HEALTH QUALITY AND SAFETY COMMISSION

Annual Report 2011/2012

1 July 2011 to 30 June 2012

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HEALTH QUALITY AND SAFETY COMMISSION

Chair's Report

Professor Alan Merry

"We are committed to ensuring New Zealand has a world-class, patient-centred health and disability system, through continually improving health quality and safety, equity and sustainability."

New Zealand has one of the few health systems in the world that has managed to continue increasing Vote:Health over the past few years, albeit at a lower rate than previously. Health expenditure is now 10.5 percent of GDP – the highest it has ever been. Consequently there has been no need to reduce health services and the number of clinical staff has increased. Nevertheless, like much of the world, we face serious financial challenges as a country. Even with ongoing strong performance and careful management, the medium- to long-term outlook for health expenditure is challenging. Demand is increasing due to an aging population and (in part, consequent) increases in chronic long-term conditions. The New Zealand public rightly expects excellence, including access to new technology and medications of proven benefit. It follows that the health and disability sector will continue to have to deliver efficiency improvements into the future.

New Zealand already has an excellent and cost-effective health system. The pursuit of excellence is a continuous and ongoing endeavour. There is still room for improvement in all health systems around the world, even in those that are doing well. Too many patients continue to be harmed, avoidably, by the care intended to help them, or fail to receive care that aligns with their values. At the recent Asia Pacific (APAC) Forum on Quality Improvement in Healthcare (held at Ko Awatea, Counties Manukau, supported by the Commission and attended by nearly 900 delegates) Maureen Bisognano, President and CEO of the Institute of Healthcare Improvement in Boston said we need to move from 'What's the matter?' health care to 'What matters to you?' health care. In other words, health care explicitly aligned with the things our patients value. She told a story about an older woman who declined a knee replacement because the thing she valued was kneeling to do her gardening, and the proposed surgery (while it might have reduced the pain from her arthritis) would not have allowed this. We can take pride in the fact that patient-centred care is an element of health care quality in which New Zealand already leads the world, but pride should never equal complacency.

The Commission is well placed to assist in creating a more sustainable health sector through continuing and accelerating the tangible commitment of our health professionals to quality and safety improvement, so we can continue to provide all the effective treatments our patients need with the minimum of avoidable harm and loss of life. There is no debate over the importance of avoiding harm, but the financial costs also matter. We can afford neither waste (treatments that are ineffective, or not wanted, or just wrong) nor rework, (such as treating infections, fixing fractures from falls, picking up the pieces after incorrect surgery or wrong drug administrations, and providing intensive care for patients whose deterioration could have been identified and addressed earlier). Our resources are precious and we need them to provide the right treatments and services to our patients and consumers, right first time.

The Health Quality and Safety Commission (the Commission) is a small organisation. We do not provide or fund health and disability services directly. Our value comes from using our knowledge of health quality and safety across the system, our analytic capability and our relationships and networks to advance the national quality and safety agenda and to lead and support quality and safety improvement right across the country.

Our goal is clear. We pursue the Triple Aim[1] through reducing harm, waste, inequity and cost at the same time as improving people's experiences as they use our health and disability services.

Our current focus is on delivering and supporting a small number of programmes that align with government priorities, and have a strong evidence base and a high potential return on investment (in human and financial terms). These programmes provide a base for building sector capability in improvement science while delivering demonstrably worthwhile results. At the same time we are developing a strong information base and analysis capability and developing a more comprehensive picture of where the quality and safety strengths and weaknesses are in New Zealand and of what is working locally, nationally and internationally.

These are essential building blocks for the future – a future where the Commission is a hub, both for clinical and consumer leadership and networks in the sector, from which good practice is extended, and programmes

1 See Section 1.1 for more detail on the Triple Aim.

that will add value to the sector are supported and in which improvement science underpins the successful delivery of our excellent health and disability services.

Quality and safety really is 'everyone's business' and I wish to express my thanks to the many agencies and individuals who have chosen to join us in this important work.

Professor Alan Merry, ONZM
Chair
Health Quality and Safety Commission

Chief Executive's Report

Dr Janice Wilson

"There is still a lot to do, but there is high energy and people are keen to engage with us for change and improvement."

The Commission was established in November 2010 to reduce deaths, harm and waste from preventable errors in the health and disability sector while building a culture of active examination and improvement based on the idea of 'doing the right thing, and doing it right first time'.

Much has been achieved in our first 18 months. There is now a clear focus in the sector on reducing harm with a specific focus on four priority areas: patient falls, hospital-acquired infections, surgery and medication. There are already indications these programmes are having a significant impact. Rates of central line associated bacteraemia (CLAB) infections in hospitals are decreasing, compliance with hand hygiene processes has increased and there are anecdotal reports from District Health Boards (DHBs) that use of the national medication chart for prescribing and medicine reconciliation processes are reducing medication errors.

