions	48	26	16	90
Disposals	(49)	0	0	(49)
Balance at 30 June 2017	257	334	53	644
Accumulated depreciation and impairment losses				
Balance at 1 July 2015	91	123	0	214
Depreciation expense	55	47	4	106
Elimination on disposal	0	0	0	0
Balance at 30 June 2016/1 July 2016	146	170	4	320
Depreciation expense	71	43	8	122
Elimination on disposal	(48)	0	0	(48)
Balance at 30 June 2017	169	213	12	394
Carrying amounts				
At 1 July 2015	98	104	0	202
At 30 June and 1 July 2016	112	138	33	283
At 30 June 2017	88	121	41	250

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 2015	147
Additions	61
Balance at 30 June 2016/1 July 2016	208
Additions	4
Disposals	(74)
Balance at 30 June 2017	138
Accumulated amortisation and impairment losses	
Balance at 1 July 2015	132
Amortisation expenses	10
Balance at 30 June 2016/1 July 2016	142
Amortisation expenses	25
Elimination on disposal	(72)
Balance at 30 June 2017	95
Carrying amounts	
At 1 July 2015	15
At 30 June and 1 July 2016	66
At 30 June 2017	43

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 2016 $000	Actual 2017 $000
Creditors	833	452
Accrued expenses	225	630
Other payables	0	5
Total creditors and other payables	**1,058**	**1,087**

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

Note 15: Borrowings (NZ IAS 1.77)

The Commission does not have any borrowings.

Note 16: Employee entitlements

	Actual 2016 $000	Actual 2017 $000
Current portion		
Accrued salaries and wages	57	86
Annual leave and long service	272	344
Total current portion	329	430
Non-current portion long service leave	43	45
Total employee entitlements	**372**	**475**

No provision for sick leave or retirement leave has been made in 2016/17. Provision for long service leave has been made in 2016/17.

Note 17: Equity

	Actual 2016 $000	Actual 2017 $000
General funds		
Balance at 1 July	1,274	1,170
Surplus/(deficit) for the year	(104)	(116)
Capital contributions	0	0
Balance at 30 June	**1,170**	**1,054**

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 2016 $000	Actual 2017 $000
Net surplus/(deficit)	(104)	(116)
Add/(less) movements in statement of financial position items		
Debtors and other receivables	47	96
Creditors and other payables	(418)	29
Depreciation	116	147
Prepayments	15	(56)
Employee entitlements	98	103
Net movements in working capital		
Net cash flow from operating activities	(246)	203

Note 19: Capital commitments and operating leases

CAPITAL COMMITMENTS

There were no capital commitments at balance date (2016, $nil).

OPERATING LEASES AS LESSEE

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

	Actual 2016 $000	Actual 2017 $000
Not later than one year	353	353
Later than one year and not later than five years	608	255
Later than five years	0	0
Total non-cancellable operating leases	**961**	**608**

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 $0.550 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 eight 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 (2016, $nil).

CONTINGENT ASSETS

The Commission has no contingent assets (2016, $nil).

Note 21: Related party transactions

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

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

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the Commission would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transaction 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[12] totalled $1.12 million (2016, $1.09 million).

12 Key management personnel for 2016/17 include the Chief Executive; Director, Learning & Improvement and Deputy Chief Executive; Director, Health Quality Intelligence; and Chief Financial Officer. Board members have been reported separately.

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

The total value of remuneration paid or payable to each board member (or their employing organisation*) during the full 2016/17 year was as follows.

	Actual 2016 $000	Actual 2017 $000
Prof Alan Merry* (Chair)	29	29
Shelley Frost (Deputy Chair)	18	18
Dr Bev O'Keefe*	10	15
Dame Alison Paterson	15	15
Dr Dale Bramley*	15	15
Robert Henderson*	19	16
Heather Shotter	15	15
Gwendoline Tepania-Palmer	15	15
Total Board member remuneration	**136**	**138**

Fees were in accordance with the Cabinet Fees Framework.

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

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

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

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

Note 23: Employee remuneration

Total remuneration paid or payable was as follows:

	Employees 2016	Employees 2017
$100,000–$109,999	2	8
$110,000–$119,999	10	7
$120,000–$129,999	3	9
$130,000–$139,999	1	1
$140,000–$149,999	2	1
$150,000–$159,999	2	0
$160,000–$169,999	2	3
$170,000–$179,999	0	1
$200,000–$209,999	1	0
$210,000–$219,999	1	2
$220,000–$229,999	0	0
$230,000–$239,999	1	0
$240,000–$249,999	1	1
$250,000–$259,999	0	2
$320,000–$329,999	1	0
$390,000–$399,999	1	0
$410,000–$419,999	0	1
Total employees	**28**	**36**

During the year ended 30 June 2017 no employees received compensation or other benefits in relation to cessation.

