HEALTH QUALITY AND SAFETY COMMISSION

10 November 2010 to 30 June 2011

Annual Report 2011

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Health Quality and Safety Commission

Chair's Report

In this, the Health Quality and Safety Commission's first year, we have made great progress in establishing ourselves as a credible organisation in the sector, accelerating work on existing health quality and safety programmes, and setting the scene for significant gains in our second year.

Key achievements

- Progress on reducing preventable errors and harm, deaths and costs that result from medication error, and through medication safety initiatives. Thirty-five percent of major secondary/tertiary public hospitals have started using the national medication chart and 58 percent have introduced a formal medicines reconciliation process.
- Progress on infection prevention and control programmes to reduce the harm and cost of avoidable infection. Our initial focus has been on hand hygiene as well as central line associated bacteraemia and surgical site infection.
- Highlighting priorities and identifying approaches that work through quality and safety reports, including the serious and sentinel events report *Making Our Hospitals Safer* and mortality review committee reports.
- Supporting a programme to help consumers understand the alternatives available to them and how to choose the options that best meet their individual needs and wishes.
- Engaging strong clinical leadership in our key work programmes and developing clinical support for our work.

The sector has been eager to welcome the new Commission and is increasingly looking to us for guidance and leadership.

As well as progressing our work programme, we have established ourselves as a fully functional organisation. When we were set up in November 2010 we had a Board, a bank account and a few seconded staff; by the end of June 2011 we had key staff in place and a structure appropriate to the 'decentralised' way that we work. We were well into the process of moving into our new premises and had successfully brought together several functions from other agencies, including the four mortality review committees and the Medication Safety Programme. Bringing these programmes under one umbrella has been particularly valuable and has enabled mutual learning and support that was not possible before.

These achievements, and others, are outlined in more detail in section 3 of this report.

Professor Alan Merry

Dr Janice Wilson, our Chief Executive, has an outstanding track record of achievement in the sector. The Board is confident she will work effectively with others in the sector to achieve the sustainable process of continuous improvement needed to keep us at the forefront of quality and safety standards internationally. We thank our staff and the many people from the sector who have engaged with us and provided us with guidance. Finally, we thank the Chairs and members of the mortality review committees who joined the Commission in April this year and who are now an integral part of our organisation. Their work is critical to informing and monitoring our activities.

What next?

Our work plan for 2011/12 is ambitious. It includes specific quality and safety programmes and work to embed an improved culture of safety and quality in the sector. We will increasingly include public, private and non-government organisation (NGO) providers, and the primary care, hospital, aged care, mental health and disability support sectors in our activities.

The Government has clearly signalled its desire for a more efficient and effective health sector and wants the Commission to play a role in achieving this. By working with the sector to 'do the right thing, and do it right the first time' we can save and improve lives, reduce waste and provide better value for money. Money saved in one area can be used in another, providing more of the services consumers really need.

This is the challenge we have set ourselves for 2011/12 and future years.

Professor Alan Merry, ONZM
Chair
Health Quality and Safety Commission

Statement of Responsibility

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

The Board of the Health Quality and Safety Commission has the responsibility 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 the statement of service performance fairly reflect the financial position and operations of the Health Quality and Safety Commission for the year ended 30 June 2011.

Signed on behalf of the Board:

Professor Alan Merry, ONZM
Chair
28 October 2011

Dr Peter Foley
Deputy Chair
28 October 2011

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Part One

1.0 The Health Quality and Safety Commission

Background

The Commission was established as a Crown entity under the New Zealand Public Health and Disability Act 2000 (the Act) in November 2010. The Commission's establishment recognised the substantial human and financial costs associated with medical errors. There was concern that only modest improvements in quality and safety had been achieved, and experts argued that a strong mandate to drive quality-related activities, greater co-ordination of appropriate quality interventions at a national level, and strong clinical engagement, was pivotal to achieving substantial quality gains.

Objectives and outcomes

The Commission's objectives, as set out in legislation, are to lead and co-ordinate work across the health and disability sector for the purposes of:

- monitoring and improving the quality and safety of health and disability support services
- helping providers across the health and disability sector to improve the quality and safety of health and disability support services.

The Commission is also required to advise the Minister on the quality and safety of health and disability support services and on mortality in general.

The Commission has collaborated with the National Health Board to develop the shared overall outcomes expressed in a modification for New Zealand of the 'Triple Aim' of the Institute for Health Care Improvement (a not-for-profit organisation based in the USA that has gained international respect for its initiatives to improve health care). Our shared overarching objective is the simultaneous pursuit of three aims.

- Improved quality, safety and experience of care.
- Improved health and equity for all populations.
- Best value from public health system resources.

Achieving these outcomes will contribute to the broader Government health and disability system outcomes which are for all 'New Zealanders to lead longer, healthier and more independent lives' and that 'New Zealand's economic growth is supported'.

Our core functions

To achieve the Triple Aim the Commission grouped its activities into three distinct lines of business or output classes. Our intentions for these three output classes are articulated in the 2010 to 2013 Statement of Intent.

1. Information, analysis, prioritisation and advice

As required by legislation, the Commission will determine quality and safety indicators and use them to measure the quality and safety of health and disability support services. We will provide a clear picture of sector performance over time through national and international benchmarking. We will highlight system-wide, local and regional issues and opportunities for improvement, and identify practical indicators of progress in addressing these.

2. Sector tools, techniques and methodologies

The Commission will fund and support programmes to help providers improve the quality and safety of services. This includes programmes to reduce patient harm and economic waste from adverse events such as hospital-acquired infections and errors in medication. We will prioritise and develop new programmes (in consultation with all appropriate sectors) for health and disability services, including the primary, hospital, aged care, mental health, child and youth, and disability sectors.

3. Influencing quality and safety practice

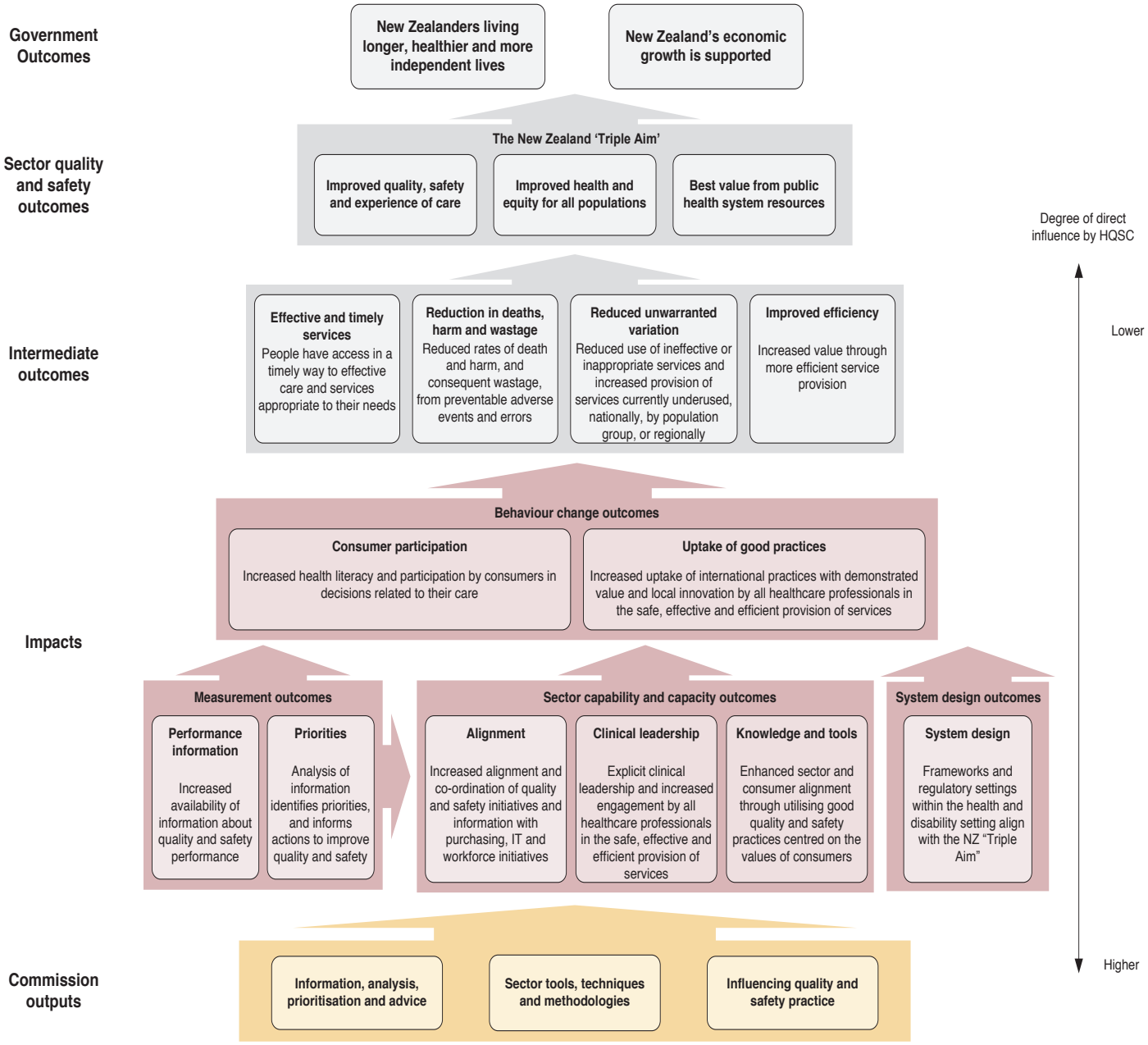
The Commission influences change through its work with clinicians and consumers and through ongoing engagement and communication with the sector to share learnings, encourage leadership of change from within the sector, align information and sector activities and reduce duplication.