We play a major role in 'shining the light' on issues to ensure the most important areas for improvement are examined and addressed. As an example, our *Making Our Hospitals Safer – Serious and Sentinel Events reported by District Health Boards 2010/11* report identified that falls in hospitals accounted for 52 percent of all reported serious and sentinel events. This provided a major impetus for our national programme to reduce harm from patient falls.

Six reports during the year from our four mortality review committees also highlighted important areas where deaths and harm can be avoided. This included deaths of children and young people related to driveway run-overs and alcohol, mothers who die by suicide, deaths as a result of family violence, and deaths related to surgery. The committees have been working successfully with relevant agencies to ensure recommendations are implemented to reduce these tragic and potentially avoidable deaths in future. I thank the Chairs and members of these committees for their important work.

In June we launched our first New Zealand Atlas of Healthcare Variation (the Atlas). This is a new online tool for clinicians, users and providers of health services that demonstrates variation in the health care received by people in different geographical regions. The purpose of the Atlas is to stimulate questions and debate about the reasons for variation in care or interventions and the degree to which this variation aligns with what is considered appropriate care for specific populations. Alongside this we have developed a set of quality and safety indicators designed to be the basis upon which we judge and report on the quality and safety of the whole health system. These indicators will also include those that tell us what progress we are making on identified priorities, and are currently being refined through discussions with the sector. Similarly our work on the specific four priority areas (reducing harm from patient falls, hospital-acquired infections, surgery and medication) was given added momentum and profile by the Minister of Health requesting the Commission engages with the sector to develop quality and safety markers for these, aimed at demonstrating and tracking progress by DHBs.

Reviewing and reporting adverse events in a way that encourages a learning culture is important for improving the safety of our services. The Commission's national reportable events policy, promulgated in February 2012, gives all providers a systematic way to analyse what happened when things went wrong, why it happened, and what can be done (if anything) to prevent it happening again. It is a formal, structured and standardised procedure which provides transparency and assurance to service users that these adverse events are taken seriously. Importantly the policy requires Chief Executive (or equivalent) sign-off, committing management at the highest level to ensuring effective analysis and response to reportable events.

Achieving enduring improvement in quality and safety practices involves more than supporting programmes of work in specific areas and providing information. It is equally important to build a constituency and momentum across the sector that will drive improvement 'from within'. The Commission has an important role to work with the sector, particularly with clinical leaders and consumers, to enable them to create the changes required. We started this process by appointing clinical leaders for all our key programmes, establishing clinical leadership networks for those programmes and supporting the Consumer Collaborative of Aotearoa to develop the capacity and capability to facilitate consumer engagement and partnership with health and disability services. But developing capability is a complex task with many possible approaches, so while it has been important for us to make an early start, we also took the time during the year to develop evidence-based and planned approaches

to guide our future work. We are excited about putting these plans into practice in the coming years.

Initially our work focused mainly on the public hospital sector as we continued to implement the hospital-based programmes that were in place when we were established. During the year we broadened this focus. We are developing an aged residential care medication chart, increasing the range of providers across the sector that report serious and sentinel events and involving private hospitals in our programmes. Our *Partners in Care* framework and action plan will also support consumer engagement and participation at all levels in the health and disability sector.

2012/13 will be another important year for the Commission. It will be the year we really start to see the added value we provide – when all our planning and initial activities start to achieve measurable results.

I look forward to reporting and quantifying significant reductions in harm in our four priority areas. I look forward to increased debate and change as a result of our reporting and analysis work, to continuing to work with clinicians. I also look forward to making real progress in building provider/consumer partnerships and sector capability in improvement science.

Finally, I would like to thank Commission management and staff. Our success over the past year would not have been possible without their hard work, commitment and expertise.

Dr Janice Wilson
Chief Executive, 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 statement of service performance fairly reflect the financial position and operations of the Health Quality and Safety Commission for the year ended 30 June 2012.

Signed on behalf of the Board:

Professor Alan Merry, ONZM
Chair
18 October 2012

Dr Peter Foley
Deputy Chair
18 October 2012

Doing the right thing, and doing it right, first time.