Note 24: Events after the balance date

There were no material events after the balance date.

Note 25: Financial instruments

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

Note 26: Capital management

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

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

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

Note 27: Explanation of major variances against budget

Explanations for major variances from the Commission's budgeted figures in the 2016/17 Statement of Service Expectations follow.

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSES

The year-end result for the year to 30 June 2017 is a $0.116 million deficit against a planned Statement of Performance Expectations deficit of $0.250 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.

Increases in other expenses are associated with travel, printing, communications, contractor, advisory groups, leasing costs, information technology (IT) support and software licensing for the additional staff required to deliver on the additional revenue during 2016/17.

STATEMENT OF FINANCIAL POSITION

Cash and cash equivalents were lower than budgeted due to higher prepayments and lower year-end creditors and because the Commission purchased additional computer hardware and had furniture and fit out costs associated with the additional third-party revenue.

Property, plant and equipment are higher than planned as the Commission's purchased additional IT equipment during the period and additional new office furniture for the additiona full-time equivalents employed in 2016/17 associated with additional third-party revenue.

STATEMENT OF CHANGES IN CASH FLOW

Because the Commission received an additional $1.7 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 2016/17 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 2016/17 $000	Budget 2016/17 $000	Location of end-of-year performance information
Crown Funding (Vote Health – Monitoring and Protecting Health and Disability Consumer Interests (M36))	12,976	12,976	The end-of-year performance information for this appropriation is reported in the Statement of Performance as given in section 8.1.

The Commission also received Crown funding of:

- $0.500 million from Vote Health – Monitoring and Protection of Health Consumer Interests.
- $0.280 million from Vote Health – Health Workforce and Training
- $0.215 million from Vote Health – National Personal Health Services
- $0.213 million from Vote Health – National Health Information Services
- $0.040 million from Vote Health – Primary Health Care Strategy (M36) appropriation
- $0.040 million from Vote Health – Departmental Regulatory

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 2017.

Signed on behalf of the Board:

Prof Alan Merry ONZM FRSNZ
Chair
30 October 2017

Shelley Frost
Deputy Chair
30 October 2017

12.0 Auditor's report

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 2017

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

Opinion

We have audited:

- the financial statements of the Commission on pages 37 to 51, that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements including a summary of significant accounting policies and other explanatory information; and
- the performance information of the Commission on pages 27 to 35 and 56 to 60.

In our opinion:

- the financial statements of the Commission on pages 37 to 51:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2017; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Accounting Standards, with reduced disclosure requirements.
- the performance information on pages 27 to 36 and 56 to 60:
  - presents fairly, in all material respects, the Commission's performance for the year ended 30 June 2017, including:
    - for each class of reportable outputs:
      - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
      - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 31 October 2017. This is the date at which our opinion is expressed.

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

Basis for our opinion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 2 to 26 and 52, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

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

Appendix 1: Measuring progress against the quality and safety markers

The QSMs measure changes in practice and outcomes for priority programmes. The tables below use bold to highlight the baselines against which we are measuring the progress of New Zealand's health and disability system. All figures are non-risk adjusted.

Table 1: Reducing harm from healthcare associated infections

Measure	Actual 2011/12	Actual 2012/13	Actual 2013/14	Actual 2014/15	Actual 2015/16	Target 2016/17	Actual 2016/17	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	82% (June 2016) 14 out of 20 DHBs meeting the target	80%	84% (June 2017)	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 measured – CLAB marker retired December 2014	Not applicable	Not measured – CLAB marker retired December 2014	*Target CLAB Zero* programme
Outcome measures								
Rate of healthcare associated *Staphylococcus aureus* bacteraemia[13] per 1,000 inpatient days	0.14	**0.11**	0.12	0.12 (July 2014 to March 2015)	0.14	Maintenance of rate between 0.07 infections and 0.11 per 1,000 bed-days	Median rate remained at 0.13 for the year end March 2017 since January 2012	Hand Hygiene New Zealand programme
Rate of central line associated bacteraemia (CLAB) per 1,000 line days	**3.5**[14]	0.49	0.52	0.42 (July to December 2014)	Not measured – CLAB marker retired 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 - March 2016, full-year data not available)	Literature suggests that a reduction of 25-27 percent should be possible	1.1 (July 2016 – March 2017	National monitor system (ICNet)