We will support and co-ordinate leadership in health and disability services, and promote regular sharing of information about quality and safety.

We are required to ensure the sector works more actively and effectively with consumers, so they have meaningful input into issues that affect them and make choices based on their own needs and values. Our initial focus is to work out what would help service users participate more fully in the design and evaluation of service delivery, and to develop resources to improve health literacy.

Outcomes framework

This framework shows how the Commission's work contributes to achieving the sector quality and safety outcomes, and ultimately, the Government's outcomes.



2.0 Progress towards achieving our impacts and outcomes

Assessing impact to date

There are some early signs our work is starting to achieve the desired impact and intermediate outcomes in the outcomes framework.

Our work	Impact/outcomes
Medication safety (including rolling out the national medication chart and the medicines reconciliation process in hospitals).	This is resulting in *'uptake of good practices'*, and will, over time, reduce the harm and cost of avoidable medication errors.
Infection control and the surgical checklist.	This is a key first step towards the *'uptake of good practices'* impact and will, over time, reduce the harm and cost of avoidable infection.
Setting the platform for more effective consumer engagement and building consumer capacity and capability.	This is a key first step in a more deliberate and organised approach towards achieving the *'consumer participation'* impact.
National policy and guidelines for reporting and management of health care incidents.	This contributes to the '*system design*' impact and will assist in identifying, understanding and rectifying systemic issues and developing a learning culture.
Mortality review committee and serious and sentinel events reports.	These reports contribute to '*uptake of good practice*' by highlighting priorities for action.

During the year we started developing a prioritisation framework to help us make decisions about current and future work programmes, campaigns and funding. The criteria will focus on achieving our outcomes as well as evidence of effectiveness, consumer orientation and value for money. The work and discussion on this framework during the year is an important step toward achieving our outcomes.

We also began developing a set of health quality and safety indicators which will be used to demonstrate and motivate success across the sector, and will provide time series information to track performance toward our intended impacts and outcomes.

Evaluation

All our key programmes will be evaluated. This will usually include an economic analysis as well as an assessment of the programme's impact on:

- reducing avoidable deaths, harm and wastage
- improving health outcomes
- improving equity
- improving value for money.

We will also use consumer satisfaction surveys, audits based on random sampling methods and other tools to show improvements in consumers' satisfaction with their health care experiences and treatment.

Future impact assessment

Cabinet directed the Ministry of Health to evaluate the impact of the Commission's activities in 2015. We will work with the Ministry of Health to demonstrate that better health care quality delivers better value and supports the viability of the health and disability system. We have commissioned and received a report which provides guidance on the methodologies and approaches that could be used to demonstrate how the Commission adds value to the sector.

3.0 Operational review 2010/11

3.1 Output class 1: Information, analysis, prioritisation and advice

Public reports

One of our key functions is to provide public reports on the quality and safety of health and disability support services which identify priorities and opportunities for improvement. By having a clear picture of sector quality and safety available over time, the Commission can highlight system-wide priorities for improvement nationally, regionally and locally. Used wisely, the reports encourage discussion and promote learning.

Two major reports were published:

- the serious and sentinel events[1] (2009/10) report *Making Our Hospitals Safer*. The report has a particular focus on falls, clinical management and suicide and notes that,

  'the total number of incidents is not the focus of this report; rather it is changes in patterns, and how we might learn to prevent similar incidents in the future.'

  To demonstrate this, the report outlines improvements made as a result of lessons learnt from past serious and sentinel events, demonstrating the influence that sharing this type of information can have on changing practice

We also made progress on a number of other public reports which will be published during 2011/12 and will stimulate further debate and change.

- The first report against national and international measures and indicators of quality and safety which will be produced by 30 June 2012. We have gathered information on how other countries measure quality and safety within their systems, what is currently reported in New Zealand and what information is easily accessible from national collections.

- The first health care variation report which will identify unwarranted health care outcomes and practices. Variation reporting is designed to encourage discussion by clinicians about good practice and contributes to consumers getting appropriate treatment regardless of who their practitioner is or where they live.

- Mortality review committee reports which will provide information on deaths with a view to preventing those that are avoidable in future:
  - the Child and Youth Mortality Review Committee report *Low Speed Run Over Mortality*. The report, published in August 2011, identified that most low speed run over deaths happen in driveways and involve children under six years old. The report made recommendations

He matenga ohorere, he wairua uiui, wairua mutanga-kore.

The grief of a sudden, untimely death will never be forgotten.

- the Perinatal and Maternal Mortality Review Committee report. The report estimates the numbers and rates of perinatal and maternal deaths, describes risk factors and seeks to identify where the attention of maternity and neonatal services might be best focused to reduce the preventable proportion of these very sad events.

  - the Child and Youth Mortality Review Committee report *The Involvement of Alcohol Consumption in the Deaths of Children and Young People in New Zealand during the years 2005–2007*. The report, published in September 2011, highlighted the strong contribution of alcohol to the dramatic increase in the rate of death

1 A serious event is one that requires significant additional treatment, but is not life threatening and has not resulted in a major loss of function. A sentinel event is life threatening or has led to an unanticipated death or major loss of function.

by injury after the age of 15 and made recommendations
  - the Perinatal and Maternal Mortality Review Committee report. The report, published in July 2011, identified that there is clearly more to do for teenage mothers and those having a baby against a background of deprivation
  - the Family Violence Death Review Committee Report which will focus on deaths resulting from family violence
  - the inaugural Perioperative Mortality Review Committee Report which will focus on deaths following invasive procedures and anaesthesia.

Reporting and management of health care incidents

A New Zealand report suggested that 12.9 percent of hospital admissions were associated with an adverse event, although many of these events were relatively minor[2]. About half of these events are thought to be preventable. This preventable harm produces substantial human and financial cost.

The purpose of reporting and managing health care incidents is to increase patient safety in health and disability services by:

- increasing awareness and understanding of the frequency and type of preventable serious incidents occurring in New Zealand's health system
- identifying, understanding and rectifying systemic issues
- developing a learning culture within health and disability services settings, not a punitive or blaming one.

We became the host national agency for supporting health incident reporting and learning, and worked with the sector to test a national reportable events policy and guidelines which were in draft form (but being used) since 2008. The final policy and guidelines will be rolled out sector-wide – extending across primary care, aged residential care, disability services, NGOs and pharmacies from January 2012. The Commission will support implementation of the policy and guidelines by education and skills training based on a train-the-trainer model.

Measuring consumer experiences

The Commission provided project support to the District Health Board (DHB) quality and risk managers in reviewing the national inpatient satisfaction survey. The vision for the project is:

> ***'that the consumer experience of health and disability service delivery drives change designed to continually improve that experience.'***

During 2011/12 our work with DHBs on reviewing the survey will be complete and we expect new measures, covering a wider range of health care settings, will be introduced in 2012/13.

Trigger tool surveillance

Trigger tools are clues to identify adverse events on medical records. They help organisations track and learn from their behaviours over time. The tools identify actual harm or injury to patients rather than errors or potential harm. We have investigated the use of trigger tools and plan to initially support those DHBs which are currently implementing the New Zealand version of the Global Trigger Tool. We will also support use of the medication safety module of the Global Trigger Tool as part of the evaluation framework for the Medication Safety Programme, initially in the four 'centres of excellence' for medication safety.

2 Davis P, Lay-Yee R, Briant R, Ali W, Scott A, Schug S. Adverse events in New Zealand public hospitals 1: occurrence and impact. *NZ Med J* 2002; 115:U271.

