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Health Quality & Safety Commission New Zealand

Kupu Taurangi Hauora o Aotearoa

Annual report 2018/19

Pūrongo ā-tau 2018/19

Ko te whāinga rangatira hei tūāpapa mō Te Kupu Taurangi Hauora o Aotearoa;
Ko te whakatutuki i te mana taurite hauora mō ngā tāngata puta noa i te motu
Ko ngā mātāpuna o Te Tiriti o Waitangi hei whāriki e whai ake i tēnei moemoeā.

Pou hihiri
Pou rarama
Pou o te whakaaro
Pou o te tangata
Pou o te aroha
Te pou e here nei i a tātou

Mauri ora, ki ngā tāngata katoa!

The principal aim for the Health Quality & Safety Commission
Is the creation of a health system capable of meeting the equity needs of all people in Aotearoa.
Using the principles sourced from the Treaty of Waitangi to provide the foundational weaving
Let us all work together to achieve this dream.

When your spirits awaken
When your body's alive
When love is unconditional
Enlightenment flows
When our minds and spirit are in tune – we can achieve anything.

Mauri ora

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This document is available on the Health Quality & Safety Commission website at: www.hqsc.govt.nz.

Acknowledgement and thanks to Tu Whakairiora (former Chair of Te Rōpū Advisory Committee) who gifted these words of wisdom to the Commission.

Photo acknowledgement (front cover) and thank you to the Commission's consumer network, who provide the consumer lens over the work we do. In the cover photograph (top right), is John Hannifin, who sadly recently passed away. We would like to acknowledge the valuable work John did for the Commission. He will be greatly missed.

Thank you and acknowledgements for photos supplied in this document by various people who have had contact touchpoints throughout our work.

Acknowledgement to Ministry of Business, Innovation and Employment for the use and the provision of the cover photo for Priority three: Reducing harm and improving safety.

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

Annual report 2018/19
Pūrongo ā-tau 2018/19

FOR THE PERIOD
1 JULY 2018 TO 30 JUNE 2019

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

Our vision | Tō mātou moemoeā

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

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

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

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

Māori are two to three times more likely to die from conditions that effective and timely care might have prevented. The health of substantial numbers of our young people reflects the impact of this growing inequity, and child poverty is a leading problem for New Zealand. Whilst we have had an explicit focus on achieving health equity for Māori as part of meeting our obligations to Te Tiriti o Waitangi, for this reportable year and into the future, we are also committed to reducing the health inequities for Pacific peoples and those from disadvantaged socioeconomic populations.

Equity has been central to the Commission's definition of quality since its establishment. Equity concerns are also part of the Commission's decision-making and prioritisation processes. In our broader work, we support specific equity improvement programmes to address health equity issues in the sector.

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

Our values | Ō mātou uara

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

It's about people | Mō te iwi – We are driven by what matters to patients/consumers, their 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.

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Foreword | Kupu whakataki

We are proud to present the Health Quality & Safety Commission's (the Commission's) annual report for 2018/19.

2018/19 has been a turning point for the Commission. The Minister of Health through his Letter of Expectations has been clear about the priority of meeting Treaty of Waitangi obligations and having an explicit focus on achieving health equity for Māori. Making a strong contribution to achieving Māori health equity has been a priority for the Commission in 2018/19 and will continue to be a priority in the future.

The Commission has also identified inequity in general, and consumer partnerships, as key areas of focus. We believe poorer health outcomes for some groups is one of the most pressing issues affecting New Zealanders. This is particularly apparent among Māori, Pacific peoples, and those from disadvantaged socioeconomic environments.

Our annual publication *A window on the quality of Aotearoa New Zealand's health care* (the Window) considers where our health system performs well and where performance could be improved. Since the first edition of the Window in 2015, the Commission has been 'shining the light' on health inequity between different groups, identifying inequity as a quality issue for the health sector.

The latest report, *A window on the quality of Aotearoa New Zealand's health care 2019: A view on Māori health equity* (Window 2019), was developed during 2018/19. Window 2019 shows that our current systems are supporting non-Māori to live healthier, longer lives than Māori. Across the life course, we see inequity in many of the indicators considered, from before birth, through childhood and youth, through adulthood and into old age. We see the diseases commonly associated with older age starting younger in Māori than non-Māori, higher rates of disability and of multiple disability for Māori, and we see a stark difference in life expectancy.

In 2018 the Commission was challenged by the sector for measures presented on a web dashboard in which the use of colour-coding inadvertently suggested inequitable mortality rates for Māori were acceptable. This challenge served as a catalyst for us to consider and determine new ways of approaching our work.

Thus, in early 2019, the Commission began a performance improvement framework self-review, which included a specific focus on how well placed we were to contribute to achieving health equity for Māori, within the scope of our mandated role. The four-year excellence horizon, developed through the review process, will focus on the most effective role the Commission can play in an all-of-government approach to advancing Māori health.

We are in the third year of our current Statement of Intent, and while we can demonstrate progress towards outcomes, there is much more to be done. A new strategic priority of advancing Māori health has been added to the existing four Commission priorities.

The government has prioritised mental health through the release of the *Report of the Government Inquiry into Mental Health and Addiction – He Ara Oranga* and include the mental health and addiction improvement work the Commission leads with district health boards, and our work in suicide mortality review. We have continued to expand our improvement work in partnership with primary care through the Whakakotahi programme, supporting local practices to work on topics that are important to them. All current Whakakotahi projects focus on improving equity and consumer engagement.

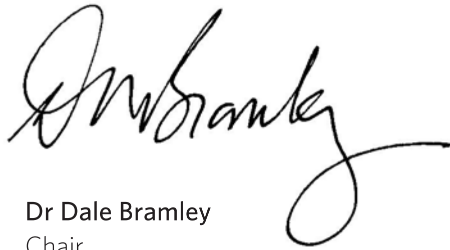
We are determined to have a robust, inclusive organisation that can contribute effectively to advancing Māori health and to achieving equity in outcomes for Māori, and equity with the health system. We understand that, as an improvement agency, we need to focus inwardly as well as outwardly and continually improve our own performance.

With this year's priorities, we are taking a system-wide approach as well as strengthening our position, for quality improvement in the reduction of inequity – particularly in Māori health. In doing so, the importance we place in recognising Māori as tangata whenua under the Treaty of Waitangi will be paramount in our engagement and quality improvement activities with iwi, hāpū and whānau.

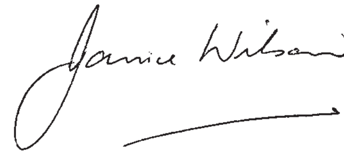
To make the differences we need to make, we must partner with organisations reflecting a kaupapa Māori approach to health care alongside the health perspectives of Pacific peoples.

We would like to acknowledge the enormous contribution of departing chair Professor Alan Merry. Professor Merry has chaired the board since the establishment of the Commission. His vast experience as a senior clinician and his knowledge of quality care and patient safety has been instrumental in guiding the Commission. He has also brought to the role wisdom and credibility from his research and academic career and his high standing among his peers, nationally and internationally. The commitment and valuable input of recent outgoing board members Bob Henderson, Bev O'Keefe, Dame Alison Paterson and Gwen Tepania-Palmer will also be greatly missed.

We welcome the opportunity to share the story of our successful year in 2018/19 and look forward to continued achievement and successful partnerships in the year ahead.



Dr Dale Bramley
Chair
30 October 2019



Dr Janice Wilson
Chief Executive
30 October 2019

Priority one: Improving consumer and whānau experience of care | Whakaarotau tahi: Ko te whakapiki i ngā wheako manaaki o ngā kiritaki me ngā whānau

The Commission's first priority is consumers of health care services and their whānau. Their knowledge and experience help to improve health care and the health and disability system. Working with people and communities underpins all our work programmes. Our consumer engagement team, Partners in Care, leads this work for the Commission.

Consumers matter

How consumers and their whānau experience health care in Aotearoa New Zealand is at the heart of the Commission's work.

If we want to improve health, we need to start with consumers and understand their stories and experiences. Evidence shows that engaging with consumers and whānau is linked with improved health outcomes and experiences of health care. Consumers and whānau who are enabled and knowledgeable are far more likely to seek information about their care and make choices that are best for them and their health.

We supported services to make a difference

Engaging with consumers should take place at all levels of health service delivery: direct level of care, service planning and policy, and governance. In 2018/19 we continued to respond to consumer experience data and to support co-design. We also conducted a 'train-the-trainer' programme with consumers and providers.

Train-the-trainer programme (SPE 7b[1])

We developed and delivered three train-the-trainer workshops, in Wellington, Auckland and Christchurch, for health providers and consumers interested in delivering training to consumer representatives. The training helps participants understand the health system, gain skills to contribute as representatives on various groups and at forums, and to increase their confidence in the role.

'Just brilliant to have the benefit of the mix of minds in the room, and to get so many options on the table for working with consumers. I really enjoyed the discussions and the perspectives we heard. I learnt so many things that will make it easier for consumers to work with us.'[2]

What is co-design? (SPE 7a)

We continue to promote co-design as a way of improving health and disability services based on the experiences of consumers, whānau and staff. Co-design is integral to the sector-wide work of the Commission.

We support services to work in partnership with consumers to co-design solutions to everyday system challenges. For example, this year we supported a co-design programme at Capital & Coast District Health Board (DHB), and also supported five teams from Pegasus Health in Canterbury to deliver projects.

Train-the-trainer workshops

3

workshops in Auckland, Wellington and Christchurch

56

attendees

83%

of respondents said the training gave them the skills and knowledge needed to deliver training in their own service

A co-design case study resourced by the Commission: Gender-affirming care in Canterbury

One group sought to improve both the quality of, and access to, gender-affirming health care in Canterbury. The team was made up of three members of the transgender community, a member of Manawhenua ki Waitaha, a general practitioner (GP) with an interest in transgender health and a Pegasus health manager. They saw the co-design process as an opportunity to improve the current situation in Canterbury.

Gender-affirming services involve interactions between clients and a multitude of health professionals and services, including but not limited to GPs, mental health professionals, endocrinologists and surgeons.

1. Deliverable 7b from the Commission's Statement of Performance Expectations 2018/19 (www.hqsc.govt.nz/publications-and-resources/publication/3693/).
2. Comment from a provider attending a train-the-trainer session.

The group's work has contributed positively to these outcomes:

- The number of health professionals in practices seeking support for their transgender clients and to form a network of champions has grown to around 15 GPs, up from less than five widely known to be supportive only two years ago.
- HealthInfo is a health information website for the general public, funded by Canterbury DHB. The information is specific to Canterbury, New Zealand, and has a mix of health information, including factsheets on different topics and descriptions of local health services and supports. It also has links to recommended websites for further reading and research. HealthInfo has been updated from a simple and outdated single page on gender dysphoria to over 10 pages of information on gender identity, gender diversity, support networks and gender-affirming care.
- The HealthInfo information will now also feed into the Leading Lights pathway for primary health teachers supporting gender-questioning and gender-diverse students.
- The gender-affirming care pathways on the Canterbury Health Pathways are in final draft stages. The current single pathway on gender dysphoria will be replaced by five health pathways for different ages and services, including a new surgical pathway.
- There is increased communication between the community and health professionals, particularly in primary health care.
- The co-design group has worked as a pilot for a shared community and clinical advisory board to advise on gender-affirming care services design. This advisory board would be valuable as an ongoing resource to the Canterbury health system to contribute to quality improvement, service updates and community engagement and education.

The co-design team attended the first Aotearoa transgender health symposium in Hamilton in May 2019, sponsored by the Commission and supported by Pegasus Health.

The complete case study can be found at: www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/Co-design-gender-affirming-care-Jun-2019.pdf.

Supporting services to respond to consumer experience surveys

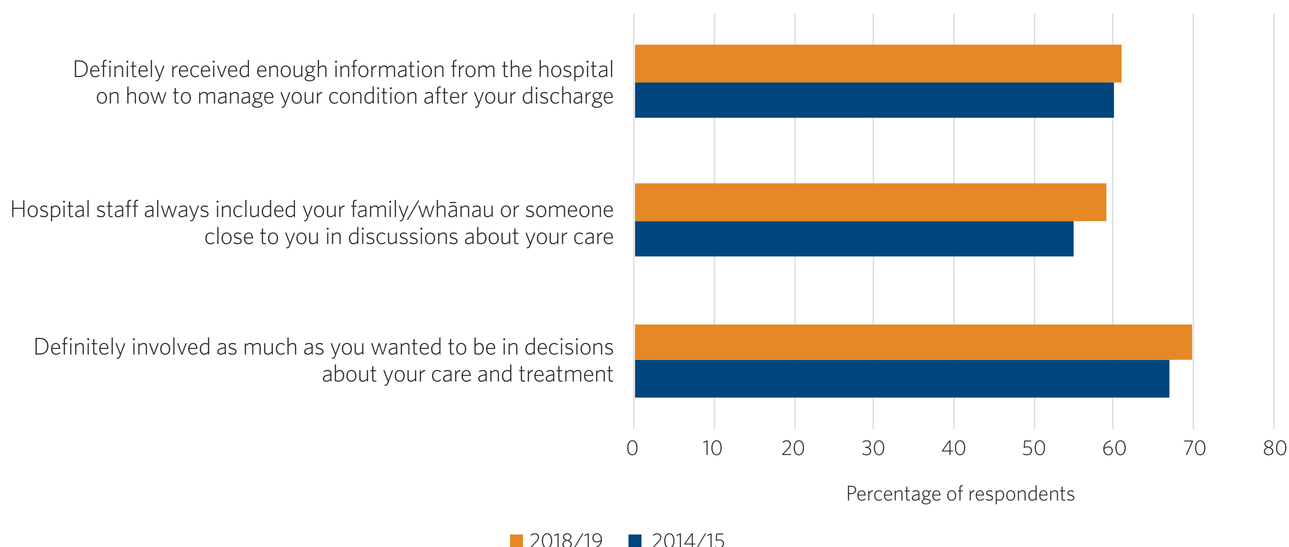
Hospital survey (SPE 1C)

The Commission has coordinated the national inpatient experience survey since 2014. The survey seeks to understand hospital patients' views of the care they receive, and to make health care more responsive to their needs. Four further iterations of the survey were undertaken and published in 2018/19.