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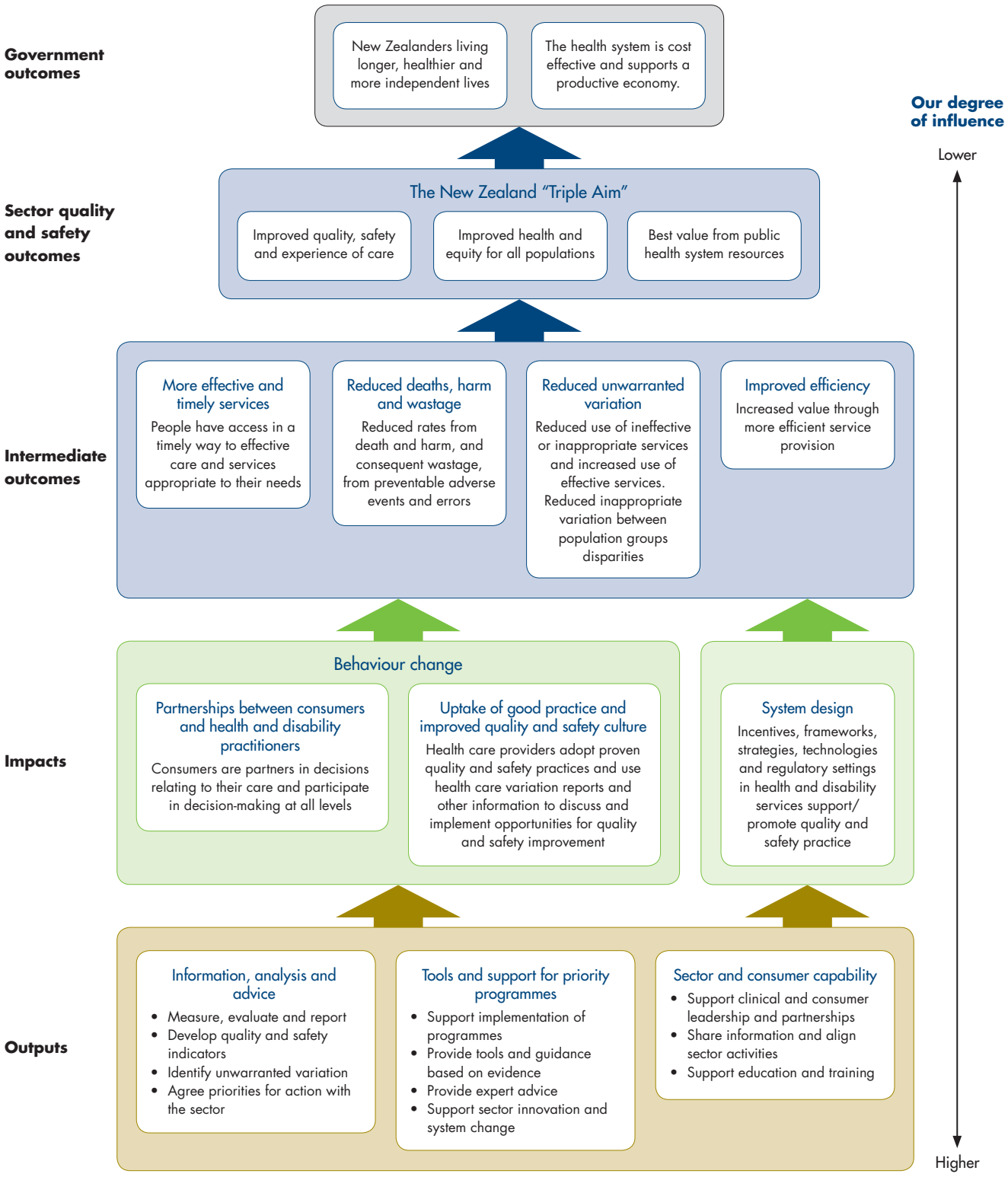
Outcomes Framework



Part One

1.0 The Health Quality and Safety Commission

The Commission was established in November 2010 to lead and coordinate work across the health and disability sector for the purposes of:

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

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

1.1 Triple Aim

The Commission's Triple Aim for the New Zealand health and disability sector is:

- improved quality, safety and experience of care
- improved health and equity for all populations
- best value for public health system resources.

The New Zealand Triple Aim has been accepted by the Ministry of Health (including the National Health Board, the National Health IT Board, the National Health Committee and Health Workforce New Zealand), DHBs, Health Benefits Ltd and PHARMAC. This common purpose is central to achieving the goal of improving the quality and safety of health and disability services across the whole sector.

1.2 Achieving Government's outcomes through the Triple Aim

The outcomes framework (page vi, left) shows how the Commission's work contributes to achieving the sector's quality and safety outcomes, and ultimately, the Government's health and disability system outcomes:

- for all New Zealanders to lead longer, healthier and more independent lives
- that the health system is cost effective and supports a productive economy.

The Triple Aim also 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.