3.2 Output class 2: Sector tools, techniques and methodologies

Much of the Commission's work is about leading, supporting or participating in programmes of work to develop good sector practice and capability in key areas of concern. This will lead to less waste, fewer deaths and less harm, as well as greater understanding of, and commitment to, the process of quality improvement.

We made progress in the following areas.

Medication Safety

The Medication Safety Programme aims to reduce harm from medication errors and increase the efficiency and integrity of medication management systems. Medication errors are an ongoing and potentially serious cause of patient harm. Estimates vary, but somewhere between 2 and 13 percent of patients admitted to hospital are estimated to have an adverse drug event of some description.[3]

> ***A patient was given too much insulin, causing her to have severely low blood sugar levels. Low blood sugar levels can cause brain damage or even death.***
>
> ***After a medication error, a patient developed a slow heart rhythm and low blood pressure. He suffered a cardiac arrest, but responded to emergency treatment.[4]***

As well as potential for reducing harm and even death from medication errors, there is potential for substantial financial savings.

The first step in the programme has been the rollout of:

- the paper-based national adult medication chart which is a simple but effective way of reducing medication errors (including a pre-printed decimal point to avoid 'classic' ten-fold errors in dose due to illegible prescribing and misunderstandings about dosage)
- medicines reconciliation which ensures that patient medicines are checked at critical handover times, such as when patients are admitted to or discharged from hospital.

Targets were established for rollout of these projects and these have been exceeded. Thirty-five percent (target 25 percent) of major public hospitals have begun introducing the national medication chart and 58 percent (target 50 percent) have initiated the medicines reconciliation process. It has been a phased approach and the Commission continues to work closely with DHBs to help them roll out these two projects.

It is making a difference.

The Commission has also provided funding to four DHBs (Southern, Taranaki, Counties Manukau and Waitemata) to continue the pilot projects on electronic medicine reconciliation, electronic charting and administration and the integration of an end-to-end electronic solution for a patient's medical record.

Although the Commission is the lead agency for medication safety, the programme has a representative stakeholder governance, advisory and operational structure with strong clinical leadership.

Physician and clinical pharmacologist Dr Chris Cameron, who chairs the medicines committee at Capital and Coast DHB, says seeing how many medication omissions and adverse events have been picked up since the medicines reconciliation process was introduced has been surprising.

"We are getting much better, accurate and reliable information now about the medicines patients are on when they come into the hospital. It's a fantastic system."

3 Øvretveit J. 2009. *Does improving quality save money? A review of evidence of which improvements to quality reduce costs to health service providers.* London: The Health Foundation.

4 Health Quality & Safety Commission. 2010. *Making Our Hospitals Safer: Serious and Sentinel Events 2009/10.* Wellington: HQSC.

Infection Prevention and Control

Dr Sally Roberts (Clinical Lead for the Infection Prevention and Control Programme)

The Infection Prevention and Control Programme aims to reduce the harm and cost associated with preventable infection. Each case of hospital-acquired infection can cost an additional $20,000 to $45,000, depending on the severity of the infection and the treatment needed.[5]

During the year the Commission assumed the lead for supporting the sector's implementation of these programmes. The initial focus has been on the national Hand Hygiene Programme, central line bacteraemia prevention and control (CLAB) and surgical site infection surveillance.

Following a tender process, we selected providers to manage the Hand Hygiene Programme and the CLAB programme, and work began early in 2011/12. In the meantime, the Hand Hygiene Programme continued to progress, largely due to the goodwill and perseverance of hand hygiene auditors and coordinators in DHBs as well as Auckland DHB's continuing data management services.

A cost-benefit analysis of a proposed national surgical site infection surveillance and response programme was completed and we have decided to go ahead with the programme. The cost-benefit analysis estimates that over a 10-year period between 473 and 3,641 surgical site infections and between 14 and 109 deaths could be avoided. By year 10, annual savings could be between $1.1 million and $11 million. Clinical leadership is a key to success and an advisory group has been formed to lead this work.

Surgical Checklist

Dr Leona Wilson (Clinical Lead for the Surgical Checklist Programme)

About half of surgical complications are considered preventable.[6] This includes events related to wrong patient, site or procedure and retained instruments or swabs.

A patient undergoing cervical spine surgery had the wrong level fused.

A swab was left in a patient after surgery because of an incorrect count: a second operation was needed to remove it.[7]

Use of the World Health Organization (WHO) Safe Surgery Checklist in New Zealand has already substantially reduced the harm associated with surgery.

We surveyed all DHBs on the use of the checklist in DHB operating theatres. Implementation varies across DHBs and it is evident that we are not yet achieving the full potential of this very effective and evidence-based technique. We will support implementation through a

Promoting hand hygiene in Starship Hospital's newborn intensive care unit (NICU) is paying off with greater compliance and fewer infections. Over the last three years there has been a reduction of between 20 and 25 percent in late onset infections.

The NICU had 61 percent hand hygiene compliance when it was chosen as one of Auckland DHB's pilot sites for the hand hygiene rollout. A year and a half later compliance is being maintained at 88 to 91 percent.

Charge Nurse Manager Dale Garton says 'there's hand gel everywhere now. Before we used to wash our hands in the sinks but now we use the gel all the time. It's so effective and we have it throughout the unit. We've also noticed that parents are coming onto the ward and following our lead. They're washing their hands much more, which is fantastic'.

5 Evaluation of the Middlemore Hospital ICU's implementation of the standardised checklist of interventions, 'the Central Line Bundle' to prevent catheter-related blood stream infection.

6 Gawande AA, Thomas EJ, Zinner MJ, Brennan TA. The incidence and nature of surgical adverse events in Colorado and Utah in 1992. *Surgery* 1999;126:66-75 and Kable AK, Gibberd RW, Spigelman AD. Adverse events in surgical patients in Australia. *Int J Qual Health Care* 2002;14:269-276.

7 Health Quality & Safety Commission. 2010. *Making Our Hospitals Safer: Serious and Sentinel Events 2009/10.* Wellington: HQSC.

variety of means, including appointment of a clinical champion for the checklist, establishing an advisory group, linking in with experts and networks, promotion, and measuring compliance and patient outcomes.

Reducing falls resulting in injury in public hospitals

Falls were the largest category of serious and sentinel events reported by hospitals in 2009/10 at 34 percent of all events. Three percent resulted in deaths.

> ***A patient slipped on the wet hospital floor and fractured her hip. She required surgery and a longer stay in hospital for rehabilitation.***
>
> ***A patient was found on a hospital floor with a fractured ankle following a fall. Surgery was not required but he needed a longer stay in hospital.[8]***

During the year the Commission surveyed all DHBs to ascertain what activities to reduce falls are underway in the sector. Many DHBs have implemented or improved falls prevention programmes.

The Commission has adopted the Canterbury DHB model for falls prevention in inpatient, residential and community settings. The next step is to work with Canterbury DHB, Accident Compensation Corporation (ACC) and the Ministry of Health to develop implementation plans for the various parts of the sector over time.

Canterbury DHB: Alison Gallant, Charge Nurse Manager, Ward 31, fills in one of the patient safety crosses. Patient safety crosses mark how many days it has been since the last patient fall. The location maps show where falls are occurring, identifying higher-risk areas that can be made safer.

8 Health Quality & Safety Commission. 2010. *Making Our Hospitals Safer: Serious and Sentinel Events 2009/10.* Wellington: HQSC.

3.3 Output class 3: Influencing quality and safety practice

The Commission supports strong leadership and partnership for influencing change through:

- its work with clinicians and consumers
- ongoing engagement and communication with the sector to share learnings, align information and sector activities and reduce duplication.

We also have an important role in facilitating and supporting innovation in the sector and creating a 'learning system'. We have made progress in the following areas.

Consumer partnership in the sector

Research suggests there are substantial benefits – including a reduction in harm, greater patient satisfaction and reduced costs – when consumers are actively involved in making decisions about their own health and disability services.

We entered into contracts to advance work on engaging consumers and building consumer capacity and capability. The outcome we are seeking is that consumers will understand the alternatives available to them and how to choose the options that best meet their individual needs and wishes.

Research New Zealand is doing a needs assessment of consumer organisations and individuals, and developing a directory with up-to-date contact details and information about the role, scope and spread of groups.

The New Zealand Guidelines Group is helping the Consumer Collaboration of Aotearoa to develop as a sustainable organisation with the capacity and capability to actively facilitate consumer engagement and to partner with health and disability providers and services. The New Zealand Guidelines Group will also review health literacy tools and resources on medication safety available in New Zealand.