The inclusion of the patient experience survey in the System Level Measures Framework has focused attention on activities to improve some of the patient experience issues identified. All DHBs included actions to respond to the patient experience survey in their 2018/19 annual plans, with improving information about medication on discharge and better involvement with whānau in common areas of activity.

For the first time in 2018/19, we started to see evidence of improvement in the responses to the survey questions (Figure 1). In total, 16 percent of survey questions across DHBs showed significant, sustained and meaningful improvement since the 2014/15 baseline. The overall effects of these improvements matter. For example, the percentage increase in hospital inpatients who definitely felt they had been involved in decisions about their treatment is equivalent to about an additional 30,000 people.

Figure 1: Improvements in patient experience



Primary care survey (SPE 1d)

The Commission also coordinates the primary care patient experience survey. This survey is designed to find out what patients' experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists and hospital staff.

The response rate for Māori is 19 percent (compared with 24 percent for European and other, and 14 percent for both Pacific peoples and Asian) – this gives in excess of 1,500 responders each quarter. Improving response rates for Māori is a focus, and a range of initiatives are either in place or planned.

Activities underway include:

- translating the flyers into te reo Māori
- encouraging practices to improve the collection of email addresses, particularly for Māori
- encouraging practices to play videos informing patients of the survey during survey week (this includes a version in te reo)
- suggesting practices use kaiāwhina and health navigators to distribute flyers about the survey
- encouraging primary health organisations (PHOs) to demonstrate the value of the survey to front desk staff – for example, by sharing survey feedback with the team
- monitoring survey statistics by ethnicity.

Future activities include:

- using Māori radio stations to promote the survey during survey week
- developing quarterly newsletters with a focus on responses for groups including Māori
- exploring with mobile data companies the provision of free mobile data for respondents to complete the survey.

In 2018/19, results from the primary care patient experience survey were made publicly available on the Commission's website for the first time.

There were over 4,000 views of the February 2019 report. Our focus in 2018/19 has been to maintain a high uptake rate and encourage responses.

Consumer engagement quality and safety marker (SPE 6)

In 2018/19 we worked with consumers, the Ministry of Health and DHBs to co-design a way of recording progress in involving consumers in health care. We developed the supporting, understanding, responding, evaluation (SURE) framework to track progress in building consumer capability, responding to consumer feedback and improving consumer experience. The framework is being tested in four DHBs and will be fully implemented in the new financial year.

Primary care patient experience survey participation takes off

- **August 2017**

314 practices in 24 PHOs participated

5,600 responses received

- **May 2018**

713 practices in 27 PHOs participated

21,800 responses received

- **May 2019**

827 practices in 31 PHOs participated

26,000 responses received

The biggest health survey in Aotearoa New Zealand

DHB co-design case study: Scheduling at Kenepuru Community Hospital's inpatient rehabilitation unit

Making progress towards greater independence through therapy is crucial for patients and whānau. Rehabilitation is a process of adapting to impairments because of injury, illness or disease.

A team at Kenepuru Community Hospital's inpatient rehabilitation unit completed a co-design project working with therapists, other clinical staff, patients and whānau to create a patient-centred bedside schedule and, ultimately, improve clinical outcomes.

The challenge was to develop a schedule involving the many health care disciplines that work with the patient. It was an opportunity to create a schedule that was truly centred on the patient.

The team developed new patient and staff information to improve scheduling communication. Using a co-design approach resulted in improvements for patients admitted to the ward and for staff working with them.

What improvements were made?

- The patient scheduling information was relocated from the main reception to the patient's bedside.
- The patient information takes into account evidence-based information about available options, the

provider's knowledge and experience, and the patient's values and preferences. This has enabled shared decision-making.

- Bedside information includes a folder with the patient's therapy timetable and information about the team engaged with rehabilitation.

What do staff and patients think?

- *'Brilliant idea. As well as all the information/reasoning outlined in the document about why you'd provide this, having it by 4.00pm on a Friday means all the weekend visitors can see what particular sessions they can make it to (or if they want to see the medical/nursing staff) – eg, my dad would've loved seeing some physio sessions, but he didn't know when they were precisely and always had meetings.'* – patient experience quote
- *'The photo [of staff] really helped me to remember and keeping my daily plan on my table helps me to stay motivated.'* – patient
- *'Saved so much time… loved the colours… can't wait until we use tables at the bedside.'* – staff member

What principles were adopted on the ward following this project?

- Staff on the ward should work collectively and have a team culture with appropriate knowledge, skills and focus on supporting effective patient rehabilitation.
- Patients admitted to the ward will have been assessed before admission and have been identified as having the potential to make a functional gain.
- Patients are involved in their rehabilitation planning and should actively participate in therapies and other activities.
- Interventions will be evidence-based where the evidence exists and will be regularly reviewed to maximise the rehabilitation opportunities a patient has.
- Patients, whānau and other patient supports (groups or individuals) are an integral part of the team involved in the patient's rehabilitation.

The complete case study can be found here: www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/Co-design-patient-scheduling-Jun-2019.pdf.

Kōrero mai (SPE 8c)

Kōrero mai is part of the Commission's patient deterioration programme. It aims to improve communication between health staff and patients in acute hospital settings, particularly when families and whānau recognise subtle signs of patient deterioration even when vital signs are normal.

Three sites (Southern Cross Hospital Christchurch, Canterbury DHB and Waitematā DHB) explored the complexity of communication relating to patient and whānau escalation. Using an observation tool, data was collected over the three sites. The data showed that the majority of patients were informed and understood how to call for help.

Importantly, the experience data from the three sites highlighted that even when patients were told how to escalate concerns, there was a reluctance to call due to the idea of nursing staff being 'busy' or not wanting to disturb nurses. This was despite nurses being consistently observed inviting patients to call for help. The DHBs explored ways to encourage patients to tell health staff about their concerns. Canterbury DHB used co-design to explore ways to overcome the barriers to families and whānau feeling able to call for help.

Both Southern Cross Hospital Christchurch and Canterbury DHB plan to implement their Kōrero mai escalation systems hospital-wide later in 2019. They will aim to start in a defined area, then spread across hospital sites. Following its testing process, Waitematā DHB launched Kōrero mai in November 2018 across two hospital sites and in all departments, including its emergency departments.

To gain a better understanding of the cultural aspects of whānau escalation, the Commission worked with Bay of Plenty DHB during the year to co-design a kaupapa Māori approach to escalation in the Bay of Plenty DHB kaupapa Māori ward. Further information about the project's progress can be found here.[3] This work will continue in 2019/20.

3. Source http://digest.nzma.org.nz/?id=163806#folio=16.

Advance care planning programme 2018/19

The Commission coordinates the advance care planning (ACP) programme for DHBs. The programme focuses on five workstreams: promotions, resources, training, monitoring and evaluation, and implementation.

Our 2018/19 activities included the following:

- We launched the *Kia kōrero* | *Let's talk* campaign, which received good media coverage and a large number of website hits and social media views. The campaign videos were watched 243,613 times on social media during the six-week campaign period.
- The Serious Illness Conversation Guide (SICG) was introduced to New Zealand, which improves the frequency and quality of patient-centric conversations with seriously ill consumers. A te Āo Māori focus has been built into the guide and adapted for a New Zealand context.
- Over 100 DHB employees were trained to deliver the ACP programme and the SICG using a train-the-trainer model.
- An ACP Māori advisory group was formed to create the Māori guide for whānau.
- DHB progress against the standards set out in the ACP guide was assessed through a national stocktake in March/April 2019. This found that 17 of the 20 DHBs are able to store, flag and access advance care plans, and seven of these have full electronic solutions. Eighteen DHBs have an ACP steering group, with 15 having a current ACP policy.
- We worked with DHB ACP teams to develop and build systems and processes to support training and the recording, retrieval, storage and use of advance care plans.

Priority two: Advancing Māori health and achieving equity for all | Whakaarotau rua: Ko te whakapiki i te hauora o Ngāi Māori me te whakatutuki mana taurite ā-hauora mō te katoa

The Commission is clear about its responsibilities to Māori under Te Tiriti o Waitangi as a Crown entity, as well as our continued focus in achieving health equity for all. The changing political landscape and a refocus on Te Tiriti as central to Māori health has been a turning point for us. A new strategic priority of advancing Māori health has been added to the four existing priorities outlined in our Statement of Intent 2017–21.

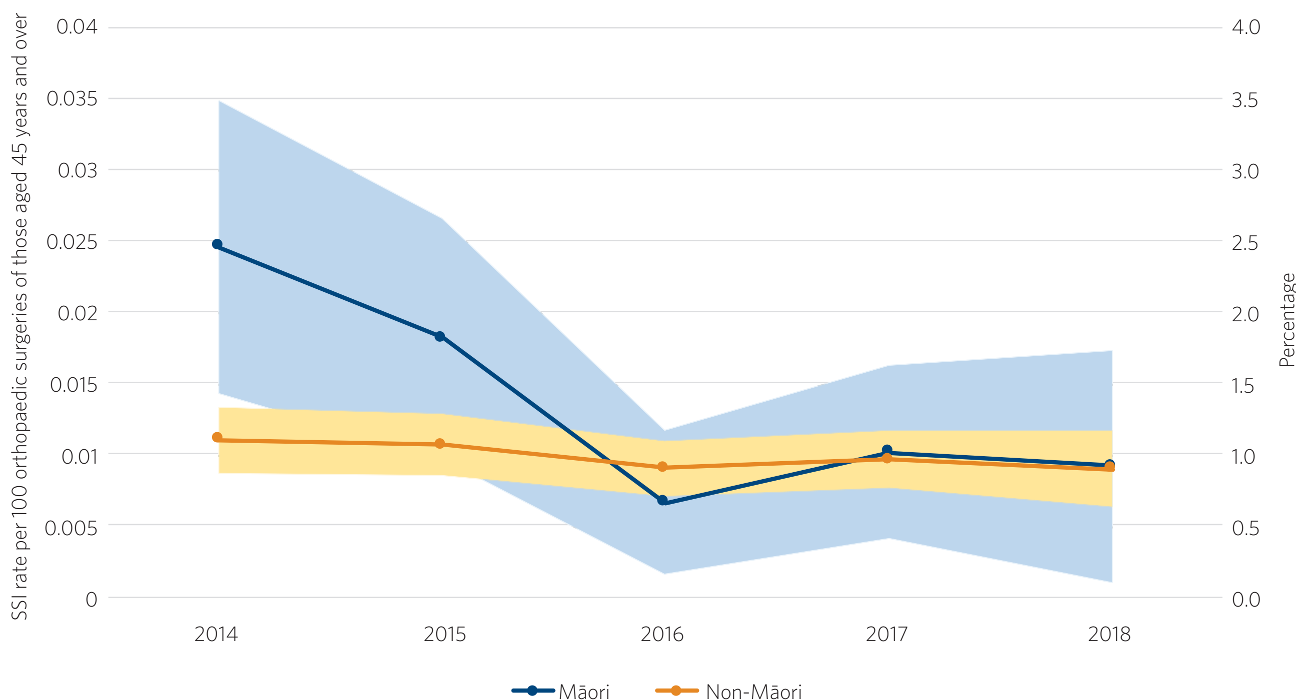
We have proactively engaged with a wide range of Māori stakeholders and experts to guide health quality improvement in areas that matter to Māori and their whānau.

The Commission aims to energise and support the health sector to use data, information and proven methods to improve services and build capability for continuous quality improvement. Our future challenge is to look critically at the tools we are using and the frameworks we are applying. We will consider how we might work differently to advance Māori health and respond better to our responsibilities as a Te Tiriti partner.