1.3 Focusing on what matters most

There are many issues to address and opportunities for improvement across the sector. But our resources are limited and we have been selective about the priorities for attention and investment to deliver the best value for money. In addition to the priorities identified in the Minister's Letter of Expectations and other correspondence, we considered a range of factors in deciding where we would focus our efforts including:

- the size of the potential benefit in terms of improving quality and safety outcomes and reducing wastage and cost
- the strength of the evidence base to support intervention
- how much the Commission can influence change
- the likely timeframe to see results
- whether Commission involvement will help to generate enduring change/benefit
- the likely investment by the Commission to achieve results – is this value for money?
- the extent to which the work leverages off existing activity and leaders within the sector
- the relevance of the work to the Commission and the sector's own objectives and priorities.

For the programmes inherited by the Commission (such as the medication safety and mortality review programmes), it has been important to ensure we get the best value for the money already invested.

Our specific priorities during 2011/12 and for the coming few years are:

- reducing medication errors and improving medication safety
- reducing health care associated infections
- reducing falls in health care settings
- reducing surgical errors and improving surgical safety.

Four central elements underpin this work:

- collating, analysing and using reliable information about quality and safety
- facilitating consumer partnerships and values-based decision-making
- building sector capability and clinical leadership
- building a culture of quality and safety improvement.

During 2011/12 we established Roopu Māori, to advise the Board and Chief Executive on strategic issues, priorities and frameworks for Māori and to identify key issues for Māori consumers and organisations. This will enable the Commission to focus more clearly on what is needed to improve equity of health and disability outcomes for Māori.

1.4 Our partners

Partnerships are critical to achieving the improvements needed in quality and safety. All organisations and individuals involved in providing health and disability services have a role in ensuring quality and safety, and their roles cover a broad spectrum including:

- quality and safety assurance activities such as legislation, regulation, standards, certification, auditing and credentialing
- a wide range of quality and safety improvement activities supported by a range of organisations and networks including the Commission, Ministry of Health, Health Sector Forum, DHBs, primary health organisations (PHOs), professional groups, clinical networks, private and non-government organisations (NGOs).

All health and disability professionals and workers also have an individual responsibility at all times for the quality and safety of their own practice. Quality and safety is 'everyone's business'. The Commission has an important leadership role as well as a responsibility to build partnerships, maintain an overview and ensure integration of the whole quality and safety landscape.

1.5 Identifying the value of our work

The Commission identifies the potential value of every programme (through a business case and/or cost-benefit analysis[2]) before deciding whether or not to proceed.

SURGICAL SITE INFECTION SURVEILLANCE

A cost-benefit analysis estimated 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.

SURGICAL SAFETY

A cost-benefit analysis funded by the Commission during 2011/12 estimated that, in New Zealand, potentially preventable complications arise in 10 to 15 percent of all surgical procedures. The analysis estimated that more systematic use of the surgical checklist is likely to result in a net financial benefit of $43 million over 10 years to the publicly-funded health system. Start-up costs in year one are estimated to be $470,000 nationally and ongoing costs $174,000 annually.

MEDICATION SAFETY

Medication errors are an ongoing and potentially serious cause of patient harm. Estimates vary, but internationally about 6.5 percent of patients admitted to hospital are estimated to have an adverse drug event of some description.[3] Around 60 percent of these events are thought to be preventable. A basic extrapolation using the preventable New Zealand adverse drug events[4] and the cost of one preventable adverse drug event (estimated to be $11,024)[5], gives an estimated cost for preventable adverse drug events in New Zealand of $158 million a year.

The electronic medicines management cost-benefit analysis estimated a potential cost of up to $58 million over 10 years to implement electronic medicine reconciliation and electronic prescribing and administration in all DHBs. It estimated quantified benefits of $91.7 million in value (a return on investment (ROI) of 107 percent).

2 Many of the cost-benefit analyses show a breadth of the range of benefits in the sensitivity analyses due to limitations in the currently available evidence.

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 Davis P, Lay-Yee R, Briant R, et al. 2001. Adverse events in New Zealand public hospitals 1: occurrence and impact. *New Zealand Journal of Medicine*. 115: U271.

5 Brown P, McArthur C, Newby L, et al. 2002. Cost of medical injury in New Zealand: a retrospective cohort study. *Journal of Health Services Research and Policy*.

PATIENT FALLS

An analysis of a number of datasets suggests direct costs of inpatient falls alone could be in the order of $5 million per year nationwide for public hospitals. On a broader scale there are a total of 47,000 falls-related discharges per annum, which account for 5 percent of all discharges and cost public hospitals $205 million per year. We are currently working on estimating the potential effect of prevention initiatives on the rate of falls.

2.0 Operational review 2011/12

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

One of our key roles, established in legislation, is surveillance or broad assessment of the quality and safety of the sector, including national and international comparisons to identify areas where improvement is needed. International literature provides 20 years of evidence that measuring the quality of health care and communicating the results in a variety of ways and settings is a powerful way to stimulate improvement in health care.

By ensuring effective and transparent reporting and analysis of quality and safety issues, incidents and trends, the Commission can help ensure quality and safety issues are identified and prioritised for action. Used wisely, the reports encourage discussion and promote learning.