Clinical champions

We need to engage with clinical leaders and champions to ensure our work is grounded in the most up-to-date evidence-based knowledge, that it is translated into tools, techniques and methodologies, and that it is promoted and implemented across the sector. At first we successfully focused on clinical leadership for each of our key clinical programmes. We will now develop a broad network of clinical leaders and expert advisors who can be called on as required for specific programmes, to be engaged in broad discussions about the Commission's work and direction, and to provide leadership in the sector for implementation.

> ***'The effective spread of innovation is determined more by inter-personal and inter-organisational interaction than by structures – like rugby, innovation is a contact sport.[9]***

We are also forming international links with clinical experts to advise us on international best practice in our priority work areas.

About 56 percent of adult New Zealanders have poor health literacy skills, scoring below the minimum required to meet the demands of everyday life and work[9].

This affects:

- ***their confidence to take part in decision-making about themselves***
- ***understanding an (informed) consent form for medical treatment***
- ***finding a health provider***
- ***following instructions for a diabetes regime***
- ***correct use of medicines***
- ***complying with medical directions***
- ***calculating the amount of medicine for a child***
- ***understanding of the goals and expectations of a therapy***
- ***correct use of medicines***
- ***compliance with medical directions***
- ***. . . and more.***

9 Ministry of Health. 2010. *Korero Marama: Health Literacy and Māori.* Wellington: Ministry of Health.
10 Ministry of Health. 2008. *Formalised Informality: An action plan to spread proven health innovations.* Wellington: Ministry of Health.

Communication

Our communication and engagement work aims to:

- raise our profile and ensure we are visible in the sector so we can positively influence the understanding of, and commitment to, quality and safety in health and disability services
- ensure the sector and New Zealanders generally are familiar with our role and understand how it relates to their work and interests
- promote to the sector the benefits of, and means to, increased health quality and safety.

Our activities included:

- substantial staff and board engagement with many individuals and organisations in the sector on the health quality and safety agenda (see Appendix Two)
- a regularly updated website (the number of registered users continues to increase)
- bi-monthly newsletters and factsheets (which started in April)
- communication to ensure our work and publications were well publicised (eg, when we released the 2009/2010 serious and sentinel events report *Making Our Hospitals Safer* and the associated summary brochure)
- information about the Commission, including brochures and flyers circulated to more than 2000 stakeholders
- articles about the Commission and its work, published in several medical media including *Pharmacy Today, Medical Council News, Pharmacy Guild* and *Best Practice* magazine
- media releases distributed to about 600 media and stakeholders – which have been both responsive (to events) and proactive (eg, publications and special days).

An important next step is to develop a new website. Having an effective website is an important communications tool for the Commission. It provides a cost-effective way to communicate health quality and safety improvement information, projects and contacts. It also enables the Commission to present its work as part of a co-ordinated suite of activity occurring across the sector, and it offers opportunities for direct dialogue and engagement with the Commission's stakeholders.

Education and training

Our role in working with the sector on education and skills opportunities and facilitating the availability of skills training is evolving. Initially we worked with other organisations to support their programmes, eg, we co-sponsored the Executive Quality Academy targeted at senior clinical and executive teams and the Asia Pacific Colloquium. This focused on innovation and action and had an impressive line-up of international and national presenters. We are now developing a longer-term view on the best way to support education and training in the sector.

4.0 Maintaining and developing organisational capability

During 2010/11 we established ourselves as an organisation. We made particularly good progress in recruiting staff, with most positions filled by 30 June 2011, and were well into the process of moving into our new premises. We established financial processes and controls and started developing the full range of policies and controls appropriate to a Crown entity. A draft governance manual was produced to guide the Board in fulfilling its statutory requirements and using best practice.

4.1 The Commission's progress against the indicators in the 2010 to 2013 Statement of Intent

Build capacity and capability of the Commission

Performance measure and standard	Progress
All key positions filled by 30 June 2011 or being managed by appropriate secondments or contractors.	Recruitment has progressed extremely well. As at 30 June 2011 only seven vacancies remained out of a total of 27 permanent positions. There were a large number of applicants for all advertised positions and the standard of applicants was very high. The remaining roles are being filled by secondees and contractors until the remaining permanent positions are filled.
Mortality review functions successfully received by 23 April 2011.	Mortality review committee staff and functions were received by the Commission on 23 April 2011. Those staff employed by the Ministry of Health to support the mortality review committees transferred to the Commission under the Health Sector (Transfers) Act 1993. This Act provides a mechanism for transferring staff between health sector agencies.

Accommodation

Performance measure and standard	Progress
By 30 June 2011 the Commission will be housed in appropriate accommodation.	The Commission signed a lease for permanent accommodation in Classic House, 15–17 Murphy Street in June 2011. The accommodation meets all of the Commission's requirements. During 2010/11 the Commission was based in Ministry of Health premises.

Shared services

Performance measure and standard	Progress
By 30 June 2011 the Commission will have entered into agreements with other parties on sharing a number of support services such as accounts and human resources.	During 2010/11 the Ministry of Health provided the Commission with • human resource assistance • financial assistance • IT support • legal support. As part of the move into our new premises we have engaged in the "All of Government" procurement processes for some of the following: single and multi-function print devices; office consumables; desktops and laptops and ongoing IT support. As at 30 June 2011 we were finalising an agreement with the Ministry of Health to source ongoing lease arrangements at the Ministry's Penrose office for our Auckland-based staff. This lease has since been signed. We are looking at hosting arrangements for payroll and will review other functions during 2011/12.

4.2 Good employer obligations (including our equal employment opportunities programme)

The Commission is committed to providing a work environment where equality and diversity are valued and actively practiced. In recruiting our workforce we have sought to provide for diversity in new appointments once we have identified those equal on merit. In addition we offer flexible work practices for our staff and are family-friendly to accommodate the needs of dependents from both the younger and older generation.

We are now developing our human resources policies to reflect the public service equal employment opportunity policy of equality and diversity, as well as standards of integrity and conduct as set out the State Sector Code of Conduct.

4.3 Māori responsiveness

Commitment to equity

The 'Triple Aim' includes a focus on improving equity for all populations. This will involve giving priority to activities or programmes that improve quality and safety of health services for all New Zealanders **and** improve equity.

Using information

In the 2010 to 2013 Statement of Intent, we noted the importance of including ethnicity in the information we collect (because the benefits and harms of health and disability services are not distributed equally). Work that started during the year on possible national quality and safety indicators and measures for the sector has identified the availability of ethnicity information as one of the key criteria to be taken into account when considering these indicators.

The current collection of data for the serious and sentinel events reports does not include ethnicity (or age or gender). An important element of our work with the sector on incident reporting during the year has included discussion on the collection of ethnicity, age and gender data. This discussion has resulted in the new reportable events brief now including a section to record details of consumers' age, gender and ethnicity.

Expert advice and leadership

The Commission is in the process of establishing an advisory group, Roopu Māori to provide leadership and advice on strategic issues, priorities and frameworks from a Māori world view and to identify key quality and safety issues for Māori patients and organisations. Roopu Māori will also maintain strong links with the Māori Caucus of the mortality review committee which offers solutions and guidance on mortality review issues that relate to Māori.

Services

Rheumatic fever is a condition with high Māori prevalence. The Commission has recently engaged with the New Zealand College of General Practitioners about using a quality improvement methodology to help the six DHBs who are required to improve the response to rheumatic fever. We are now talking to the Ministry of Health about possible implementation.

4.4 Permission to act despite being interested in a matter

The Board has a process of disclosure at the start of each Board meeting. For the period covered by this report, permission was given to act despite being interested in a matter on the following occasion.

Board member having interest	Item under discussion and date	Particulars of interest	Board action/ resolution
Shelley Frost	Community ePrescribing 8 April 2011	Mrs Frost declared her interest in the community ePrescribing because of her involvement in General Practice New Zealand, and Patients First.	Unanimous agreement that Mrs Frost remain in the meeting but not take part.

Part Two

5.0 Reporting

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

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

Section 50D(3b) of the New Zealand Public Health and Disability Act 2000 requires the Commission to, at least annually, provide the Minister of Health with a report on the progress of mortality review committees; and must include each such report in the Commission's next annual report. The first report on progress will be due in April 2012, when the mortality review committees have been part of the Commission for a year.

6.0 Report against the Statement of Service Performance

This Statement of Service Performance has been prepared in accordance with generally accepted accounting practice. It describes each class of outputs supplied by the Commission during 2010/11 and includes, for each class of outputs:

- the standards of delivery performance achieved by the Commission, as compared with the forecast standards included in the Commission's statement of forecast service performance at the start of the financial year
- the actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the Commission's statement of forecast service performance at the start of the financial year.