One of the projects we have started is a review of our national clinical governance guidance. We have brought together a small group of Māori health experts to review from a Te Tiriti o Waitangi and Māori health clinical perspective, the clinical governance framework tools used by DHBs. These tools already provide guidance on governance and leadership for improvement and have an established place within the sector. The revised tools will include how a Te Tiriti partnership will be reflected and empowered in governance and leadership for improvement.

Targeted improvement activity can achieve equity for very defined measures. A good example of this is the reduction and equalisation of surgical site infection (SSI) for hip and knee operations. In 2014, infection rates were more than twice as high for Māori patients than for non-Māori. Since 2016, following the successful introduction and near-universal uptake of an infection control 'bundle' as part of the Commission's infection prevention and control programme, this inequity has been eliminated (Figure 2).

Figure 2: SSI rate per 100 orthopaedic surgeries of those aged 45 years and over (age standardised), financial years, Aotearoa New Zealand, 2014–18[4]



Te Iti Me Te Rahi, the health sector inter-agency equity hub coordinated by the Commission, has continued to be well attended during 2018/19. Te Iti Me Te Rahi brings together government health agencies to share initiatives that focus on achieving equity developed within their respective work programmes.

4. Source: Window 2019, Figure 40.

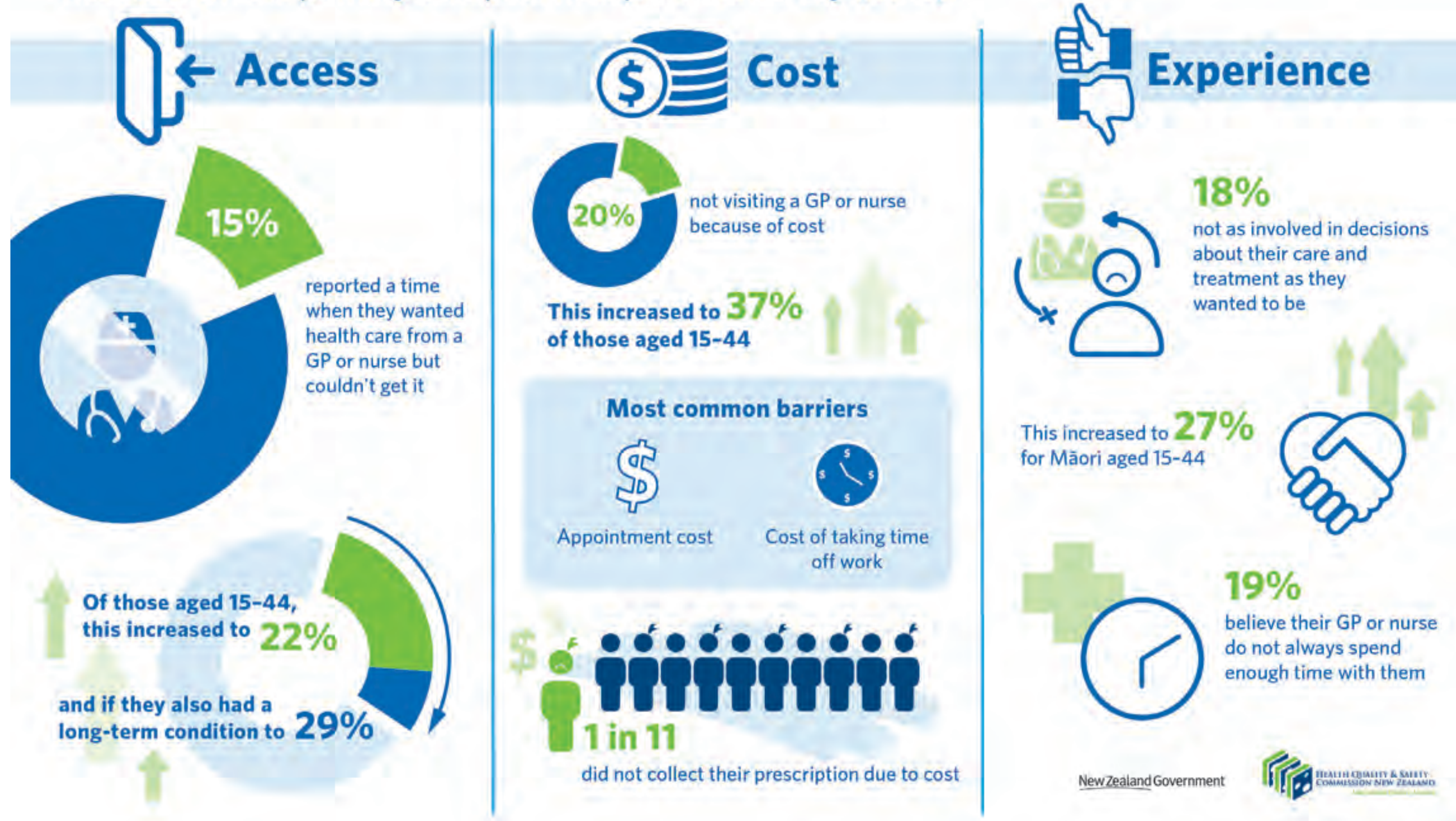
A window on the quality of Aotearoa New Zealand's health care 2019: A view on Māori health equity (Window 2019) (SPE 1a)

This year, the Commission's annual review of the quality of the health system has concentrated specifically on health equity for Māori. Window 2019 was written with Māori health experts and commentators. It demonstrates inequity in access to, and quality of, services across the life course, investigates causes and highlights solutions. This report was developed in partnership with Māori stakeholders and drew on mātauranga Māori[5] for its commentary.

Atlas of Healthcare Variation (SPE 5)

The Atlas of Healthcare Variation uses responses from the primary care patient experience survey to investigate whether there are differences by geographic region and/or patient demographics in access to health care as distinct from use.[6]

Atlas of Healthcare Variation



5. Mātauranga Māori is about a Māori way of being and engaging in the world – in its simplistic form, it uses kawa (cultural practices) and tikanga (cultural principles) to critique, examine, analyse and understand the world.
6. Levesque JF, Harris M, Russell G. 2013. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health* 12: 18.

Mental health and addiction quality improvement programme (SPE 10b)

The current priorities for our mental health and addiction quality improvement programme are reducing seclusion and connecting care. Baseline measurements for seclusion have shown that there are greater seclusion rates for Māori. Change ideas being tested to reduce and eliminate seclusion include access to cultural tools, whānau involvement in care and de-escalation techniques. Work to develop kaupapa Māori quality improvement methodology has begun. The programme is also undertaking unconscious bias education and training with the sector.

Whakakotahi primary care (SPE 9)

Primary care is complex, made up of numerous and diverse providers of health, including kaupapa Māori organisations. Research indicates that traditional large-scale approaches to quality improvement in secondary care generally operate within a Western medical model and may therefore not be suited for all primary care.

Whakakotahi is Māori for 'to be as one'. Whakakotahi is the Commission's primary care quality improvement programme, which began in 2017. The programme comprises small-scale sector-led projects, with a focus on addressing equity and integration, using consumer engagement and co-design. Equity has increasingly become the main focus of Whakakotahi projects.

In 2018/19 we supported six Whakakotahi teams through their implementation phase and nine teams in their initiation phase. The projects selected include topics that are considered to be important to the local population. The Commission has encouraged teams to align their work with the System Level Measures, mandated by the Ministry of Health. While projects were locally driven to meet the needs of the population, many have focused on areas identified in national data as having inequitable outcomes and variation in service delivery – for example, diabetes, asthma and gout.

Developing relationships in the sector and engaging with partners has been a big part of Whakakotahi. The Commission has entered into a partnership with Te Tihi o Ruahine Whānau Ora Alliance (Te Tihi), an alliance of nine iwi, hapū and Māori organisations working collectively to deliver whānau-centred services based on te ara whānau ora process. Te Tihi is actively supporting the Whakakotahi programme to appropriately and equitably engage with Māori health providers, aligning to kaupapa, kawa and te ao Māori. Our collaboration with Te Tihi is enabling us to design and implement our programme of work, acknowledge the principles of Te Tiriti o Waitangi, and target equity at a broader population health level. This will enable Whakakotahi to contribute to the Commission's work with tangata whenua towards developing a kaupapa Māori quality improvement model.

We highlight a sample of successful co-designed and consumer-informed projects, where the Whakakotahi kaupapa Māori model has been used to support both Māori and Pacific consumers and whānau.

Māori

Gonville Health, Whanganui: This project aimed to help patients become engaged with both the practice and their health care journey as soon as possible. The average time between enrolment and the first appointment reduced from around 63 days to under 30 days.

Pacific

The Fono, West Auckland: The 'Happy Skin' project aimed to reduce the rate of skin and soft tissue infections by 25 percent by November 2018 in the West Auckland Tuvaluan community and achieved a 36 percent relative reduction.

Māori and Pacific

Russell Street Unichem Pharmacy, Hastings: This project aimed for 80 percent of Māori and Pacific children (0–18 years old) to improve their asthma control test (ACT) score by December 2018. The team introduced a 'respiratory warrant of-fitness' into the pharmacy. Eighty-three percent of patients achieved their own personal ACT target scores by December 2018. There was also a significant increase in dispensing of preventer inhalers from a median of 7.5/month to 12.5/month and an accompanying decrease in emergency steroid collection.

The results from these programmes are available at: www.hqsc.govt.nz/our-programmes/primary-care/whakakotahi/whakakotahi-2018/learning-session-3.

Unichem Russell Street

OUR AIM

80% of Māori + Pacific children (0-18 yrs) improve their asthma control test (ACT) score from current score to target score by December 2018

CASE STUDY: 'Johnny' – 3 years old + placed with an Oranga Tamariki Caregiver who smoked. Caregiver given info. to help stop smoking. He was registered with a G.P. Referred to Breathe Hawkes Bay support foundation.

Positive outcome: improved health literacy + understanding of asthma management – wraparound care, integration + consumer engagement.

WHAT WE DID:

- Let patients choose their own target
- Spacer + mask were available at our pharmacy
- Referral pathway between pharmacy + Breathe Hawkes Bay

CHILDHOOD RESPIRATORY WARRANT of FITNESS

MĀORI + PACIFIC CHILDREN

WHAT WE DID... (Continued)

- Respiratory warrant of fitness checklist developed + tested with patients
- Patient education session developed
- Teaching sessions for staff

RESULTS:

- The number of preventer inhalers has steadily increased over time of the project from a median of 7.5 to a median of 12.5
- Average ACT scores increased from 13.7 to 21.7.

KEY LEARNINGS:

- Funding + resourcing are ongoing issues.

RESULTS CONTINUED:

- Patients who achieved their ACT score went from 0% at the beginning to 83% at the end of the project.
- A case study clearly described the patient and whānau/family impact through a reduction in urgent care visits.

Health Quality & Safety Commission New Zealand

Unichem

Drawn Together

Further details on all Whakakotahi projects, their improvement journey and achievements, is available at: www.hqsc.govt.nz/our-programmes/primary-care/whakakotahi/whakakotahi-2018.

Reporting on mortality (SPE 2)

The Commission's mortality review committees review particular deaths, or the deaths of particular people, to learn how to best prevent these deaths in the future.

Mortality review committees produced two reports in 2018/19 intended to contribute to a reduction in deaths and to promote quality improvement.

The Child and Youth Mortality Review Committee (CYMRC) collects information on children and young people who died aged 28 days to 24 years. The CYMRC produced its 14th data report in June 2019, detailing mortality in children and young people, including causes of deaths and describing variations in mortality rates in different communities. The information is used by the CYMRC, policy writers, researchers and commentators to monitor the mortality of children and young people.

In 2018/19 the CYMRC, the Suicide Mortality Review Committee and the mortality review Māori caucus, Ngā Pou Arawhenua, worked together on a report on rangatahi (Māori youth) suicide. This was the first time the mortality review committees have cooperated together on a report, and the first time Ngā Pou Arawhenua has contributed to a report as an equal partner. The report will be released in December 2019, but the work in 2018/19 to develop its findings has revealed that the Māori community bears a disproportionate burden of youth suicide, at a rate of almost three times higher than non-Māori, non-Pacific communities. The report uses an equity approach to rangatahi suicide because there are factors contributing to the high rate of Māori suicide that are distinct from other populations and groups.

The Family Violence Death Review Committee (FVDRC) reviews and reports to the Commission on family violence deaths with a view to reducing those deaths. In 2018/19 the FVDRC chose a different approach to its conventional broad summary reports and instead focused on advice and recommendations to the mental health and addiction sector to improve clinicians' understanding of family violence and their role in reducing it. In an article to the *International*

Journal of Mental Health Nursing, the FVDRC outlined how practitioners can identify and respond proactively to family violence to minimise its impact and avoid inadvertently compounding risk in existing violent relationships. A central message is that to create an environment that builds safer responses for people and whānau, practitioners need to understand family violence as a form of social entrapment.