While the health system can enable a fairer distribution of good health, limited national data is available to measure health equity. Linking ethnicity with quality and safety information allows us to examine health care disparities. Once key areas of disparity are identified, effective strategies can be developed to improve the quality of care for all people regardless of ethnicity.

MEASUREMENT AND EVALUATION

We have a responsibility to report on the overall quality of health care, to monitor and drive improvement.

New Zealand Atlas of Healthcare Variation

In June 2012, the Commission's Atlas of Healthcare Variation (the Atlas) was published. The Atlas displays easy-to-use maps, graphs, tables and commentary that highlight variations by geographic area in the provision and use of specific health services and health outcomes.

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

The Atlas highlights variation but does not suggest an ideal level (ie, high is not necessarily good or bad; the average is not necessarily the ideal). This means it should not be used as a tool for judging the performance of one geographic area against another, rather it should promote agreement on when and how particular types of care should be provided. It should drive improvement by ensuring variation can be explained by differences in the needs of patients, rather than by differences in practice, resourcing, or access.

The first maps present information on maternity services, variations in life expectancy and other demographic features of the population. New subjects will be added regularly to the Atlas.

The Atlas is also a powerful tool for improving equity. In future every domain of the Atlas will reflect variation by ethnicity, and the expert advisory group for each Atlas domain will have Māori representation.

New Zealand quality and safety indicators

The quality and safety indicators are a small set of summary indicators that provide the public and the health and disability sector with a clear picture of the quality and safety of health and disability services in New Zealand, including changes over time, and comparisons with other countries.

The over-arching goal of reporting against a set of quality and safety indicators is to provide robust information to support achievement and measure progress against delivery of the outcomes articulated in the New Zealand Triple Aim framework.

The indicators will:

- provide the public and the health and disability sector with a clear picture of the quality and safety of health and disability services in New Zealand, including changes over time

The point of reporting on these events is to learn from them, and to take actions that will make our health services progressively safer.

Professor Alan Merry, Chair of the Commission

We can only be sure to improve what we can actually measure.

Raleigh SV, Foot C. 2010. Getting the measure of quality – Opportunities and challenges. The King's Fund: 2010.

- inform quality improvement activities of service providers by providing information to support learning and peer review in clinical settings
- support the identification of key quality and safety issues and prioritisation of improvements to the quality and safety of health and disability support services
- support improved equity by stratifying results for all indicators by population group.

The indicator set will eventually cover services throughout the patient's journey, provided across the entire health and disability sector, including public, private and NGO providers, primary care, hospital, aged care, mental health and disability support sectors.

New Zealand quality and safety markers

In February 2012, the Minister of Health Hon Tony Ryall and Associate Health Minister Hon Jo Goodhew asked the Commission to develop quality and safety markers for the sector, focused on our four priority areas: reducing harm from in-patient falls, hospital-acquired infections, surgery and medication. The markers are a mix of process and outcome measures. They are designed to track progress and through public reporting stimulate improvement.

Between March and June 2012 the Commission developed a draft set of markers for the first three areas and commenced discussion with the sector. With a very few exceptions, there was general support for the principle of the markers, and broad support for the areas being looked at, while helpful feedback and suggestions about precise measures and methods were received.

During the early part of 2012/13 we will work with the sector to address the issues raised in the consultation and plan to finalise the set of markers by the end of the calendar year.

Library of quality measures

The Commission has supported the ongoing development of a library of quality measures. This online tool, based on research, provides definitions of how to use and interpret a range of measures within the health sector. It will also house the Commission's national quality and safety indicator set. The library is hosted by Patients First Limited, which is a joint programme of work between the Royal New Zealand College of General Practitioners and General Practice New Zealand. The library can be accessed via the Patients First website www.patientsfirst.org.nz/hqml.

Measuring consumer experiences

During 2011/12 the DHB quality and safety managers (facilitated by the Commission, and in consultation with consumers) developed a 'how to' guide and a toolkit for measuring consumer experience. The next step is to build this into a nationally consistent set of measures that all DHBs will be required to use.

REPORTING AND MANAGEMENT OF HEALTH CARE INCIDENTS

Reportable events policy

Reporting adverse events in the health system helps service providers to identify and manage the risks of their clinical care. During 2011/12 the Commission worked with the sector to develop and agree a national policy for reporting and managing health care incidents.[6] The policy is designed to help providers identify and address systemic issues in their own organisations that lead to medical errors. This policy required Chief Executive (or equivalent) sign off,

6 Health Quality & Safety Commission, 2012. *The NZ Health and Disability Services National Reportable Events Policy 2012. http://www.hqsc.govt.nz/assets/Reportable-Events/Publicatoins/Reportable-Events-Policy-Mar12.pdf*

Measuring and responding to the consumer experience of health and disability service delivery drives change designed to continually improve that experience.