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

Table 2: Reducing perioperative harm

Marker	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14[15]	Actual 2014/15	Actual 2015/16	Target 2016/17	Actual 2016/17	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 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)	Not specified	Not measured: replaced with teamwork and communication QSM from December 2016	Chart reviews[16]
Outcome measures									
Postoperative sepsis rate[17] per 1,000 surgical episodes	8.37[18]	8.9	**10.77**	12.3 (see note 1)	12.9[19]	13.1	Literature suggests that a reduction of around 30% should be possible. This would equate to: • postoperative sepsis 6.3 per 1,000 episodes • postoperative sepsis (elective)	11.8	National Minimum Dataset (NMDS)
Postoperative sepsis rate (elective) per 1,000 surgical episodes	3.68[20]	4.08	**3.66**	5.89	6.6 (July 2014 to December 2014)	All postoperative only now reported		4.0	NMDS
Postoperative DVT/PE rate per 1,000 surgical episodes	3.94[21]	3.97	**3.81**	4.18[22]	4.2[23]	4.3		4.4	NMDS
Other reducing perioperative harm outcome measures	Eight reducing perioperative harm outcome measures originally listed in our Statement of Intent 2014–18 (Appendix 2, p.37) have not been reported in our Annual Reports during the period of the SOI. These 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 inhospital deaths associated with sepsis; excess number of inhospital deaths associated with sepsis (elective); excess number of inhospital deaths associated with DVT/PE.								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.

15 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.

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

17 Calculated as the number of surgical admissions where postoperative sepsis and postoperative deep vein thrombosis/pulmonary embolism (DVT/PE) were recorded within the initial surgical episode or where a re-admission was associated with postoperative sepsis and DVT/PE occurred within 28 days of discharge from an initial surgical episode per 1,000 surgical episodes.

18 The numbers for 2010/11 to 2012/13 differ from those previously reported because we began to use an improved definition of readmission in the context of the markers. The new definition has been used to recalculate the numbers for those years.

19 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.

20 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.

21 Haynes et al 2008. *op. cit.*

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

23 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	Actual 2015/16	Target 2016/17	Actual 2016/17	Data source
	Process measures								
Percentage of older patients given a falls risk assessment			**77%**	90%	90%	91% (June 2016)	No target identified	92% (June 2017)	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%	95% (June 2016)	No target identified	95% (June 2017)	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)	70	Reduction of falls with FNOF of 10–30% over three years	76 in the year ending June 2017	NMDS
Additional occupied bed-days (OBDs) following in-hospital FNOF	4,124	3,944	**2,677**	513[24]	3,204 (April 2014 to March 2015)	See note 1	Measurement of associated reduction in additional OBDs and cost	No longer reported in QSM update, instead, a cost/saving for increased/avoided FNOF is reported based on the FNOF rate per 100,000 admissions in the baseline period of July 2010 to June 2012. Since July 2012, there were 117 avoided FNOF and saving $5.5m. In the year end June 2017, these numbers were 35 and $1.7m.	NMDS
Cost of additional OBDs associated with FNOF			**$2.06m**	$0.4m	$2.4m	See note 1		See above	NMDS/cost data from New Zealand Institute of Economic Research (NZIER)[25]

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 to June 2012.

Note 2: One reducing harm from falls outcome measure listed in our Statement of Intent 2014–18 (Appendix 2, p 38) is no longer included in our annual reports. The Statement of Intent notes that this measure, mortality following in-hospital FNOF, produces numbers that are too small to be reliable. It continues to do so, and this measure is no longer included in our annual reports.

24 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.

25 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)	Actual 2015/16 (Jan–Mar 2016)	Target 2016/17	Actual 2016/17 (Jan–Mar 2017) (see Note 1)	Data source
Process measures							
Antibiotic given at right time	**85%**	92%	94%	97%	No annual target identified	97%	ICNet
Right antibiotic and right dose (2 g cefazolin)	**55%**	78%	90%	96% (see note 2)		97%	
Right skin preparation	**91%**	98%	98%	99% (see note 3)		Retired due to continual high compliance	
Outcome measures							
SSIs (total across period)	**30**	24	25	31	No annual target identified	30	
Infections per 1,000 hip and knee operations (rate in the final quarter)	**13**	10	10	12		11	
Sum of estimated incident cost ($)	**$0.53m**	$0.425m	$0.44m	$0.71m		$0.69m	

Note 1: For the 90-day outcome measure for surgical site infection, data runs one quarter behind other QSM measures.

Note 2: Fourteen DHBs have reached the 95 percent threshold compared with only three at 2013 baseline.

Note 3: Thirteen DHBs met the 100 percent target. Six more DHBs are achieving 99 percent.

Table 5: Reducing medication errors

Marker	Baseline 30 June 2015	June 2016	June 2017	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)	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 accurately 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	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%	43-60% for these two DHBs	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%	22-54% for these two DHBs two	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%	50-60% for these two DHBs two	Not specified	DHB eMR system

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