6.1 Output class 1: Information, analysis, prioritisation and advice

A national all-sector approach to reporting on incidents and events (serious and sentinel)

Performance measure	Standard 2010/11	Status	Progress report
Number, relevance and timeliness of reports.	Publication of Serious and Sentinel Events Report 2009/10 in November 2010.	Achieved	*Making Our Hospitals Safer*, the 2009/2010 serious and sentinel events report was published in November 2010. The report is on the Commission's website www.hqsc.govt.nz.
	Testing of the draft national reportable events policy completed by 30 June 2011.	Achieved	Testing of the draft national reportable events policy is complete. A report for the Commission on how best to improve the draft policy was delivered in December 2010 and the Board agreed in March 2011 to revise and finalise the policy as a health and disability sector-wide policy (ie, broader than just hospitals). The final policy will be publicised in December 2011 (SOI deliverable for 2011/12).
Record of number of preventable deaths and harmed patients in identified key areas.	By 30 June 2011 relevant baseline measures are established.	Achieved	The 2009/2010 serious and sentinel events report, *Making Our Hospitals Safer* provides the relevant baseline information on pages 3 and 4. The report is on the Commission's website www.hqsc.govt.nz.

Mortality review

Performance measure	Standard 2010/11	Status	Progress report
Functions of the mortality review committees are received by the Commission and momentum of work maintained.	Functions of the mortality review committees undertaken by the Commission from 23 April 2011.	Achieved	Mortality review committee staff and functions were received by the Commission on 23 April 2011.
Number, quality and timeliness of reports.	An annual report[11] from each of the four committees, published by 30 June 2011.	Not achieved (two months behind schedule)	**Child and Youth Mortality Review Committee** Although the series of special reports was not published by the target date of 30 June, the *Low Speed Run Over Mortality* report was complete and in the process of being laid out for publication at this date. The publication was delayed due to the need for the Commission to develop a response to those recommendations in the report which related to the Commission's activities. The *Low Speed Run Over Mortality* report was published in August and *The Involvement of Alcohol Consumption in the Deaths of Children and Young People in New Zealand during the years 2005–2007* in September.
		Achieved	**Perinatal and Maternal Mortality Review Committee** *Perinatal and Maternal Mortality in New Zealand 2008: 4th Report to the Minister of Health July 2009–June 2010* was published on 15 October 2010. The report can be found on www.pmmrc.health.govt.nz. The 5th report was published ahead of schedule on 28 July 2011.
		Not Achieved	**Family Violence Death Review Committee** The 2009 to 2010 report will be ready for publishing later in the year. It is unlikely to be published before December 2011 due to protocols around publishing reports in the period immediately before an election. The finalisation of the report was delayed due to staff turnover.
		Not achieved	**Perioperative Mortality Review Committee** The inaugural annual report of this Committee was due in August 2011 (as the Committee was established in August 2010).

11 Each report reviews and reports on specified classes of deaths with a view to reducing the numbers of those deaths in future.

Trigger tools

Performance measure	Standard 2010/11	Status	Progress report
Trigger tool surveillance tool developed.	Scoping of development of trigger tool surveillance complete by 30 June 2011.	Achieved	We held discussions with DHBs who have been using trigger tools and those that are keen to implement them, scoped the work and prepared a paper with recommendations on how the Commission can support use of trigger tool surveillance.

6.2 Output class 2: Sector tools, techniques and methodologies

Safer medicines management – programme lead for the implementation of the national adult medication chart, programme lead for the implementation of the medicines reconciliation process and programme co-ordination for longer term medication safety strategies

Performance measure	Standard 2010/11	Status	Progress report
Number of health care providers consistently using the national tools and processes for safer medicines management.	The adult national medication chart is implemented[12] in at least 25% of public hospitals[13] by June 2011.	Achieved (35%)	Eleven out of a total of 31 major secondary/tertiary public hospitals have commenced implementation of the national medication chart. The remaining DHBs will commence implementation during 2011/12. Initial implementation was targeted at acute adult medical and surgical wards and 2011/12 will see expansion of the chart's applicability to other clinical areas.
	The national standard paper-based medicines reconciliation process is implemented[14] in at least 50% of public hospitals by June 2011.	Achieved (58%)	Eighteen out of a total of 31 major secondary/tertiary public hospitals have initiated the medicines reconciliation process (either paper-based or electronic). Initial rollout focused on medicine reconciliation at admission and increasing the number of patients whose medicines are reconciled. In 2012/13 we will focus on extending implementation to include reconciliation when patients are discharged.

12 Implementation in this context means that the hospital has commenced implementation (not necessarily completed full implementation).
13 Public hospitals in this context covers the major secondary/tertiary hospitals (31 in total).
14 Implementation in this context means that the hospital has commenced implementation (not necessarily completed full implementation).

Programme lead for the national Hand Hygiene Programme

Performance measure	Standard 2010/11	Status	Progress report
Percentage of health care providers compliant with the Hand Hygiene Programme (as shown by regular auditing).	By 30 June 2011 baseline information is identified against which to measure progress.	Achieved	The report *Infection Prevention and Control Hand Hygiene NZ: Summary of DHB data held in the central database October 2010* provides baseline information (October 2010) for the various occupational groups in DHBs.

Facilitate uptake of good practice in falls reduction while maintaining the reasonable independence of at-risk consumers

Performance measure	Standard 2010/11	Status	Progress report
Number of falls causing harm in health care settings.	By 30 June 2011 scoping of current good practice commenced.	Achieved	The Commission has adopted the Canterbury DHB model for falls prevention in inpatient, residential and community settings. The next step is to work with Canterbury DHB, ACC and the Ministry of Health to develop implementation plans for the various parts of the sector over time.
	By 30 June 2011 relevant baseline measures on falls are established against which to measure progress.	Achieved	The serious and sentinel events report for 2009/10 *Making Our Hospitals Safer* provides baseline information on the number of falls in hospital settings on page 4 of the report. The report is on the Commission's website www.hqsc.govt.nz. This information will provide a short-term baseline against which to measure progress. However, as noted in the 2010 to 2013 SOI, information from serious and sentinel reports is not the best way to estimate the prevalence of harm, or measure the impact of initiatives designed to reduce adverse events. The Commission is developing a number of more robust tools for this purpose including trigger tools.

6.3 Output class 3: Influencing quality and safety practice

Funding and supporting a programme to build consumer capability and strengthen consumer engagement with improving the quality and safety of health and disability services

Performance measure	Standard 2010/11	Status	Progress report
A strong consumer network that ensures consumers are actively involved in decision making about their health care and about the nature of the services they use, and able to support and inform the work of the Commission.	By 30 June 2011 a contract is in place to provide a national consumer network.	Achieved	The New Zealand Guidelines Group has been contracted to help the Consumer Collaborative of Aotearoa to: • develop as a sustainable organisation that is truly representative of health and disability consumers • have the capacity and capability to actively facilitate consumer engagement and partnership with health and disability providers and services.

The knowledge library – a clearing-house function for information on adverse events and improving quality

Performance measure	Standard 2010/11	Status	Progress report
Knowledge library established.	Knowledge library with initial content goes live by 30 June 2011.	Not achieved	The original intent was for the Commission to assume leadership of the existing Health Improvement and Innovation Resource Centre (HIIRC) during 2010/11. However, the Ministry of Health has continued to take the lead and discussion is underway on the respective roles of each of the parties in future. Regardless of who takes the lead in future, the Commission will continue to work with the Ministry of Health to ensure that the objective of having a comprehensive, up-to-date clearing-house function for information about improving quality and safety is achieved.

Communication and engagement

Performance measure	Standard 2010/11	Status	Progress report
Commission engagement with the broader sector.	The Commission demonstrates that the broader sector has been engaged in discussions by 30 June 2011 including disability, aged care, primary, mental health, hospital, private and public.	Achieved	Appendix Two provides information to demonstrate the broad engagement that has taken place during 2010/11. Whilst there has been some engagement with the aged care and disability sector in 2010/11, these are areas where significantly increased engagement is planned in 2011/12.