Adapted from the vision statement for the DHB project on measuring consumer experience

The more we understand about what is happening and why, the easier it will be for providers to put in place quality and safety improvements that will make a real difference for patients.

Dr Janice Wilson, Commission Chief Executive

committing management at the highest level to ensuring effective analysis and response to reportable events. The new policy requires organisations to report the key findings and recommendations to the Commission – which will allow lessons learnt from incidents to be shared across the sector. The Commission established a database to collect, analyse and report incidents, and during 2012/13 will develop systems to allow those lessons to be shared.

Other agencies also collect information on adverse events and we have started working with ACC, the Health and Disability Commissioner and the Ministry of Health to develop processes that will allow sharing of analysis of events.

Mental health serious events

In consultation with senior mental health professionals and consumer representatives, the Commission concluded that outpatient suicides reported in previous years are different in nature from, for example, a wrong-sided operation or harm to a patient from a fall. In order to develop a more effective approach to addressing these distressing events, the Commission took them out of the general reporting process and worked with a group of experts from the mental health sector to develop a more appropriate system. As a result an alternative approach has been developed, which is consistent with the national policy but provides discretion for agencies[7] to investigate incidents based on an initial triage process. It emphasises a consumer, family/whānau-centred approach to encourage open disclosure, transparency and partnership between consumers, their families and health professionals. An annual report of these incidents will be published.

Making Our Hospitals Safer – Serious and Sentinel Events reported by District Health Boards in 2010/11

The 2010/11 serious and sentinel events report was published in February 2012 and identified that, for the fourth successive year, the number of serious and sentinel events[8] reported by DHBs had increased, mainly due to the number of falls being reported. As a result, the Commission further investigated the value of falls prevention programmes in health care settings and has commenced implementation.

The 2010/11 report discusses the importance of better consumer engagement as one way of reducing these events as well as the importance of communicating with grieving families. It outlines the role of the Commission in working with providers, partnerships with providers and education and training. The report also outlines simple improvements made in a number of DHBs that are having a real impact on patient safety.

An increasing number of non-DHB providers are reporting serious and sentinel events to the Commission including the National Screening Unit. It is expected serious and sentinel events relating to disability services (residential and home-based) will be reported to the Commission from 1 July 2012 and it is hoped home and community providers will follow.

Trigger tool for measuring patient harm

Gillian Robb is clinical lead for the Commission's Global Trigger Tool work. She is a professional teaching fellow at Auckland University, and a Senior Quality Manager at Counties Manukau DHB.

The Global Trigger Tool programme is an international initiative to reduce patient harm caused by errors in hospitals. This methodology involves a retrospective review of a random sample of patient medical record using 'triggers' (or clues) to screen for potential adverse events, assess the level of harm from each adverse event, and determine whether adverse events are reduced as a result of improvement efforts. It is not intended as a means of benchmarking between organisations, rather it is used locally for continuous improvement purposes and as a complement to existing voluntary error reporting.[9]

During 2011/12 we appointed our clinical lead, and undertook extensive engagement with all DHBs to

7 The term 'agencies' refers to public, private and non-government organisations who provide mental health services.

8 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.

9 Overseas research finds that only 10 to 20 percent of errors are ever reported.

identify the status of Global Trigger Tool implementation and assess how we could facilitate increased uptake across the sector. In summary, 10 DHBs have either implemented Global Trigger Tool methodology in their organisations, or have undertaken training. Of these DHBs, six have already implemented the Medication Module triggers.

Through its Quality and Safety Challenge[10], the Commission supported Southern DHB to implement the Medication Module triggers with a focus on detecting the level of adverse drug events before and after the implementation of electronic prescribing and administration.

Trigger tools can be an important tool in primary care services as well. Primary Health Care Northland and Manaia Health PHO are developing and piloting a general practice trigger tool. This was also funded as part of the Commission's Quality and Safety Challenge.

MORTALITY REVIEW COMMITTEES

A mortality review committee is a statutory body empowered by legislation to review and analyse the circumstances that result in preventable death, in order to provide evidence-based advice on how they can be avoided in future. The Commission's four committees published the following reports in 2011/12 summarising key findings and advice.

The Fifth and Sixth Perinatal and Maternal Mortality Review Committee Reports

These two reports provide the numbers and rates of perinatal and maternal deaths, describe risk factors and seek to identify where the attention of maternity and neonatal services might be best focused to reduce the preventable proportion of these tragic events. The fifth 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. Of all perinatal deaths, 14 percent were thought to be potentially avoidable – that amounts to 98 lives that could potentially have been saved.