Sudden unexplained death in infancy (SUDI) notifications process

A quality improvement initiative from the CYMRC's work in 2018/19 is piloting a communications process with clinicians to ensure early death notifications are circulated quickly to all those who are scheduled to have contact with the family and whānau of the baby that died, before they visit them (eg, Well Child Tamariki Ora providers, hearing and vision screening technicians). This process is intended to prevent routine health visits to avoid retraumatising those dealing with the loss of their child and to respect the privacy and grieving processes of these families and whānau. A pilot in two Auckland region DHBs has been successful and there is potential for this process to be adopted as a quality improvement practice across the country.

Priority three: Reducing harm and improving safety | Whakaarotau toru: Ko te whakaiti wharanga me te whakapiki haumarutanga

When consumers access health and disability care services, there is a risk of unintended harm occurring. In high income countries, such as Aotearoa New Zealand, it is estimated that as many as four out of ten patients in primary care, and one out of ten in hospital care will experience preventable harm.[7]

The Commission focuses on supporting the health and disability sector, consumers, families and whānau to improve patient safety and reduce preventable harm. Providing health care is complex, involving consumer variability, multiple care exchanges, uncertainty and care settings that are constantly changing.[8] It is important that a collaborative approach is taken to enable integration and alignment with consumer, health and disability sector and government priorities aimed at reducing preventable harm.

Key achievements in 2018/19 include:

- three new quality and safety markers (QSMs) to reduce preventable harm in hospitals
- a 50 percent decrease in specific SSIs with a bundle of pre-operative interventions
- beginning a DHB-led mental health and addiction quality improvement programme focused on zero seclusion
- raising the profile of preventing harm in aged residential care
- providing two new workshops to improve understanding of the revised (2017) process of adverse event reporting, review and learnings
- releasing a national guidance tool for maternity services.

New quality and safety markers (SPE 1e)

QSMs enable DHBs to measure the progress made in addressing particular areas of harm, such as healthcare associated infections or surgery.

The Commission publishes QSMs every three months on its website, and in 2018/19 developed a simplified secure process for hospitals to submit their information. We also expanded the QSMs to include additional measures to support our improvement work on opioid medicines, pressure injuries and patient deterioration.

Falls rate[9]

As at March 2019, 136 fewer falls resulting in a broken hip have occurred inside our hospitals than in 2013.

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

$6.4 million saved

Margaret shares her experience on the side effects of morphine. Her story is available at: www.hqsc.govt.nz/our-programmes/medication-safety/publications-and-resources/publication/3141.

Opioids

Opioids (morphine, oxycodone, fentanyl, methadone, tramadol, codeine) are high-risk medicines that are excellent at controlling pain but have several known side-effects such as constipation, nausea and vomiting. Opioids can also cause serious harm. Opioids are associated with 32 percent of all medicine-associated harm in hospitals.[10]

7. http://apps.who.int/gb/ebwha/pdf_files/EB144/B144_29-en.pdf
8. Vosper H, Hignett S, Bowie P. 2017. *Twelve tips for embedding human factors and ergonomics principles in healthcare education, Medical Teacher.* DOI: 10.1080/0142159X.2017.1387240.
9. Disclaimer – this information is not part of the audit plan for 2018/19 year.
10. Robb G, Loe E, Maharaj A, et al. 2017. Medication-related patient harm in New Zealand hospitals. *New Zealand Medical Journal* 130(1460): 21–32.

The opioid QSM was introduced to monitor the application by DHB hospitals of a package of improvements and changes in opioid-related adverse drug events, following the national quality improvement initiative led by the Commission in 2014–16.

Following the introduction of the QSM from 1 October 2018, over three-quarters of DHB hospitals now provide the information required. Public reporting of this QSM is planned to start in 2020.

Patient deterioration

Courtenay Mihinui shares the story of her daughter Demar, who contracted meningitis at five months old and deteriorated quickly in hospital. See their story at: www.hqsc.govt.nz/our-programmes/patient-deterioration/patient-stories.

Acute deterioration can happen at any point during a patient's admission to hospital. If recognised early and responded to appropriately, patient outcomes can be improved. In 2016, the Commission began a five-year national patient deterioration programme aiming to reduce harm from failures to recognise or respond to acute deterioration for all adult inpatients by July 2021.

This particular QSM monitors implementation of the patient deterioration recognition and response system known as the New Zealand Early Warning Score (NZEWS). This includes use of the nationally consistent vital signs observation chart, adherence to the local response (escalation) pathways, and outcomes in relation to reducing in-hospital cardiopulmonary arrests and increasing rapid response to acute deterioration.

All 20 DHBs have now implemented or are in the process of implementing the NZEWS in their hospitals. Over 90 percent of DHBs are correctly calculating the early warning score, and about 70 percent of DHBs are responding appropriately to escalations. However, there is still significant variation in the appropriate response to escalation, and this represents the greatest opportunity for improvement.

Pressure injuries

Pressure injuries (also known as pressure ulcers, decubitus ulcers, pressure areas and bed sores) are a cause of preventable harm for people using health care services, including hospital, aged residential care and home or community care.

Pressure injuries can have significant negative impact on patients' lives and their families and whānau. They can lead to a longer stay in hospital and are often an indicator of the quality of care being provided.

Following a successful pilot at four DHB hospitals, the pressure injury QSM was introduced in July 2018 to monitor assessments of the patient's risk of developing a pressure injury and documentation of an individualised care plan. After the introduction of the QSM, almost all DHB hospitals are now reporting data, and public reporting began in June 2019.

John, a widower of 71 and recently retired, was admitted to hospital with an ischaemic leg, and developed a pressure injury. John's case highlights how simple preventable action could have saved considerable suffering. See John's story at: www.hqsc.govt.nz/our-programmes/pressure-injury-prevention/publications-and-resources/publication/3120.

Using data to identify and respond to risk through an integrated dashboard (SPE 4)

We endeavoured to make our data more easily available in one place by providing an integrated dashboard that collects indicators from across our work programmes. Four updates of the current view were provided in 2018/19, while a redesign of the equity view was undertaken. The dashboard is well used, with nearly 5,000 unique visitors to the webpage and over 18,000 individual views of the dashboard.

We are working with our partner agencies to combine our collective data sources to identify system-level risks across the health and disability sector and inform how best to respond.

Improving teamwork and communication in operating theatres (SPE 8a)

All public and some private hospitals continue to implement surgical safety checklists in their operating theatres as part of the Safe Surgery NZ programme. Our focus during 2018/19 was engaging with DHBs to understand their implementation of all components of the checklists and how they have been used to engage teamwork. We held a national promotional campaign in June 2019 to encourage all surgical teams to 'Spend five to save lives' by undertaking start-of-list briefings.

In 2019, we conducted a third iteration of the national surgical safety culture survey, which highlighted several statistically significant improvements since the first survey in 2015, including:

- a 30 percent increase in participants saying team discussions (briefings and debriefings) are common
- a 20 percent increase in surgical teams always discussing the operative plan
- a 14 percent increase in surgical team members from different disciplines always discussing patients' conditions and progress.

Deep vein thrombosis[11]

Deep vein thrombosis (DVT) describes a range of blood clots which can reach the lungs and become a pulmonary embolism (PE).

As at June 2019, 352 **DVT/PE cases have been avoided since April 2012We have worked with DHBs to implement the Safe Surgery NZ programme since 2013.**

11. Disclaimer – this information is not part of the audit plan for 2018/19 year.

Safe Surgery NZ[12]

Safe Surgery NZ

Progress towards improving safety culture and reducing patient harm

Safe Surgery NZ is a Health Quality & Safety Commission initiative

Paperless surgical safety checklists

Implemented by all 20 DHBs (the majority also using start-of-list briefings)

20/20

98% compliance with checklist components nationally (target is 100%)

Increasing number of DHBs can demonstrate high levels of team engagement with the checklist

352

Tangible success

323 fewer cases of deep vein thrombosis/pulmonary embolism than expected, based on historic trends (April 2012–June 2019), resulting in $7.4 million saved

Improved culture

Culture is one of the hardest things to change

The 2019 culture survey showed significant improvements:

Surgical team members share key information when it becomes available

69% (2015), 78% (2019) AGREE

Team discussions (eg, debriefings) are common

51% (2015), 82% (2019) AGREE

Planning for complex patients always done during perioperative briefings

67% (2015), 83% (2019) AGREE

Surgical teams always discuss the operative plan before incision

52% (2015), 72% (2019) AGREE

211 additional years of healthy life

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

Spend five to save lives

Surgical briefing awareness campaign

A start-of-list briefing is a five-minute discussion with the whole surgical team to create greater understanding about what needs to happen each operation day.

In June 2019 over 60 surgical teams across NZ participated in a 'Surgical briefing awareness day'. Many participating teams reported that the morning briefing had a significant and positive impact on patient safety.

Surgical briefing resource toolkit (https://www.hqsc.govt.nz/our-programmes/safe-surgery-nz/surgical-briefing-awareness-day-toolkit/) – resources that highlight the evidence for undertaking briefings, the benefits and how-to undertake a start-of-list briefing.

A recent study has shown improvements in surgical culture are associated with a decrease in 30-day postoperative death rates.[1]

Improved responses to questions on respect, clinical leadership and assertiveness were associated with the greatest reduction in death rates.

[1] Molina G, Berry WR, Lipsitz SR, et al. 2017. Perception of safety of surgical practice among operating room personnel from survey data is associated with all-cause 30-day postoperative death rate in South Carolina. Ann Surg 266: 658–66.

Potential savings

Successful implementation could lead to

$5.5 million per year potential savings

for public health system (Value-for-money modelling)

Safe Surgery NZ New Zealand Government

Reducing surgical site infections (SPE 8b)

SSIs are a frequent cause of morbidity following surgical procedures and have been shown to increase mortality, re-admission rates, length of hospital stays and costs for patient who incur them.[13] They are also a leading reason for Accident Compensation Corporation (ACC) treatment injury claims. SSIs can be reduced through consistent use of interventions, including giving the right dose and timing of antibiotics before surgery, sterilising skin with alcohol-based antiseptic before surgery, and clipping hair at the incision site rather than shaving.

A specific bacterium called *Staphylococcus aureus* causes most SSIs in patients having hip, knee or cardiac surgery. A bundle of pre-operative interventions to reduce *Staphylococcus aureus* SSIs was introduced to orthopaedic and cardiac surgical patients in hospitals that volunteered to participate. The bundle involved the decolonisation (removal of bugs) of the patient's skin and nose just before surgery. In these hospitals there has been a 50 percent decrease in *Staphylococcus aureus* SSIs since the bundle was implemented.

External evaluation showed that while SSI rates for Māori have fluctuated across the years since the programme has been established, the annual SSI rate per 100 procedures for Māori patients has reduced by a statistically significant rate from 2.53 in 2013/14 to 0.93 in 2018. The evaluation found that the odds of an SSI occurring in a procedure that received all three programme interventions were 43 percent lower than the odds for a procedure that did not receive all three interventions.

An educational video for general surgical patients was developed (available in English, te reo Māori and Samoan) as a resource for all hospitals. The video reminds patients of things they can do to reduce their risk of an SSI before and after surgery. Many public and private hospitals use the video to educate patients prior to surgery. The videos are online at: www.hqsc.govt.nz/staysafe.

12. Disclaimer – this information is not part of the audit plan for 2018/19 year.
13. Institute for Healthcare Improvement. 2012. *How-to Guide: Prevent Surgical Site Infections*. Page 4. URL: www.ihi.org/resources/Pages/Tools/HowtoGuidePreventSurgicalSiteInfection.aspx.

SSI rate[14]

As at March 2019, the SSI rate was

0.9% (down from 1.2% in 2015)

This reduced rate means

108 fewer infections since August 2015

Saving up to $4.3 million

Mental health and addiction quality improvement programme (SPE 10a & b)

The Zero seclusion quality improvement project aims to end the use of seclusion by mental health and addiction services. DHB-led project teams were established and began a six-month co-design phase, followed by a nine-month quality improvement phase. The Commission's programme team assisted the DHB-led teams to develop their zero-seclusion suite of measures. During the baseline period of measurement (January 2016 to September 2018) the national median monthly rate of seclusion was 4.9 percent. DHBs have begun testing their change ideas to reduce and eliminate seclusion – for example, use of peer support, sensory modulation, access to cultural tools, attention to the environment, whānau involvement in care and de-escalation techniques. Once there is sufficient measurement data, we can begin to understand the impact of this work.

A Connecting care: improving service transitions quality improvement project was launched in August 2018 beginning with a six-month co-design phase. Multi-disciplinary DHB-led project teams have been established to focus on one of three prioritised transitions: adult inpatient to adult community services, community services to primary care, and youth community services to adult community services.

The 'learning from adverse events and consumer, family and whānau experience' quality improvement project will begin in 2019/20.

Aged residential care quality improvement programme (SPE 11)

We aim to improve residents' experience of care and build improvement capability across the sector. Exploratory work and analysis of national data sets, including interRAI (a suite of seamless and comprehensive clinical assessment tools used in aged residential care), have helped identify areas of priority.

The year has been one of relationship and foundation building to support improvement activity that will focus on medicines management, identifying and responding to resident decline, and improving quality and safety through learning from adverse events. Two key achievements have been the development of frailty care guides for the nursing workforce and the publication of stories from residents.