7.0 Revenue/expenses incurred in 2010/11 for each class of outputs

	Output Class 1 Actual Information, analysis, prioritisation and advice ($000)	Output Class 1 Budget Information, analysis, prioritisation and advice ($000)	Output Class 2 Actual Sector tools, techniques and methodologies ($000)	Output Class 2 Budget Sector tools, techniques and methodologies ($000)	Output Class 3 Actual Influencing quality and safety practice ($000)	Output Class 3 Budget Influencing quality and safety practice ($000)	Total Actual ($000)	Total Budget ($000)
Funding from National Health Contracts appropriation								
Operational	1,548	2,374	1,485	530	194	322	3,227	3,227
Programme	2,162	3,313	2,417	740	270	450	4,849	4,503
Interest income	20	7	20	2	2	1	42	10
Total income	**3,730**	**5,695**	**3,922**	**1,272**	**466**	**773**	**8,118**	**7,740**
Operating expenditure	1,051	1,724	1,008	385	131	234	2,190	2,343
Programme expenditure	1,499	2,807	1,088	299	244	212	2,831	3,319
Total expenditure	**2,550**	**4,531**	**2,096**	**684**	**375**	**447**	**5,021**	**5,662**
Surplus/ (deficit)	**1,180**	**1,163**	**1,826**	**588**	**91**	**327**	**3,097**	**2,078**

Note: Numbers are rounded

Explanation of variance

There is a difference between actual and budgeted revenue and expenditure in output classes 1 and 2. This is because the Medication Safety Programme was originally budgeted in output class 1, but has been reported (correctly) in output class 2.

8.0 Financial statements for the year ended 30 June 2011

Statement of comprehensive income for the year ended 30 June 2011[15]

	Notes	Actual 8 Months to 30 June 2011 ($000)	Budget 8 Months to 30 June 2011 ($000)
Income			
Revenue from Crown	2	7,730	7,730
Interest income		42	10
Other income	3	346	0
Total income		**8,118**	**7,740**
Expenditure			
Personnel costs	4	671	1,063
Depreciation and amortisation	12,13	0	0
Other expenses	6	1,519	1,280
Quality and safety programmes		1,341	1,969
Mortality programmes		1,490	1,350
Total expenditure		**5,021**	**5,662**
Surplus/(deficit)		**3,097**	**2,078**
Other comprehensive income		0	0
Total comprehensive income		**3,097**	**2,078**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

15 There is no comparative information in respect of 2009/10 as required under NZ IAS 1.38 for any of the financial statements as the Commission was not yet established.

Statement of financial position as at 30 June 2011

	Notes	Actual 8 Months to 30 June 2011 ($000)	Budget 8 Months to 30 June 2011 ($000)
Assets			
Current assets			
Cash and cash equivalents	7	6,607	2,469
GST receivable		209	37
Debtors and other receivables	8	397	0
Prepayments		49	0
Total current assets		**7,262**	**2,506**
Non-current assets			
Property, plant and equipment	12	0	350
Intangible assets	13	0	50
Total non-current assets		**0**	**400**
Total assets		**7,262**	**2,906**
Liabilities			
Current liabilities			
Creditors and other payables	14	4,104	304
Employee entitlements	16	61	23
Non-current liabilities		**0**	**0**
Total liabilities		**4,165**	**327**
Net assets		**3,097**	**2,578**
Equity			
Contributed capital		0	500
Surplus/(deficit)		3,097	2,078
Total equity		**3,097**	**2,578**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2011

	Notes	Actual 8 Months to 30 June 2011 ($000)	Budget 8 Months to 30 June 2011 ($000)
Balance at 1 July		0	0
Comprehensive income			
Surplus/(deficit)		3,097	2,078
Other comprehensive income		0	0
Total comprehensive income		**3,097**	**2,078**
Owner transactions			
Capital contribution	23	0	500
Repayment of capital		0	0
Balance at 30 June	25	**3,097**	**2,578**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2011

	Notes	Actual 8 Months to 30 June 2011 ($000)	Budget 8 Months to 30 June 2011 ($000)
Cash flows from operating activities			
Receipts from Crown and other revenue		7,730	7,730
Interest received		42	10
Payments to suppliers and employees		(1076)	(5,334)
Goods and Services Tax		(89)	(37)
Net cash flow from operating activities		**6,607**	**2,369**
Cash flows from investing activities			
Purchase of property, plant and equipment		0	(350)
Purchase of intangible assets		0	(50)
Net cash flow from investing activities		**0**	**(400)**
Capital flows from financing activities			
Capital contribution		0	500
Net cash flows from financing activities		**0**	**500**
Net (decrease)/increase in cash and cash equivalents		6,607	2,469
Cash and cash equivalents at the beginning of the year		0	0
Cash and cash equivalents at the end of the year	7	**6,607**	**2,469**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

The GST (net) component of cash flows from operating activities reflects the GST paid to and received from the Inland Revenue Department. The GST (net) component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial statement purposes and to be consistent with the presentation basis of other primary financial statements.

Notes to the financial statements

Note 1: Statement of accounting policies

Reporting entity

The Health Quality and 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 public services to the New Zealand public, as opposed to that of making a financial return. Accordingly, the Commission has designated itself as a public benefit entity for the purposes of the New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

The financial statements for the Commission are for the year ended 30 June 2011, and were approved by the Board on 28 October 2011.

Basis of preparation

Statement of Compliance

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

The financial statements comply with NZ IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Measurement base

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

Functional and presentation currency

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

Changes in accounting policies

The rate for computer depreciation was reported as five years in the prospective financial accounts for 2010/11. However the rate to be used by the Commission will be three years straight-line method. There have been no other changes in accounting policies.

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

Standards, amendments, and interpretations issued but not yet effective, that are relevant to the Authority, but which have not been early adopted, are:

- NZ IAS 24 Related Party Disclosures (Revised 2009) replaces NZ IAS 24 Related Party Disclosures (Issued 2004) and is effective for reporting periods commencing on or after 1 January 2011. The revised standard:
  - removes the previous disclosure concessions applied by the Authority for arm's-length transactions between the Authority and entities controlled or significantly influenced by the Crown. The effect of the revised standard is that more information is required to be disclosed about transactions between the Authority and entities controlled or significantly influenced by the Crown
  - provides clarity on the disclosure of related party transactions with Ministers of the Crown. Further, with the exception of the Minister of Health, the Commission will be provided with an exemption from certain disclosure requirements relating to transactions with other Ministers of the Crown. The clarification could result in additional disclosures should there be any related party transactions with Ministers of the Crown
  - clarifies that related party transactions include commitments with related parties.

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement.

NZ IAS 39 is being replaced through the following three main phases: Phase 1 Classification and Measurement; Phase 2 Impairment Methodology; and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. This uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments

(its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ending 30 June 2014.

Significant accounting policies

Revenue

Revenue is measured at fair value and is recognised as income when earned and is reported in the financial period to which it relates.

Revenue from the Crown

The Commission is primarily funded through revenue received from the Crown, which is restricted in its use for the purpose of the Commission meeting its objectives as specified in its SOI. Revenue from the Crown is recognised as revenue when earned and is reported in the financial period to which it relates.

Interest

Interest income is recognised using the effective interest method.

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 in the statement of comprehensive income.

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 fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. There are no provisions for impairment in 2010/11.

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.

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 2010/11.

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 shown 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 included in the statement of comprehensive income.

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 prospective statement of comprehensive income as they are incurred.

The Commission held no property, plant or capitalised equipment at the end of June 2011 as it was being hosted by the Ministry of Health. Assets have only been purchased post June 2011 and will attract depreciation in 2011/12.

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

The Commission held no property, plant or capitalised equipment at the end of June 2011 as it was being hosted by the Ministry of Health. Assets have only been purchased post June 2011.

Intangibles

Software acquisition
Acquired computer software licenses 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.

Amortisation
Amortisation begins when the asset is available for use and ceases at the date that the asset is de-recognised.

The amortisation charge for each period is recognised in the prospective statement of financial performance.

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 non-financial assets

Property, plant, 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.

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 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 *Monitoring and Protecting Health and Disability Consumer Interests* (M36) appropriation. Apart from these general restrictions, there are no unfulfilled conditions or contingencies attached to government funding.

Note 3: Other income

The only other income was from an additional $0.35m, received from the Ministry of Health associated with the Medication Safety Programme wash-up from Hutt Valley DHB in 2010/11.

Note 4: Personnel costs

	Actual 2010/11 $000
Salaries and wages	472
Recruitment	114
Defined contribution plan employer contributions	24
Increase/(decrease) in employee entitlements	61
Total personnel costs	**671**

Employer contributions to defined contribution plans include KiwiSaver, State Sector Retirement Savings Scheme (seconded staff member), the Government Superannuation Fund and the DBP Contributors Scheme.