The sixth report, published in June 2012, showed that suicide continues to be the leading cause of maternal deaths. Counties Manukau DHB has set up a panel of experts to look at how maternity care could be improved or delivered differently, given results in the fifth report indicating more mothers and babies are at risk in that DHB. The Ministry of Health has indicated support for establishing a mother and baby unit in the North Island.

The Child and Youth Mortality Review Committee Report – Low Speed Run Over Mortality

This 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 a number of recommendations. The Safekids campaign on driveway run-overs used the information in the report as the basis for its awareness campaign. Housing New Zealand has agreed with the recommendations that it should modify its existing housing stock and ensure new housing stock has separate driveways and safe play areas for children. It is currently in the process of developing guidelines. The New Zealand Transport Agency is considering taking on the data collection responsibility for low-speed child run-over injuries and mortality and the Ministry of Health is considering how it could ensure driveway safety is part of the Well Child programme.

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

This report, published in September 2011, highlighted the strong contribution of alcohol to a dramatic increase in the rate of death by injury after the age of fifteen. The Land Transport (Road Safety and Other Matters) Amendment Act 2011 incorporated two key recommendations of this report about driving and alcohol in young people. These recommendations were first publicised by the Committee in 2010 when it undertook the preliminary analysis for the report.

10 The Quality and Safety Challenge is described in Section 2.3.

The death of a baby or mother is a tragedy and we need to learn from these deaths to make improvements that will, ultimately, save lives.

Professor Cynthia Farquhar,
Chair of the Perinatal and Maternal Mortality Review Committee

The inaugural Perioperative Mortality Review Committee Report

This report, published in February 2012, provided an overview of perioperative mortality in New Zealand, identified gaps, and provided a starting point for developing a national perioperative mortality review system. While between 4000 and 5000 patients die following any form of surgical procedure or anaesthesia each year in New Zealand, in many cases the operation played no part in the patient's death. The report's main conclusion was a recommendation that building upon existing data collections will enable the establishment of a whole-of-health-care system mortality review process. In response to the report, the New Zealand Private Surgical Hospitals Association has indicated its support for private hospitals to be part of this system.

The Second Family Violence Death Review Committee Report

This report, published in December 2011, identified that each year between one-third and one-half of all homicides in New Zealand are the result of violence within families. In 2009, 42 people in New Zealand were killed directly by members of their own family (out of 88 total homicides) and in 2010 the number was 26[11] out of 72. As a result of the recommendations in the report, the New Zealand Police has increased first-responder domestic violence training and the Department of Corrections has made changes to its home-detention planning.

The mortality review committees have a Māori caucus. The role of the caucus is to achieve health gains for Māori by supporting Māori members of the national mortality review committees by advising on Māori mortality and morbidity.

QUALITY ACCOUNTS

During 2011/12 the Commission supported the development of a guidance manual for all providers of health and disability services within New Zealand explaining the purpose of quality accounts and giving step-by-step guidance for their preparation. This was finalised in June 2012 and is based on best practice as well as feedback from a working group and staff from the wider health and disability sector.

Quality accounts reinforce the importance of quality of care by placing the reporting of quality on an equal footing with financial reporting. They are not a compliance tool, but rather a means for each health and disability service provider to:

- demonstrate their commitment to continuous, evidence-based quality improvement across all services
- set out to the public where improvements are needed and planned
- receive challenges and support from the public and wider sector on what they are trying to achieve
- be held to account by the public and local stakeholders for delivering quality improvements.

Some DHBs already publish quality accounts, and it is intended all will do so by June 2013.

11 Preliminary count at the time of writing the report.

2.2 Output class 2: Sector tools, techniques and methodologies

We've seen big improvements in the clarity and legibility of prescribing medicine. We're really excited about how this will help us improve patient safety.

Pharmacist Avril Lee,
a member of the Waitemata DHB national medication chart project team

Providing good practice tools, techniques and methodologies to help providers improve the quality and safety of services is important to ensure uptake of proven quality and safety practices. Our view across the sector enables us to identify strong improvement initiatives and best practices across the country, understand why things are working well, and work with the sector to extend and disseminate initiatives that are making a real difference. Our broader view also enables us to identify international best practices and work to introduce those relevant to New Zealand.

NATIONAL MEDICATION SAFETY PROGRAMME

The National Medication Safety Programme aims to reduce harm and cost from medication errors and increase the efficiency and integrity of medication management systems. As well as causing harm and death, the estimated financial cost for preventable adverse drug events in New Zealand is $158 million a year.

National medication chart

The paper-based national medication chart 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).

By 30 June 2012, 15 DHBs and a small number of hospices and private hospitals had introduced the chart. The Commission has been working with the remaining five DHBs to overcome barriers to implementation. Feedback on the original chart was sought this year and as a result refinements and enhancements were implemented, including changes to make the chart suitable for paediatric wards and expand its duration to eight days. A new 16-day chart has been introduced to meet the needs of long stay patients and a short stay/day case chart is being developed to complete the suite of charts.