Learning from mortality review (SPE 12)

Our mortality review committees held two national meetings in 2018/19.

CYMRC local coordinators, chairs and national committee members met for two days in November 2018. Their meeting included a workshop on the experience of local chairs and committee members. Highlights of the presentations included:

- the relationship between alcohol and suicide
- a public health approach to address inequalities
- understanding diagnosis and management of neurodevelopmental disorders/disability
- mobilising localised collaborative crisis intervention with a focus on addressing social wellbeing issues.

Perinatal and Maternal Mortality Review Committee (PMMRC) local coordinators met in March 2019. Highlights of the presentations were:

- understanding the national perinatal pathology services
- achievements of the maternal morbidity working group
- an introduction to the 'sleep on side' campaign
- the family's experience of perinatal mortality.

14. Disclaimer – this information is not part of the audit plan for 2018/19 year.

Strengthening improvement capability (SPE 13)

Mental health and addiction DHB staff who hold quality positions meet nationally three times a year as part of the quality improvement network (QIN). The role of the QIN is to enhance communication between members and provide opportunities for sharing knowledge, experience and resources, as well as professional development and networking. The mental health and addiction quality improvement facilitator course had 21 participants who undertook an improvement project on zero seclusion or connecting care.

In primary care, the Commission continued to support the PHOs QIN and became a strategic partner of the Primary Health Alliance. The Primary Health Alliance supports closer networking with PHOs and non-governmental organisations across the primary care sector, including Māori stakeholders and service providers. The primary care quality improvement facilitator course had 19 participants, who started in early 2019.

We also funded 24 participants in the quality improvement advisor programme at Kō Awatea.

Learning from adverse events (SPE 14)

The Commission's adverse events learning programme aims to improve consumer safety by supporting organisations to report, review and learn from adverse events that occur in health and disability services. The Commission developed and provided further education to support health and disability service providers with their requirements, as outlined in the National Adverse Events Reporting Policy 2017.

A one-day national adverse event reporting workshop was piloted in two DHBs (MidCentral and Taranaki) in November 2018. It provided participants with an understanding of the process of adverse event reporting and discussed the National Adverse Events Reporting Policy.

A two-hour workshop was delivered to staff from the office of the Health and Disability Commissioner, midwifery leaders (via the Midwifery Council) and a PHO. The workshop gave participants an understanding of the role of the Commission, familiarised them with the reporting policy, and discussed just culture and what an adverse event is.

In January 2019, the Maternal Morbidity Working Group released an evidence-based maternal morbidity review toolkit for maternity services. This was developed in partnership with consumers and key stakeholders. The toolkit provides a guide for services to establish local morbidity reviews that are consistent nationally.

To support this work, the adverse events learning programme released a severity assessment code guidance document specifically for the maternity sector. This will help maternity services choose appropriate review methodologies, prioritise events and improve the quality of care.

Wiki Haumaru Tūroro | Patient Safety Week 2018

Wiki Haumaru Tūroro | Patient Safety Week was an awareness-raising week held on 4–10 November 2018. It was coordinated for the fifth time by the Commission, in partnership with ACC and the Ministry of Health. We also received support from *Choosing Wisely*.

Patient Safety Week was supported by an external 'ideas group' that included representatives from most areas of the sector, including PHOs, DHBs and consumer representatives.

The theme for Patient Safety Week 2018 was infection prevention and control. The focus for the public was 'hand hygiene', and for the sector that 'good hand hygiene helps stop the spread of antibiotic resistant infections'. The week following Patient Safety Week was World Antibiotic Awareness Week, and for that week we continued the focus on minimising antimicrobial resistance.

Patient Safety Week 2019 will focus on understanding bias in health care.

Wiki Haumaru Tūroro | Patient Safety Week 2018

30,000 people heard our radio ads

180 providers ordered Patient Safety Week resources

250 entries are received from school children for a poster competition

70% of those surveyed liked the illustration germ characters

'I really want people to understand that adverse events aren't just about what happens there and then. Behind every event is a real person, with a real family who experience a real impact. Matt had a future, and that was taken away from him because things went wrong. I'm really clear that we can never stop harm completely – people make mistakes and systems sometimes fail – but we can reduce the risk of it happening again because, while humans make mistakes, we can definitely learn from them.'
– Heather Gunter

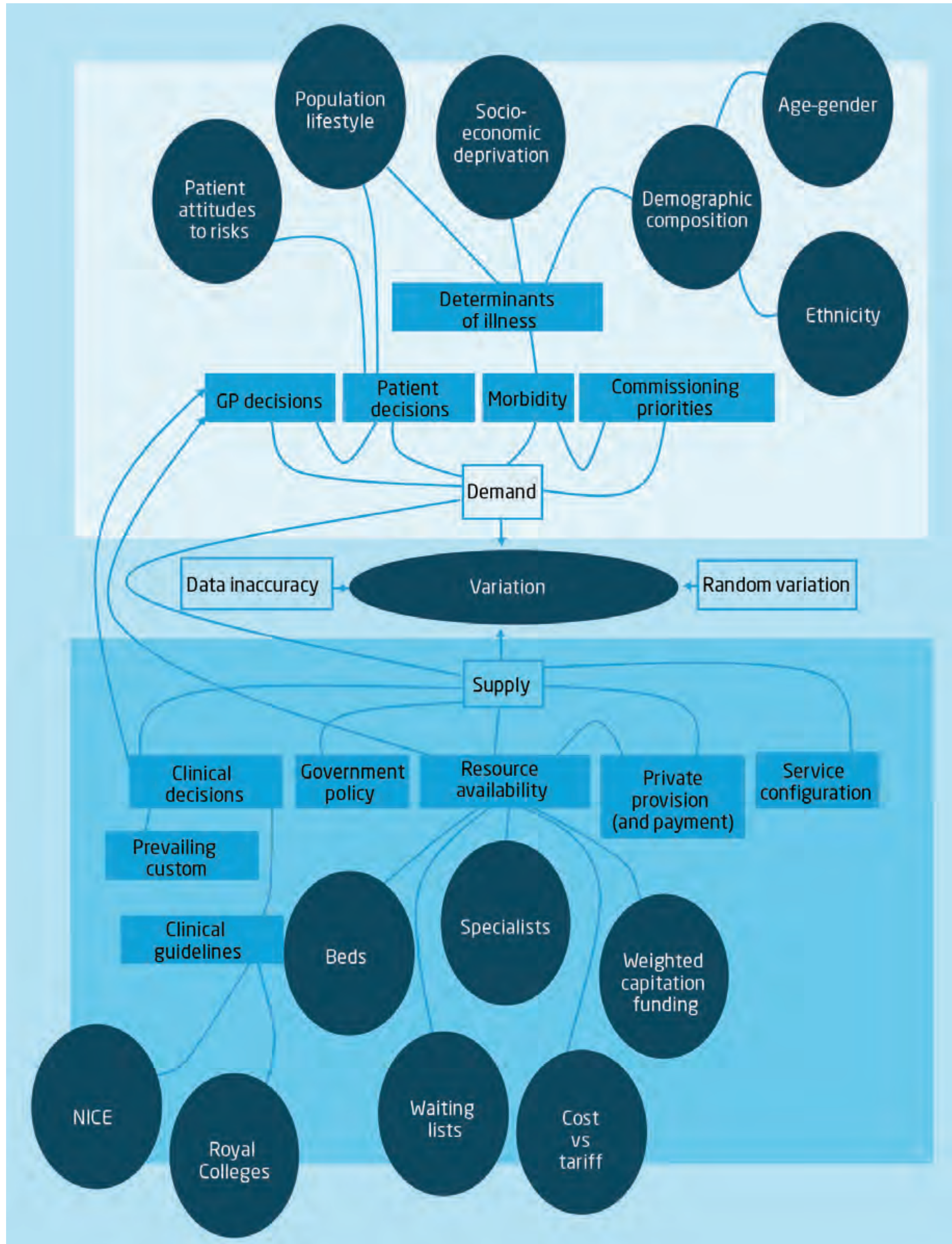
See Matt's story at:
www.hqsc.govt.nz/our-programmes/partners-in-care/publications-and-resources/publication/3445.

Priority four: Reducing unwarranted variation in care | Whakaarotau whā: Ko te whakaiti i te rerekētanga o te momo manaaki

Mapping out causes of variation[15]

The King's Fund report *Variations in health care: The good, the bad and the inexplicable* presents a diagrammatic map of potential causes of variation, which illustrates the complexity of the interactions at play (Figure 3).

Figure 3: Mapping causes of variation – diagram replicated from the King's Fund report[16]



15. Source: Love T, Ehrenberg N. 2014. *Addressing unwarranted variation: Literature review on methods for influencing practice.* URL: https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/Variation-literature-review-on-methods-for-influencing-practice-May-2014.pdf (accessed 10 September 2019).
16. Appleby J, Raleigh V, Frosini F, et al. 2011. *Variations in health care: The good, the bad and the inexplicable.* URL: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Variations-in-health-care-good-bad-inexplicable-report-The-Kings-Fund-April-2011.pdf (accessed 10 September 2019).

Unwarranted variation in New Zealand's health system

Like all health systems, New Zealand has variations in access to, processes of, and outcomes of care that cannot be explained by differences in what patients want or need. These variations are often described as unwarranted, and reducing them can improve the quality of care. Since 2012, the Commission has published its Atlas of Healthcare Variation, which now presents individual domains for more than 20 different diseases, topics or patient groups.

By producing individual domains for different diseases, we can present a more comprehensive and nuanced view by using up to 12 relevant indicators, which enhances users' ability to understand what the causes of variation might be. To ensure we measure the right things, the domains are designed in collaboration with subject matter experts, including Māori health experts and consumers. To make sure our measures are correct, we always check the accuracy of our data with the organisations and services being measured. To stimulate debate about what the results mean, we allow a 'right of reply' to DHBs and other stakeholders, which is published with the Atlas itself.

It is important to make the Atlas a tool for stimulating change rather than just reporting variation. This is complex and involves actions at individual, regional and whole-system levels, with only a small proportion of these being under the control of the Commission. It is pleasing that 13 DHBs had specific actions in their 2018/19 annual plans to address variations identified in the Atlas.

In 2018/19 the Commission had a focus on promoting Atlas findings in the medical and general media. The Atlas has consistently been one of the most visited parts of the Commission's website, and access grew further in 2018/19, with an average 1,750 site visits a month to the various domains.

In 2018/19 we produced two new Atlas domains, one on community antibiotic use and one using data from the primary care patient experience survey to understand access and barriers to care, with a particular emphasis on equity between different groups. In addition, we have produced a new 'PHO view' of atlas domains, which shows variation at the more detailed PHO level. We have also updated the domains for maternity, gout, asthma, diabetes, infection and antibiotic use following surgery, and polypharmacy in older people.

Regular updating of domains allows us to track improvements. Of the seven domains updated since the beginning of 2018, all show that an overall improvement or a reduction in variation had occurred by 2016 or 2017 for at least some of the measures (Figure 4).

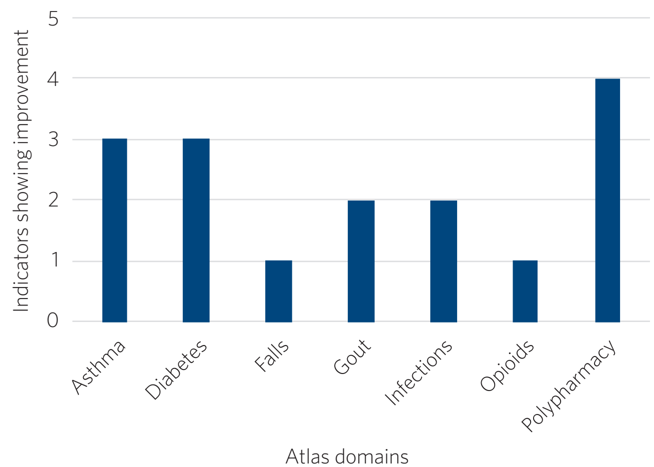


Figure 4: Number of indicators showing improvement by Atlas domain in 2018/19

Transparency of information

The Atlas is part of a wider agenda of 'shining the light' – making information about the quality of health care widely available. Done well, there is evidence that this can stimulate improvements.

In the past we have worked with the Ombudsman on what would be an appropriate approach to publishing individual clinician outcomes in New Zealand. The Ombudsman ruled against publishing individual surgeon mortality rates but required the health sector to 'by 2021: select, develop and publicly report quality of care measures (including outcomes data) that:

- are meaningful to consumers
- are meaningful to the clinicians who provide their care
- are meaningfully attributable to the clinicians or service providing that care.'

In 2018/19 the Commission worked with the All New Zealand Acute Coronary Syndrome Quality Improvement registry (ANZACS-QI) to convert registry information into a transparent reporting tool.