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 2010/11 $000
Audit fees for financial audit	18
Staff travel and accommodation	106
Printing/communications	84
Consultants and contractors	626
Board costs/mortality review committees	355
Outsourced corporate services and overhead	318
Other expenses	12
Total other expenses	**1,519**

Note 7: Cash and equivalents

	Actual 2010/11 $000
Cash at bank and on hand	6,607
Term deposits with maturities less than three months	0
Total cash and cash equivalents	**6,607**

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 2010/11 $000
Debtors and other receivables	397
Less: provision for impairment	0
Total debtors and other receivables	**397**

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. No receivables for 2010/11 are past due.

Note 9: Investments

The Commission has no term deposit or equity investments in 2010/11.

Note 10: Inventories

The Commission has no inventories for sale in 2010/11.

Note 11: Non-current assets held for sale

The Commission has no current or non-current assets held for sale in 2010/11.

Note 12: Property, plant and equipment

The Commission had no property, plant or equipment as at June 2011 as all services were being hosted by the Ministry of Health during 2010/11.

Note 13: Intangible assets

The Commission had no intangible assets as at June 2011.

Note 14: Creditors and other payables

	Actual 2010/11 $000
Creditors	1,313
Income in advance	0
Accrued expenses	2,791
Other payables	0
Total creditors and other payables	**4,104**

Creditors and other payables 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.

Creditors and other payables are $3.8m higher than budget levels. This is due to the timing of year-end recharge invoices from the Ministry of Health who were acting as a payment agent during 2010/11. All outstanding June creditors were paid during July 2011 and within payment terms. This has brought this liability down to more appropriate levels.

Note 15: Borrowings (NZ IAS 1.77)

The Commission does not have any borrowings.

Note 16: Employee entitlements

	Actual 2010/11 $000
Current portion	
Accrued salaries and wages	51
Annual leave	10
Total current portion	**61**
Non-current portion	0
Total employee entitlements	**61**

No provisions for sick leave, retirement or long service have been made in 2010/11.

Note 17: Reconciliation of net surplus/(deficit) to net cash flow from operating activities

	Actual 2010/11 $000
Net surplus/(deficit)	**3,097**
Add/(less) movements in statement of financial position items	
Debtors and other receivables	(655)
Inventories	0
Creditors and other payables	4,104
Provisions	0
Employee entitlements	61
Net movements in working capital	
Net cash flow from operating activities	**6,607**

Note 18: Capital commitments and operating leases

Capital commitments
There were no capital commitments at balance date but the Commission had received quotes for property plant and equipment, computer hardware of $95,000 and for intangible assets of $51,000 for Microsoft Office software.

Operating leases as lessee
No minimum lease payments to be paid under non-cancellable operating leases were in place at 30 June 2011 but the Commission was in negotiations for a 1 August 2011 move date into Level 6, Classic House, Thorndon, Wellington.

Note 19: Contingencies

Contingent liabilities
The Commission has no contingent liabilities.

Contingent assets
The Commission has no contingent assets.

Note 20: 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.

Significant transactions with government-related entities
The Commission has been provided with funding from the Crown of $7.7m for specific purposes as set out in its founding legislation and the scope of relevant government appropriations.

Collectively, but not individually, significant, transactions with government-related entities
In conducting its activities, the Commission is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The Commission is exempt from paying income tax.

The Commission also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. These purchases included purchases of air travel from Air New Zealand, programme activity from DHBs and hosting and occupancy services from the Ministry of Health.

Key management personnel
Salaries and other short-term employee benefits to key management personnel[16] totalled $0.215m in 2010/11.

Note 21: 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 2010/11 year was:[17]

	Actual 2010/11 $000
Professor Alan Merry (chair)	35
Dr Peter Foley	13
Mrs Shelley Frost	10
Dr David Galler	11
Dr Peter Jansen	11
Mr Geraint Martin	11
Mrs Anthea Penny	12
Total Board member remuneration	**103**

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 effected 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.

16 Key management personnel for 2010/11 include the CEO, General Manager and Chief Financial Officer. Board members have been reported separately.
17 This includes payment as an interim board.

The total value of remuneration paid or payable to each Committee member who is not a Board member during the year was:[18]

	Actual 2010/11[19] $
Perinatal and Maternal Mortality Review Committee	
Professor Cynthia Farquhar (Chair)	4,050
Dr Vicki Culling	480
Dr Stephanie Palmer	480
Mrs Anja Hale	960
Dr Beverley Lawton	480
Ms Susan Bree	480
Dr Margaret Meeks	480
Perioperative Mortality Review Committee	
Professor Iain Martin (Chair)	2,925
Dr Philip Hider	640
Dr Digby Ngan Kee	640
Dr Jonathan Koea	640
Ms Rosaleen Robertson	640
Ms Teena Robinson	640
Dr Catherine Ferguson	640
Dr Leona Wilson	640
Dr Anthony Williams	640
Child and Youth Mortality Review Committee	
Dr Nicholas Baker (Chair)	3,120
Dr Anganette Hall	480
Professor Edwin Mitchell	480
Dr Sharon Wong	480
Ms Susan Matthews	480
Ms Anthea Simcock	480
Family Violence Death Review Committee	
Ms Wendy Davis (Chair)	3,150
Ms Ngaroma Grant	800
Ms Brenda Hynes	800
Dr Alison Towns	800
Mrs Vaoga Mary Watts	800
Total remuneration to Committee members who are not Board members	**27,325**

18 The mortality review committees transferred from the Ministry of Health to the Commission on 23 April 2011, so this covers the period from 23 April 2011 to 30 June 2011. The amount refers to amount payable for this period, not the amount claimed or paid.

19 Note that this table is in actual dollars not $000 because of the small numbers involved. Note also that it covers the period from 23 April 2011 (when the mortality review committees transferred to the Commission) to 30 June 2011.

Note 22: Employee remuneration[20]

	Employees
$100,000 – $109,000	0
$110,000 – $119,000	1[21]
$120,000 – $129,000	0
Total employees	**1**

During the year ended 30 June 2011 no employees received compensation and other benefits in relation to cessation.

Note 23: Events after the balance date

There were no significant events after the balance date.

Note 24: Financial instruments

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

Note 25: 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 26: Explanation of major variances against budget

Explanations for major variances from the Commission's budgeted figures in the 2010/11 Statement of Intent are as follows.

Statement of comprehensive income
The year-end results show a surplus of $3.1m compared with a planned surplus of $2.1m ie, $1.0m higher than planned.

The main drivers of the year-end additional surplus are:

- interest revenue is higher than budgeted as income was received at the start of each quarter and the majority of the programme expenditure and operating costs occurred in the final two months of May and June.
- an additional $0.35m was received from the Ministry of Health associated with the Medication Safety Programme wash-up from Hutt Valley DHB in 2010/11.
- personnel costs are favourable by $0.39m as contractors were used while permanent staff were being recruited. This favourable variance is offset by the $0.24m reported deficit in "other expenses" where contractor costs have been reported. The balance of the favourable variance relates to Board and mortality committee operating costs being lower than budgeted. However, If the mortality committee operating and programme expenditure is combined, the total is in line with total revenue received by the Commission for mortality review committees from the Ministry of Health in 2010/11.

20 The Commission was established in November 2010 so this covers the period from 1 November 2010 to 30 June 2011.
21 The period February 2011 to 30 June 2011.

- of the $0.63m variance in quality and safety programme costs, $0.28m relates to budgeted costs of the e-medication programme which is now payable after the finalisation of phase 2 of the programme. These costs are now included in the 2011/12 work programme. About $0.2m was originally signalled for application of the web redevelopment project and education training in 2010/11. These will now occur after a successful RFP process in 2011/12. A further $0.15m was budgeted for the Atlas of Clinical Variation and the Surgical checklist. Both of these are now part of the 2011/12 work programme.

Statement of financial position
Year-end equity is $3.1m compared with planned equity of $2.6m. This variance is the result of the higher than planned surplus of $1.0m (explained above) offset by not receiving the budgeted equity injection of $0.5m until July 2011. The equity injection was not recognised in the 2010/11 accounts as the Commission operated out of Ministry of Health facilities and used Ministry of Health infrastructure until the move to new premises on 1 August 2011, so no capital was needed. No fixed assets were purchased or received by year-end and both the equity and assets will be reported in the 2011/12 accounts.

Statement of changes in cashflow
Year-end payments to suppliers and employees are $4.2m less than budget. As explained in note 14, this is due to the timing of year-end recharge invoices from the Ministry of Health who were acting as a payment agent during 2010/11.

9.0 Auditor's report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Health Quality and Safety Commission's financial statements and statement of service performance for the year ended 30 June 2011

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

We have audited:

- the financial statements of the Commission on pages 22 to 34, that comprise the statement of financial position as at 30 June 2011, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Commission on pages 16 to 21.