Transparency in cardiology in New Zealand

ANZACS-QI is a large, robust and mature clinical registry of ischemic heart disease patients with acute coronary syndrome (ACS). By May 2016 over 25,000 people with ACS and over 50,000 people referred for coronary angiography had been registered in the ANZACS-QI database. The 'open heart' co-design workshop was held in October 2017 with 14 consumers and clinical representatives to find out what New Zealanders wanted from transparency around their cardiology services.

Through an 'un-conferencing' process, the consumers attending the workshop selected better-informed discharge processes as the project to pursue. This has resulted in a co-designed standardised discharge checklist now in use at Middlemore Hospital and Auckland DHB.

A dashboard allowing simultaneous presentation of comparative performance on key acute coronary syndrome care quality indicators was created from registry data and adopted for clinical use. Public release of a co-designed consumer dashboard is now in progress.

Our performance story | Ngā kōrero mō ā mātau mahi

Statement of Performance

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

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

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

Report against the Statement of Performance Expectations

The 2018/19 Statement of Performance Expectations was prepared in line with generally accepted accounting practice. It describes progress on our two output classes during 2018/19. For each class of outputs, it includes:

- the standards of delivery performance we achieved, as compared with the forecast standards included in our statement of forecast performance for 2018/19
- the actual revenue earned, and output expenses incurred, as compared with the expected revenues and proposed output expenses included in our Statement of Performance Expectations for 2018/19.

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

Output class 1: Intelligence

One of our statutory roles is to measure and provide public reports on the quality and safety of the sector. International literature shows that measuring the quality and safety of health care, and publishing the findings stimulates improvement. Used wisely, measuring and reporting on quality and safety engages clinicians, managers and consumers, generates informed discussion and improves the efficiency of the sector.

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

Our performance measures

Report against measures of quality and safety		2017/18	2018/19
1A. Publish one 'Window on Quality' report focusing on equity, considering a range of equity dimensions including socioeconomic disparity, ethnicity, age, gender and rurality by 30 May 2019[17]	Peer reviewed	SA	SA
1B. Publish four integrated quality dashboards, August 2018 to May 2019 by 30 June 2019[18]	Peer reviewed	SA	A
1C. Publish four reports on patient experience of hospital services[19] August 2018 to May 2019, by 30 June 2019[20]	Peer reviewed	A	A
1D. Publish four reports on patient experience of primary care,[21, 22] August 2018 to May 2019 by 30 June 2019	Peer reviewed	A	A
1E. Implement new quality and safety markers for patient deterioration, opioids and pressure injuries by 30 June 2019[23]	Peer reviewed	A	A

17. Window 2019 was peer reviewed by the Ministry of Health, Te Rōpū, the consumer advisory group and academics. In the third quarterly report, the Commission advised the Ministry of Health, the Minister and the Board on the delay of this output to a later date.
18. Peer reviewed by DHBs upon release.
19. Peer reviewed by the patient experience governance group.
20. The surveys published in 2018–19 cover patients treated in May, August and November 2018 and February 2019. These were published on 31 July 2018, 31 October 2018, 1 February 2019 and 30 April 2019, respectively.
21. The surveys published in 2018–19 cover patients treated in May, August and November 2018 and February 2019. These were published on 31 July 2018, 31 October 2018, 1 February 2019 and 30 April 2019, respectively. Peer reviewed by the patient experience governance group.
22. For this reporting period, the patient experience for both hospital and primary care were split and had their own measures.
23. In prior years quality and safety markers have been reported through an integrated quality dashboard. Peer reviewed by DHBs prior to release.

Reports from mortality review committees[24]

			2017/18	2018/19
2.	Publish at least two mortality review committee reports by 30 June 2019[25]	Peer reviewed	A	SA

System-level early detection and response[26]

			2017/18	2018/19
3.	Develop and test a national Commission-led approach to identifying and responding to 'soft intelligence' to encourage a cross-agency early response to prevent harm by 30 June 2019[27]		NM	NA

Transparency of information[28]

			2017/18	2018/19
4.	Design and implement a performance dashboard for the All New Zealand Acute Coronary Syndrome registry database by 30 September 2018[29]	Peer reviewed	NM	A

Atlas of Healthcare Variation[30]

			2017/18	2018/19
5.	New Atlas domains and updates to existing domains to focus on inequity in health service access by 30 June 2019	Peer reviewed	A	A

Quality and safety markers[31]

			2017/18	2018/19
6.	Develop and test a potential consumer engagement quality and safety marker by 30 June 2019	Peer reviewed	A	A

Legend

A = achieved NM = new measure NA = not achieved SA = substantially achieved

24. We consulted on advice and recommendations from the reports with parties that may be involved in implementing them.
25. Mortality review document *The Child & Youth Mortality Review Committee's 14th Data Report* published online in June 2019 and the other was health sector-focused report by the Family Violence Death Review Committee published as an article in the *International Journal of Mental Health*. The article was not published until July as it goes through a rigorous assessment before being published. For this reason, it was coded substantially achieved (SA).
26. In our quarter three report to the Ministry of Health, we highlighted that our deliverable for system-level early detection and response was unlikely to be met within the timeframe specified due to the high level of complexity of the work. Not peer reviewed in 2018/19 as project not completed.
27. This is a new measure for 2018/19 and not audited in the previous year.
28. Technical and clinical experts were consulted in the scoping project.
39. This is a new measure for 2018/19 and not audited in the previous year.
30. Peer reviewed by DHBs prior to release.
31. Peer reviewed by DHBs prior to release.

Output class 2: Improvement

One of our key statutory roles is to 'lend a helping hand' to the sector in improving the quality and safety of services. The Commission's improvement work advances our strategic priorities in tangible ways. There is an increasing focus on partnering with Māori leaders, non-governmental organisations, consumers and whānau. We work with our intelligence hub to guide specific indicators and measures to help test and implement our improvement work.

This work includes:

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

We use expertise in New Zealand and overseas to identify and learn from innovative quality and safety practices. We use a variety of approaches to share these practices with the sector, including establishing expert advisory groups with clinical leaders and enlisting the expertise of consumers and others as needed for our programmes. These groups are vital for linking with the sector, guiding the direction of programmes and providing clinical, consumer and/or technical advice.

We will seek to understand health inequities for Māori and other populations. We will partner with consumers and whānau, and use co-design and kaupapa Māori improvement methods in our improvement programmes.

Our performance measures

Engage consumers and providers as partners in care[32]

Measure	Target	2017/18	2018/19
7A. Deliver a co-design programme for consumer–provider teams focused on key providers by 30 June 2019	Results published online	A	A
7B. Deliver training and education for consumers to develop effective consumer leaders by June 2019[33]	Training and education are based on evidence and developed in partnership with consumers and whānau	NM	A

Expert advice, tools and guidance to support specific improvement programmes

Measure	Target	2017/18	2018/19
8. Provide expert advice, tools and guidance to the sector on:			
8A. Improve teamwork and communication in DHB operating theatres by 30 June 2019	Resources and tools are based on evidence and developed in partnership with consumers and whānau	A	A
8B. Reduce surgical site infections for people having hip, knee or cardiac surgery by 30 June 2019	Resources and tools are based on evidence and developed in partnership with consumers and whānau	A	A
8C. Implement patient, family and whānau escalation processes as part of patient deterioration recognition and response systems by 30 June 2019	Resources and tools are based on evidence and developed in partnership with consumers and whānau	A	A

32. Summaries of each project were published online and had been reviewed by Consumer Advisory Group before release.
33. This is a new measure and not audited in last financial year 2017/18.

Primary care improvement[34]

		2017/18	2018/19
9. Implement chosen Whakakotahi primary care improvement programmes for 2018/19 with a specific equity focus informed by by the Atlas of Healthcare Variation, and choose next set for 2019/20 by 30 June 2019	Programme evaluated	A	A

Mental health and addiction improvement programme[35]

		2017/18	2018/19
10A. Implement chosen mental health and addiction improvement programme with a particular equity focus for 2018/19, including work on the first two priority areas of zero seclusion and transitions, and choose next set for 2019/20 by 30 June 2019	Peer reviewed	A	A
10B. Investigate specific kaupapa Māori-driven mental health and addiction initiatives, to be scoped in 2018/19 and completed in 2019/20 by 30 June 2019[36]	Peer reviewed	NM	A

Aged residential care improvement

		2017/18	2018/19
11. Implement chosen initiatives in aged residential care by 30 June 2019[37]	Peer reviewed	A	A

Mortality review national conferences[38]

		2017/18	2018/19
12. Deliver at least two mortality review national conferences to share results and recommendations, both by 30 June 2019	Evaluation completed	A	A

Build sector capability in quality improvement, including leadership

		2017/18	2018/19
13. Strengthen improvement capability in the sector by establishing quality improvement networks and continued improvement facilitator training for 13A: mental health and addiction[39] and	Evaluation completed	A	A
13B. primary care, both by 30 June 2019[40]	Evaluation completed	A	A

Support implementation of the National Adverse Events Reporting Policy

		2017/18	2018/19
14. Continue to develop education and training to support the updated National Adverse Events Reporting Policy by 30 June 2019	Resources and tools are based on evidence and developed in partnership with consumers and whānau	A	A

Legend

A – achieved NM – new measure

34. Initial evaluation completed. Full evaluation expected in next financial year. Groups chosen in 2018/19 to commence in 2019/20.
35. Peer reviewed by DHBs and clinical experts.
36. Specific actions implementing zero seclusion and scoping for connecting care during 2018/19.
37. Initiatives for aged residential peer reviewed projects before implementing in 2018/19.
38. A national advisory workshop were bought together involving national representatives (CYMRC and PMMRC). A participant evaluation was completed and recommendations for improvement were shared in both conferences.
39. The mental health and addiction DHB staff who hold quality positions meet nationally three times a year as part of the quality improvement network (QIN). The facilitator course had 21 participants who undertook an improvement project on zero seclusion or connecting care. A participant evaluation was completed.
40. The primary care quality improvement facilitator course had 19 participants who began their course early 2019. The Commission funded 24 participants to complete a quality improvement advisor programme at Kō Awatea. A participant evaluation was completed.

Who we are | Ko wai mātou

Governance

The board

The Commission is governed by a board of eight members who are appointed by the Minister of Health and led by chair Professor Alan Merry. Three board committees supported the board's work in 2018/19.

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

As a Crown agency, we must uphold our responsibilities under Te Tiriti o Waitangi. We refer to Te Tiriti principles as described in the Ministry of Health's Māori health strategy *He Korowai Oranga* and the Royal Commission on Social Policy's interpretation of Te Tiriti.[41] The principles used in this strategy were:

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

These principles have underpinned the relationship between the Government and Māori under the Treaty of Waitangi and were used as a platform for our work in 2018/19. In the next year, we will be reviewing Te Whai Oranga – the Commission's Māori advancement strategy – alongside the Statement of Intent and moving towards an articles articulation to ensure a Te Tiriti framework underpins all the Commission's work.

The Commission works to improve the quality and outcomes of care for Māori and address systemic inequity, through all we do. We have formed broad networks of Māori advice to and through our work programmes. We are proactively seeking more Māori staff, and are building the capability of our current staff to understand and apply Te Tiriti principles and an equity lens to all their work.

Te Rōpū Māori is an external group that advises our board and chief executive on strategic issues, priorities and frameworks. The group also advises on our work programme and campaigns. Membership consists of up to six Māori health sector experts whose peers across the health and disability sector recognise them for their skills and knowledge. Te Rōpū also provides ongoing leadership in the development of Te Whai Oranga and oversees its implementation. Te Whai Oranga is a practical resource, linking strategic elements with practical examples and achievable goals.

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

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

Consumer Advisory Group

The Commission's board established the Consumer Advisory Group to advise the board and chief executive on strategic issues, priorities and frameworks. This includes advice from a consumer perspective, and a consumer view on health quality and safety. There are four members on the Consumer Advisory Group, and two of these identify as Māori.

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

Audit Committee

The Audit Committee, including an independent member, provided assurance and assistance to the board on our financial statements and internal control systems. The Audit Committee is made up of Andrew Boyd, Dame Alison Paterson, Dr Dale Bramley, Bevan Sloan and Karen Orsborn.

Our staff

Staff wellness

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

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

Wellness and safety support

We have a safety and wellness committee that oversees these areas for staff. We provide staff with discreet access to the employee assistance programme if they need it. We also offer staff free life and terminal illness insurance up to $100,000, and free trauma benefits up to $20,000.

In 2018/19 staff attended resilience workshops, and we provided clinical supervision for staff in the mortality review committees, due to the often-distressing nature of this work.

We fulfilled our obligations under the Health and Safety at Work Act 2015, and trained staff in the responsibilities set out in the Act. We provided emergency preparedness training to staff. To enable staff to carry out their role, the Commission provided financial assistance to high users of visual display units for eye tests and glasses or lenses.

Working in the health sector, we supported the fundamental difference good health makes to peoples' lives by promoting good health to our staff. We supported healthy lifestyles by providing readily available drinking and carbonated water, and fruit for staff twice weekly. We also have business–house sports teams, showers and changing rooms, and have offered introductions to yoga with an active staff participation rate in various social events. In 2018/19 we obtained low-cost access to a nearby gym for staff at our Wellington office.

Rainbow Connection group

In 2018/19 the Commission attained Rainbow Tick certification, which shows the organisation is progressive, inclusive and dynamic. The State Services Commission encourages all government agencies to seek certification.

Flexible working

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

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

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

Supporting career and personal development through training

We have a dedicated staff training budget and encourage staff to identify future education and training needs and undertake programmes relevant to their work. We arranged regular education and training opportunities for staff in 2018/19.

Staff are offered an 'Institute for Healthcare Improvement (IHI) passport' in quality improvement methodology training.

Training in cultural responsiveness and Te Tiriti o Waitangi

We offer both basic and intermediate te reo training for all staff and provide an opportunity to better understand Māori tikanga through marae visits, regular waiata and holding pōwhiri for new staff.

All staff are required to attend Te Tiriti o Waitangi training within their first year with the Commission. This is delivered by an external educator.

During the year, staff were offered training on the Health Equity Assessment Tool (HEAT). In June 2019, Te Arawhiti (the office of the Māori Crown Relations) provided a full-day introduction to engaging with Māori workshop to all staff and the board chair.

Staff also attended Kapasa Pacific Policy Analysis Tool and *Yavu – Foundation of Pacific Engagement* training.

An interagency health equity hub was established in 2016 for central health organisations interested in discussing strategic planning and implementation for equity, Māori health advancement and Te Tiriti o Waitangi. The Commission supports the chair and secretariat for this group. The hub, which meets quarterly, enables organisations to build their strategic capacity for equity and to test ideas.

Equal employment opportunity policies

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

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

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

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

Staff profile

As at 30 June 2019 the Commission had 80 staff members (70 full-time equivalents, FTEs). Sixty-four were full-time (50 in 2018) and 14 were part-time (18 in 2018). Fifty-three percent had more than two years of service with the Commission (65 percent in 2018). Eighteen percent of staff were fixed-term, up from 15 percent in 2018. Seventy-eight percent of the executive leadership team are female. We have increased our Māori workforce over the last year from 6 percent to 10 percent.

Gender and ethnicity	2019	2018
Female	74%	72%
Male	26%	28%
Māori	10%	6%
Pacific peoples	1%	1%
Asian	11%	3%
NZ European	64%	79%
Other ethnicity	14%	10%
Not declared	0%	0%
Age demographics	**2019**	**2018**
Age 20–29 years	8	7
Age 30–39 years	17	17
Age 40–49 years	24	17
Age 50–59 years	21	19
60+	10	8
People with disabilities	**2019**	**2018**
(Injury, illness or disability)	5%	6%

Remuneration

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

Statistics New Zealand provides measures of gender equity for employers. Our gender pay gap based on average salaries for 2018/19 is calculated at 7 percent (7.6 percent in 2018). This remains lower than the last reported public service average pay gap,[42] which was 12 percent in 2018. If the calculation takes median hourly earnings into account, the gap is 10 percent (12.9 percent in 2018). We are unable to calculate a 'motherhood penalty' total because we do not collect this level of personal detail from staff.

In 2018/19 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 of Health and kept 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 tapped into the considerable expertise in the sector and internationally and identified and learnt from existing innovative quality and safety practices. Of particular importance were our partnerships with DHBs, the Ministry of Health, the Health and Disability Commissioner, ACC, Te Tumu Whakarae, Te Arawhiti, professional colleges and associations, clinical leaders, consumers and consumer groups, and our developing partnership with Māori. We also continued to develop strong international links, so are well connected to innovation, evidence and advice from our colleagues overseas. Māori researchers and epidemiologists have provided invaluable input into the development, design and peer review of reports and publications. These are relationships and processes the Commission would like to grow and improve.

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

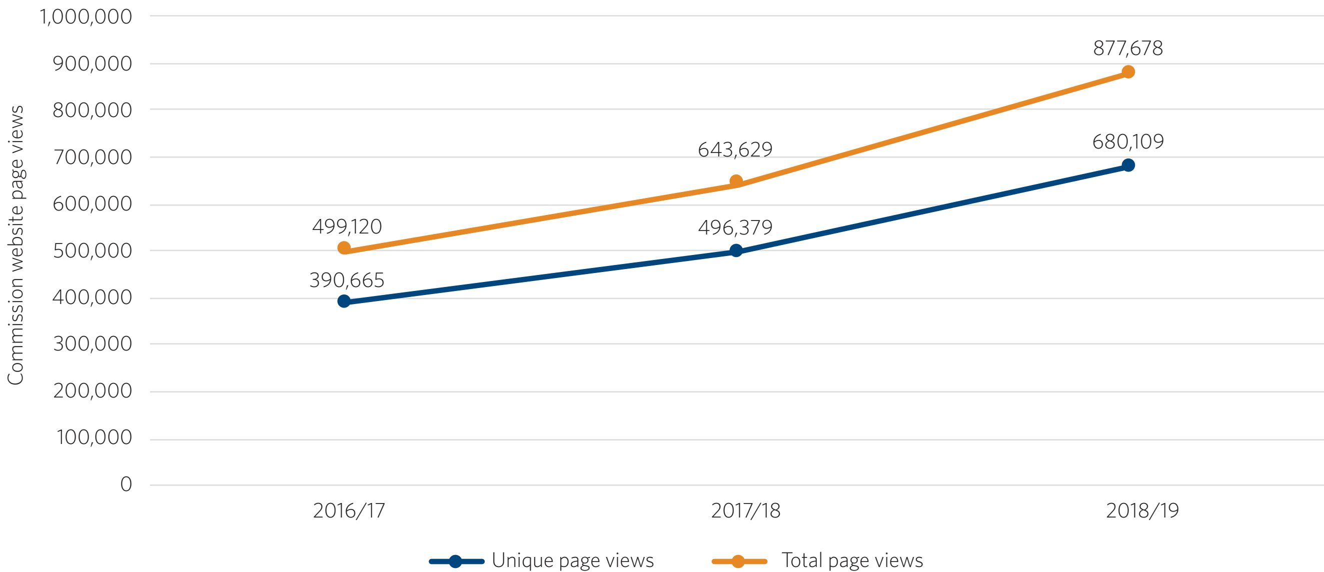
In 2018/19 we routinely engaged with the Ministry of Health in strategic planning and cooperation on joint work programmes. We also met with the Health and Disability Commissioner and ACC to support collaboration and joint planning.

42. https://ssc.govt.nz/assets/Legacy/resources/2018-Public-Service-Workforce-Data_pdf_0-v2.pdf

How we communicate

The Commission's communications team has a strategic overview of external communications, manages the Commission's relationship with the news media and raises awareness of the Commission's activities with equitable, accessible, high-quality communications.

Figure 5: Commission website page views, by financial year



This financial year's five most popular Atlas pages

Rank	Page	Page views
1	Diabetes	3,252
2	Asthma	2,178
3	Opioids	2,165
4	Polypharmacy	2,072
5	Falls	1,918

This financial year's 10 most popular publications and resources

Rank	Publication or resource	Page views
1	My advance care plan and guide	15,771
2	Patient story: Matthew Gunter	4,036
3	Family Violence Death Review Committee *Fifth Annual Report*	2,163
4	*Learning from adverse events report 2017/18*	2,112
5	Fight germs and win! Antibiotic awareness poster competition information pack	1,971
6	ALERT: Transdermal patches	1,738
7	*Twelfth Annual Report of the Perinatal and Maternal Mortality Review Committee*	1,552
8	*Learning from adverse events report 2016/17*	1,531
9	Presentations from the Hand Hygiene New Zealand workshop	1,361
10	Commission calendar of events	1,293

Strategic advice to government

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

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

Improving internal efficiency

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

Climate sustainability

The Commission is attempting to mitigate the effect of its air travel through carbon offsetting its flights and examining other means of reducing its carbon footprint, such as using Zoom video conferencing where possible and changes to internal catering policy.

Meeting our legal responsibilities

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

In 2018/19 we undertook two ComplyWith surveys for staff and one survey for board members. These continued to show a high level of overall legislative compliance with no material breaches.

In line with the whole-of-government approach agreed by Cabinet, we are required to report on our progress with implementing the New Zealand Business Number (NZBN). In 2018/19 we continued to use our NZBN (9429041905340). This number is included within our financial system documentation, and using it helps customers and suppliers get consistent information in our business interactions with them.

Risk management

The Commission maintained a risk management register in 2018/19. Risk and health and safety are a regular agenda item at both executive leadership team and board meetings.

Permission to act despite being interested in a matter

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

Revenue/expenses for output classes

	OUTPUT CLASS 1 Intelligence $000		OUTPUT CLASS 2 Improvement $000		TOTAL $000	
	Actual	Budget	Actual	Budget	Actual	Budget
Revenue						
Crown revenue	7,872	7,736	6,828	6,754	14,700	14,490
Interest revenue	28	18	32	22	60	40
Other revenue	203	70	2,886	2,589	3,089	2,659
Total revenue	**8,103**	**7,824**	**9,746**	**9,365**	**17,849**	**17,189**
Expenditure						
Operational and internal programme costs	5,503	5,209	7,345	6,984	12,848	12,193
External programme cost	2,884	2,715	2,553	2,631	5,437	5,346
Total expenditure	**8,387**	**7,924**	**9,898**	**9,615**	**18,285**	**17,539**
Surplus/(deficit)	(284)	(100)	(152)	(250)	(436)	(350)

Financial statements

Statement of comprehensive revenue and expenses for the year ended 30 June 2019

Actual 2018 $000		Notes	Actual 2019 $000	Budget 2019 $000
	Revenue			
14,895	Revenue from Crown	2	14,700	14,490
63	Interest revenue		60	40
3,677	Other revenue	3	3,089	2,659
18,635	**Total revenue**		**17,849**	**17,189**
	Expenditure			
8,709	Personnel costs	4	9,635	9,594
143	Depreciation and amortisation	12,13	191	150
3,004	Other expenses	6	3,022	2,450
3,935	External quality and safety programmes		3,545	3,391
1,673	External mortality programmes		1,892	1,954
17,465	Total expenditure		**18,285**	**17,539**
1,170	**Surplus/(deficit)**		**(436)**	**(350)**
0	Other comprehensive revenue		0	0
1,170	**Total comprehensive revenue**		**(436)**	**(350)**

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

Statement of financial position as at 30 June 2019

Actual 2018 $000		Notes	Actual 2019 $000	Budget 2019 $000
	Assets			
	Current assets			
2,699	Cash and cash equivalents	7	2,215	1,750
226	GST receivable		157	299
540	Debtors and other receivables	8	802	355
71	Prepayments		128	55
3,536	**Total current assets**		**3,302**	**2,459**
	Non-current assets			
408	Property, plant and equipment	12	367	247
21	Intangible assets	13	0	42
429	**Total non-current assets**		**367**	**289**
3,965	**Total assets**		**3,669**	**2,748**
	Liabilities			
	Current liabilities			
1,277	Creditors and other payables	14	1,365	1,138
398	Employee entitlements	16	426	464
1,675	**Total current liabilities**		**1,791**	**1,602**
	Non-current liabilities			
66	Employee entitlements	16	**90**	**90**
66	**Total non-current liabilities**		**90**	**90**
1,741	**Total liabilities**		**1,881**	**1,692**
2,224	**Net assets**		**1,788**	**1,056**
	Equity			
554	General funds July		1,724	906
500	Contributed capital	17	500	500
1,170	Surplus/(deficit)		(436)	(350)
2,224	**Total equity**		**1,788**	**1,056**

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

Statement of changes in equity for the year ended 30 June 2019

Actual 2018 $000		Notes	Actual 2019 $000	Budget 2019 $000
554	Balance at 1 July		1,724	906
	Comprehensive revenue and expenses for the year			
1,170	Surplus/(deficit)		(436)	(350)
0	Owner transactions			
500	Capital contribution		500	500
2,224	**Balance at 30 June**	**17**	**1,788**	**1,056**

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

Statement of cash flows for the year ended 30 June 2019

Actual 2018 $000		Notes	Actual 2019 $000	Budget 2019 $000
	Cash flows from operating activities			
14,895	Receipts from Crown		14,700	14,490
3,328	Other revenue		2,856	2,534
63	Interest received		60	40
(9,134)	Payments to suppliers		(9,635)	(7,775)
(7,942)	Payments to employees		(8,403)	(9,526)
(21)	Goods and services tax (net)		69	22
1,189	Net cash flow from operating activities	18	(353)	(215)
	Cash flows from investing activities			
(279)	Purchase of property, plant and equipment		(131)	(150)
0	Purchase of intangible assets		0	0
(279)	Net cash flow from investing activities		(131)	(150)
	Cash flows from financing activities			
0	Capital contribution		0	0
0	Net cash flow from financing activities	17	0	0
910	**Net (decrease)/increase in cash and cash equivalents**		**(484)**	**(365)**
1,789	Cash and cash equivalents at the beginning of the year		2,699	2,115
2,699	**Cash and cash equivalents at the end of the year**	**7**	**2,215**	**1,750**

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

Notes to the financial statements

Note 1: Statement of accounting policies

REPORTING ENTITY

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

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

The financial statements for the Commission are for the year ended 30 June 2019 and were approved by the board on 21 October 2019.