Opinion

In our opinion:

- the financial statements of the Commission on pages 22 to 34:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Commission's:
    - financial position as at 30 June 2011; and
    - financial performance and cash flows for the year ended on that date.

- the statement of service performance of the Commission on pages 16 to 21:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects, for each class of outputs for the year ended 30 June 2011, the Commission's
    - service performance compared with the forecasts in the statement of forecast service performance for the financial year; and
    - actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 28 October 2011. This is the date at which our opinion is expressed.
The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and we explain our independence.

Basis of opinion

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

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and statement of service performance. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and statement of service performance, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Commission's preparation of the financial statements and statement of service performance that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Commission's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the adequacy of all disclosures in the financial statements and statement of service performance; and
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Board

The Board is responsible for preparing financial statements and a statement of service performance that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Commission's financial position, financial performance and cash flows; and
- fairly reflect its service performance.

The Board is also responsible for such internal control as is determined necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

The Board's responsibilities arise from the Crown Entities Act 2004.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor General, which incorporate the independence requirements of the New Zealand Institute of Chartered Accountants.

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

A P Burns
Audit New Zealand
On behalf of the Auditor General
Wellington, New Zealand

Appendix One: Directory

Board members

Professor Alan Merry (chair)

Dr Peter Foley

Mrs Shelley Frost

Dr David Galler

Dr Peter Jansen

Mr Geraint Martin

Mrs Anthea Penny

Mortality review committee members

Perinatal and Maternal Mortality Review Committee	Perioperative Mortality Review Committee	Child and Youth Mortality Review Committee	Family Violence Death Review Committee
Professor Cynthia Farquhar (Chair) 	Professor Iain Martin (Chair) 	Dr Nicholas Baker (Chair) 	Ms Wendy Davis (Chair) 
Professor Lesley McCowan	Dr Digby Ngan Kee	Dr Anganette Hall	Ms Ngaroma Grant
Dr Vicki Culling	Dr Jonathan Koea	Professor Edwin Mitchell	Ms Brenda Hynes
Dr Stephanie Palmer	Ms Teena Robinson	Dr Sharon Wong	Dr Alison Towns
Mrs Anja Hale	Dr Philip Hider	Ms Susan Matthews	Mrs Vaoga Mary Watts
Dr Beverley Lawton	Dr Catherine (Cathy) Ferguson	Ms Anthea Simcock	
Ms Susan Bree	Dr Leona Wilson	Mr Erunui George	
Dr Alec Ekeroma	Dr Anthony Williams	Mr Paul Nixon	
Dr Margaret Meeks	Ms Rosaleen Robertson		
Dr Graham Sharpe			

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Auditor

Audit New Zealand on behalf of the Auditor General.

Appendix Two: Information to demonstrate that the broader sector has been engaged in discussions

This information covers the period from November 2010 (when the Commission was established) to 30 June 2011.

Engagement by staff and Board members

Minister and Minister's Office	• Commission CEO and Chair
Ministry of Health	• Medication safety • To reach agreement on jointly working toward the triple aim • IT Board and chair of IT Board Expert Advisory Group (Commission CEO) • Director-General on healthcare-associated infection • Chief nurse (rheumatic fever)
Health Workforce New Zealand	• Credentialing of diabetes nurse prescribers (half day) • Nurse credentialing • HWNZ Board meeting (Commission Chair)
DHBs	• DHB Chairs meeting (Commission Chair, Commission CEO) • DHB CEOs meeting (Commission Chair) • DHB Chief Operating Officers National Meeting (Commission CEO and General Manager) • DHBNZ (Commission CEO and General Manager with Julian Inch) • Hutt Valley DHB • Canterbury DHB • Auckland DHB • Hawke's Bay DHB (Commission CEO) • MidCentral DHB (Commission CEO). Also keynote speech at nursing awards for excellence MidCentral DHB • Southern DHB (Commission CEO) • Waitemata DHB (Commission CEO) • Whanganui DHB (Commission board member) • Midland regional DHB Chairs and CEOs (Commission CEO)
Other government agencies	• Mental Health Commission: Workshop (1 day) quality improvement methods that can be used to audit/review services and evaluation of services (Commission CEO with Chair of the MHC) • Retirement Commission (Commission CEO with Retirement Commissioner) • Standards NZ (Commission CEO with Standards NZ CEO) • National Health Committee (Commission CEO with David Graham) • Department of Prime Minister and Cabinet (Commission CEO with Mary Slater)
Doctors and pharmacists	• Medication safety project • Incident reporting • Mary Seddon (Commission CEO) • Medical Council Wellington (Commission Chair) • Director General of Health, Prof Rod Jackson, Dr D Waller on clinical variance • DHB clinical directors • Grand rounds

Nurses	• NZNO – Medication safety • Nurse credentialing • International nurses' day • DHB Directors of Nursing (Commission CEO)
DHB quality and risk managers	• National workshop on reportable events • Engagement on general quality and safety matters • Commission CEO engagement
Private health care providers	• Southern Cross on involvement in some of our programme areas • Meeting of directors of nursing, Private Hospitals Association with regards to national medication chart • Engagement on reportable events with private hospital quality risk managers • Engagement on national medication chart (Southern Cross)
Mental health	• Engagement on reportable events with quality and risk managers representing mental health
Health and disability providers	• Workshop – methods to engage consumers in the design and evaluation of services (consumers also attended) • Credentialing of diabetes nurse prescribers (half day) • Health literacy • Executive Quality Academy with nine large provider organisations (Principal Advisor, Quality and Safety)
Consumers	• Workshop – methods to engage consumers in the design and evaluation of services
Mixed audiences	• Central region conference on quality and safety in health care (facilitated by Commission – 150 attendees) • Attendances at conferences and networking with international, national and local quality leaders, community leaders etc
New Zealand Breastfeeding Authority	• Working session on quality auditing and quality improvement
Primary care	• ProCare on quality improvement projects • Pegasus Health – half day with senior management and clinicians • BPAC (Commission CEO) • RNZCGP on rheumatic fever • Primary care leaders in Christchurch (Commission CEO and Principal Advisor) • Department of GP and Primary Healthcare, University of Auckland (Commission CEO)
Ko Awatea	• Jonathon Gray (Commission CEO and Peter Jansen) • Launch (Chair, CEO, GM and Principal Advisor) – Peter Foley presented
Health Sector Forum	• Attendance by Chief Executive and Commission Chair – included the National Health Board, National IT Board, Health Workforce New Zealand, Pharmac, the Health Quality and Safety Commission, HBL, DHBNZ and National Health Committee and is chaired by the Ministry of Health
Māori	• Meeting with Tu Williams with regards to Māori advisory network (Commission CEO and Dr Peter Jansen)

University	• Commission CEO with Director National Institute of Health Improvement, Epidemiology and Biostatistics, School of Population Health, University of Auckland • Executive Council of Medical Colleges (Commission Chair)
Unions	• Commission CEO and General Manager
International	• IHI conference Amsterdam • International Forum on Quality and Safety Satellite conference (Board members) • Australian Health Round Table (Commission CEO and General Manager with Bernie Mullin and Rohan Cattell) • Australian Commission on Safety and Quality (Commission CEO with Principal Medical Advisor and Director of Information)
Other Health Crown Entities	• Chairs' meeting (Commission Chair)

Engagement by mortality review committees

Government agencies	• Ministry of Health Courts – high, district, family • Chief Coroner • National Coronial Services • Manager of Courts • Principal Family Court Judge • Corrections, Ministry of Health including National Health Board • MSD (national and local) • Manager Family Violence Unit (MSD) • Chief Social Worker (MSD) • CYFS (national and local) • Police (national and local) • ACC • Immigration • Children's Commission
DHBs	• Local mortality review committees (intersectoral committees chaired by DHBs) • DHB Violence Intervention Programme staff • Other engagement with DHBs
Private hospitals	• Private hospital representation on the Perioperative Mortality Review Committee

NGOs	• Engagement with many NGOs including:
	  ○ Family violence NGOs eg, Women's Refuge, Shine
	  ○ Water safety NGOs
	  ○ NGOs providing services and advocacy for children including Māori and Pacific NGOs
	  ○ Disability violence prevention advocacy NGO

Professional Colleges	• RNZCGP • Royal Australian and New Zealand College of Obstetricians and Gynaecologists • New Zealand College of Midwives • Royal Australasian College of Surgeons • Australian and New Zealand College of Anaesthetists • New Zealand Society of Anaesthetists
University	• School of Public Health (Auckland University)

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Health Quality and Safety Commission

New Zealand Government