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.

STANDARD EARLY ADOPTED

In line with the Financial Statements of the Government, the Commission has elected to early adopt PBE IFRS 9 Financial Instruments.

PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Information about the adoption of PBE IFRS 9 is provided in Note 30.

Statement of compliance

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

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

Measurement base

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

Functional and presentation currency

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

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 2018/19.

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 2018/19.

Property, plant and equipment

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

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

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

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

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

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

Depreciation

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

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

Intangibles

Software acquisition

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

Amortisation

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

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

Acquired computer software	3 years	33% SL

Impairment of property, plant and equipment, and intangible assets

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

Non-cash-generating assets

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

Goods and services tax

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Creditors and other payables

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

Employee entitlements

Short-term employee entitlements

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

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Note 2: Revenue from the Crown

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

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

An additional $0.210 million was received, consisting of:

- $0.135 million from the Ministry of Health for Patient Experience Survey
- $0.075 million from the Ministry of Health for bowel screening review.

Note 3: Other revenue

Total other revenue received was $3.089 million (2018: $3.677m), consisting of:

- $1.500 million (2018: $1.500m) from DHBs for the mental health and addiction quality improvement programme
- $0.793 million (2018: $0.956m) from DHBs for the advance care planning programme
- $0.243 million (2018: $0.621m) from ACC and DHBs for infection prevention and control
- $0.068 million (2018: $0.142m) from additional workshop and event revenue
- $0.149 million (2018: $0.000m) from ACC for the trauma network
- $0.109 million (2018: $0.108m) from adverse events training workshops
- $0.018 million (2018: $0.104m) from ACC for development of a falls dashboard
- $0.015 million (2018: $0.080m) from ACC for Patient Safety Week
- $0.080 million (2018: $0.000m) from PHARMAC for primary care programmes
- $0.056 million (2018: $0.048m) from DHBs for patient experience question set licensing
- $0.038 million (2018: $0.000m) from ACC and PHARMAC towards behavioural insights measurement
- $0.008 million (2018: $0.000m) insurance payment
- $0.012 million other revenue.

Note 4: Personnel costs

	Actual 2018 $000	Actual 2019 $000
Salaries and wages	7,931	8,456
Recruitment	68	98
Temporary personnel	411	687
Membership, professional fees and staff training and development	155	131
Defined contribution plan employer contributions	158	192
Increase/(decrease) in employee entitlements	(13)	71
Total personnel costs	**8,709**	**9,635**

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 2018 $000	Actual 2019 $000
Audit fees to Audit NZ for financial audit	30	36
Staff travel and accommodation	423	356
Printing/communications	220	173
Consultants and contractors	410	455
Board costs/mortality review committees	802	732
Lease rental	400	417
Outsourced corporate services and overhead	713	818
Loss on property, plant and equipment	2	27
Other expenses	4	8
Total other expenses	**3,004**	**3,022**

Note 7: Cash and equivalents

	Actual 2018 $000	Actual 2019 $000
Cash at bank and on hand	2,699	2,215
Total cash and cash equivalents	**2,699**	**2,215**

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 2018 $000	Actual 2019 $000
Debtors and other receivables	540	802
Less: provision for impairment	0	0
Total debtors and other receivables	**540**	**802**

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 2018/19.

Note 11: Non-current assets held for sale

The Commission has no current or non-current assets held for sale in 2018/19.

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 2017	257	334	53	644
Additions	268	11	0	279
Disposals	0	(4)	0	(4)
Balance at 30 June 2018/1 July 2018	525	341	53	919
Additions	84	40	32	156
Disposals	(212)	0	0	(212)
Balance at 30 June 2019	397	381	85	863
Accumulated depreciation and impairment losses				
Balance at 1 July 2017	169	213	12	394
Depreciation expense	68	41	12	121
Elimination on disposal	0	(4)	0	(4)
Balance at 30 June 2018/1 July 2018	237	250	24	511
Depreciation expense	124	45	16	185
Elimination on disposal	(200)	0	0	(200)
Balance at 30 June 2019	161	295	40	496
Carrying amounts				
At 1 July 2017	88	121	41	250
At 30 June and 1 July 2018	288	91	29	408
At 30 June 2019	236	86	45	367

The Commission does not own any buildings or motor vehicles.

Note 13: Intangible assets

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

	Acquired software $000
Cost	
Balance at 1 July 2017	138
Additions	0
Disposals	(19)
Balance at 30 June 2018/1 July 2018	119
Additions	0
Disposals	(118)
Balance at 30 June 2019	1
Accumulated amortisation and impairment losses	
Balance at 1 July 2017	95
Amortisation expenses	22
Elimination on disposal	(19)
Balance at 30 June 2018/1 July 2018	98
Amortisation expenses	6
Elimination on disposal	(103)
Balance at 30 June 2019	1
Carrying amounts	
At 1 July 2017	43
At 30 June and 1 July 2018	21
At 30 June 2019	0

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

Note 14: Creditors and other payables

	Actual 2018 $000	Actual 2019 $000
Creditors	610	609
Accrued expenses	663	752
Other payables	4	4
Total creditors and other payables	**1,277**	**1,365**

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 2018 $000	Actual 2019 $000
Current portion		
Accrued salaries and wages	88	69
Annual leave and long-service leave	310	357
Total current portion	398	426
Non-current portion long-service leave	66	90
Total employee entitlements	**464**	**516**

No provision for sick leave or retirement leave has been made in 2018/19. Provision for long-service leave has been made in 2018/19.

Note 17: Equity

	Actual 2018 $000	Actual 2019 $000
General funds		
Balance at 1 July	554	1,724
Surplus/(deficit) for the year	1,170	(436)
Capital contributions	500	500
Balance at 30 June	**2,224**	**1,788**

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 2018 $000	Actual 2019 $000
Net surplus/(deficit)	1,170	(436)
Add/(less) movements in statement of financial position items		
Debtors and other receivables	(370)	(164)
Creditors and other payables	219	59
Depreciation	143	191
Prepayments	38	(56)
Employee entitlements	(11)	53
Net movements in working capital		
Net cash flow from operating activities	1,189	(353)

Note 19: Capital commitments and operating leases

Capital commitments

There were no capital commitments at balance date (2018: nil).

Operating leases as lessee

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

	Actual 2018 $000	Actual 2019 $000
Not later than one year	334	314
Later than one year and not later than five years	549	235
Later than five years	0	0
Total non-cancellable operating leases	**883**	**549**

At balance date the Commission leases a property (from 1 March 2014) at Levels 8 and 9, 17 Whitmore Street, Wellington. The lease expires in March 2021 with one-year right of renewal. The value of the lease to March 2021 is $0.549 million.

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

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

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

Note 20: Contingencies

Contingent liabilities

The Commission has no contingent liabilities (2018: $nil).

Contingent assets

The Commission has no contingent assets (2018: $nil).

Note 21: Related party transactions

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

The Commission is a wholly owned entity of the Crown.

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

Key management personnel

Salaries and other short-term employee benefits to key management personnel[43] totalled $1.15 million (2018; $1.13m).

43. Key management personnel for 2018/19 include the chief executive; director, health quality 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 2018/19 year was as follows:

	Actual 2018 $000	Actual 2019 $000
Prof Alan Merry* (Chair)	29	29
Shelley Frost (Deputy Chair)	18	8
Dr Bev O'Keefe*	15	15
Dame Alison Paterson	15	15
Dr Dale Bramley* (Deputy Chair)	15	17
Robert Henderson*	15	15
Mr Andrew Connolly	0	9
Gwendoline Tepania-Palmer	15	15
Dr Gloria Johnson*	15	15
Total board member remuneration	**137**	**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 2018	Employees 2019
$100,000-$109,999	6	3
$110,000-$119,999	6	8
$120,000-$129,999	8	7
$130,000-$139,999	1	3
$140,000-$149,999	0	1
$150,000-$159,999	1	2
$160,000-$169,999	3	1
$170,000-$179,999	2	3
$180,000-$189,999	0	1
$190,000-$199,999	0	0
$200,000-$209,999	0	0
$210,000-$219,999	2	0
$220,000-$229,999	0	2
$230,000-$239,999	0	0
$240,000-$249,999	1	1
$250,000-$259,999	1	0
$260,000-$269,999	0	1
$270,000-$279,999	0	1
$280,000-$289,999	0	0
$290,000-$299,999	0	0
$300,000-$309,999	1	0
$400,000-$409,999	1	0
$410,000-$419,999	0	1
Total employees	**33**	**35**

During the year ended 30 June 2019 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 2018/19 Statement of Performance Expectations follow.

Statement of comprehensive revenue and expenses

The year-end result for the year to 30 June 2019 is a $0.436 million deficit against a planned Statement of Performance Expectations deficit of $0.350 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 due to the timing of suicide mortality review programme activity.

Increases in other expenses are associated with travel, printing, communications, contractors, advisory groups, leasing costs, information technology (IT) support and software licensing for the additional staff required to deliver on the additional revenue during 2018/19.

Statement of financial position

Cash and cash equivalents were higher than budgeted due to revenue to the value of $0.465 million received in both in 2017/18 and 2018/19 where the expenditure against this revenue will occur in 2019/20.

Property, plant and equipment expenditure was higher than planned as the Commission purchased additional laptops and new desk setups for the FTE growth over the financial year.

Statement of changes in cash flow

Because the Commission received an additional $0.660 million in revenue during the period, both revenue received and 'payment to suppliers and employees' are higher than budgeted figures.

Note 28: Acquisition of shares

Before the Commission subscribes for purchase or otherwise acquires shares in any company or other organisation, it will first obtain the written consent of the Minister of Health. The Commission did not acquire any such shares, 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 2018/19 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 2018/19 $000	Budget 2018/19 $000	Location of end-of-year performance information
Crown Funding (Vote Health – Monitoring and Protecting Health and Disability Consumer Interests (M36))	13,476	13,476	The end-of-year performance information for this appropriation is reported in the Statement of Performance as given in section 8.1.

The Commission also received Crown funding of:

- $0.750 million from Vote Health – Mental Health
- $0.290 million from Vote Health – National Personal Health Services
- $0.184 million from Vote Health – Primary Health Care Strategy.

Note 30: Adoption of PBE IFRS 9 Financial Instruments

Accounting policies have been updated to comply with PBE IFRS 9. The main updates are:

- Note 8 Receivables: This policy has been updated to reflect that the impairment of short-term receivables is now determined by applying an expected credit loss model.
- Note 9 Investments:
  - Equity investments: This policy has been updated to remove references to impairment losses, as NZ IFRS 9 no longer requires identification of impairment for equity investments measured at fair value through other comprehensive revenue and expense. Also, on disposal, the accumulated gains/losses are no longer transferred to surplus/(deficit) but are transferred to accumulated surplus/(deficit).
  - Term deposits: This policy has been updated to explain that a loss allowance for expected credit losses is recognised only if the estimated loss allowance is not trivial.

Any changes for 2018/19 were trivial and no adjustments have been made to cash at bank or on hand, Receivables or Derivative financial instruments. The Commission had no Investments or Term deposits in 2017/18 or 2018/19.

The measurement categories and carrying amounts for financial liabilities have not changed between the closing 30 June 2018 and opening 1 July 2018 dates as a result of the transition to PBE IFRS 9.

Statement of responsibility | Te whakapuakitanga kawenga

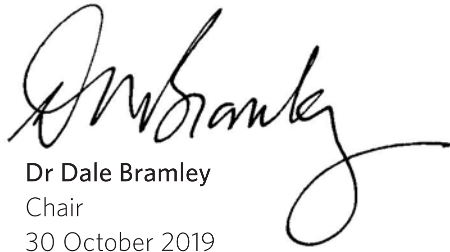
The board is responsible for the preparation of the Commission's financial statements and statement of performance, and for the judgements made in them.

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

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

In the board's opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Commission for the year ended 30 June 2019.

Signed on behalf of the board:



Dr Dale Bramley
Chair
30 October 2019

Dame Alison Paterson
Chair Audit Committee
30 October 2019

Auditor's report | Te pūrongo a te kaiarotake

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of the Health Quality & Safety Commission's financial statements and performance information for the year ended 30 June 2019

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

Opinion

We have audited:

- the financial statements of the Commission on pages 44 to 59, that comprise the statement of financial position as at 30 June 2019, 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 7 to 31 and 32 to 36.

In our opinion:

- the financial statements of the Commission on pages 44 to 59:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2019; 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 Accounting Standards Reduced Disclosure Regime; and
- the performance information on pages 7 to 31 and 32 to 36:
  - presents fairly, in all material respects, the Commission's performance for the year ended 30 June 2019, 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 30 October 2019. 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 Board, or there is no realistic alternative but to do so.

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

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

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 6, and 37 to 43, and 60 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

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