We have started developing a national medication chart for the aged residential care sector. This is an important step towards achieving national consistency and reducing medication error and its corresponding harm to aged care residents. The new national chart for the aged residential care sector is expected to be finalised in 2012/13.

Medicine reconciliation

Medicine reconciliation ensures patient medicines are checked at critical handover times, such as when patients are admitted to or discharged from hospital. Nineteen DHBs have commenced implementation of medicine reconciliation at admission, with at least half of these DHBs implementing medicine reconciliation at discharge as well. This is a substantial improvement in process and reflects considerable effort by both the Commission and the DHBs.

The Commission and DHBs are making progress in establishing national prioritisation criteria for identifying patients at risk of medication harm who may benefit from medicine reconciliation. This is based on work at Counties Manukau DHB, which is currently being validated. Results from the validation will be used to determine the next stages of the national prioritisation tool.

To assist providers and consumers we published two pamphlets on medicine reconciliation:

- *Making sure you are taking the right medicines: An important guide for people coming in to hospital*
- *Medicine reconciliation: A guide for health professionals.*

Clinicians responsible for the patient's treatment 'reconcile' the medicines prescribed with the medicines listed as being taken by the patient, using a second source of information as confirmation.

Electronic medicines management

Through our joint work with the National Health Board (including the National Health IT Board), we are working towards an electronic system that will give all health care providers access to every New Zealander's medication information and enable everyone caring for the patient to ensure the following six 'rights of patients' are achieved:

- the right patients
- the right medicine
- at the right time
- in the right dose
- by the right route
- and that it is correctly recorded.

During 2011/12, we established the foundations for development of electronic medicines management (eMM) including agreements with three DHBs who are implementing electronic prescribing and administration (ePA) and electronic medicine reconciliation (eMR).

We assessed the readiness of all DHBs to implement eMM. This will inform development of a roadmap for implementation and identify the support needed to ensure all DHBs can meet our joint goal with the National Health IT Board that eMR and ePA will be introduced into all public hospitals by 2014.

Measurement and evaluation of the National Medication Safety Programme

The Commission is leading the development of a measurement and evaluation framework for the National Medication Safety Programme, with an initial emphasis on eMM initiatives. The objective is to evaluate the roll-out of ePA and eMR systems in four DHB sites. The DHBs participating in the roll-out are Counties Manukau, Taranaki, Southern and Waitemata. The evaluation will also develop a measurement and evaluation framework for the broader National Medication Safety Programme for secondary care in the DHB setting.

During 2011/12 we awarded a contract to Sapere Research Group to develop the measurement and evaluation framework. The development of a draft overall evaluation framework and indicator set began. This will be progressively refined based on feedback from experts, stakeholders and DHB site visits during the 2012/13 year.

Medication Safety Watch

The Commission started producing a bulletin for all health professionals and health care managers working with medicines or patient safety. Two were produced during the year, in February 2012 and May 2012. *Medication Safety Watch* provides timely information about medicine-related incidents, errors and adverse drug events and their implications, and offers recommendations on how to improve medication safety. The sector has been directly contributing information for this bulletin.

High-risk medicines and situations

During 2011/12 the Commission produced four medication alerts.[12] The alerts produced are recommendations relating to either internationally recognised or locally identified high-risk medicines or situations. Alerts are sent to relevant health care providers with the latest information and advice on particular topics of concern. We also produced guidance on 'error-prone abbreviations and dose designations' in poster format.

INFECTION PREVENTION AND CONTROL PROGRAMME

Healthcare-associated infections

Dr Sally Roberts is clinical lead for the healthcare-associated infections programme. She is a clinical microbiologist and infectious diseases physician and Clinical Head of Microbiology at Auckland DHB.

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

12 Alerts on Dabigatran (July 2011), Heparin (September 2011), caffeine citrate oral solution (October 2011) and Oral Methotrexate (December 2011).

Taranaki DHB is one of the three DHBs trialling the electronic tool (along with Counties Manukau and Waitemata DHBs).

I found it excellent and easy for me to follow and to transfer into my notes. My patient's partner also found it excellent as he understood exactly what all the changes were.

Dr Peter Catt, New Plymouth GP

Cross infection rates have markedly decreased in the acute medical ward, a high risk ward, since our hand hygiene initiatives have been implemented, and the last audit showed our compliance rate sitting at 64 percent. The team on the ward has worked hard to improve hand hygiene behaviour. They have developed a sustainable approach that allows them to further improve their compliance rates.

Barbara McPherson, Hawke's Bay DHB Hand Hygiene Coordinator

$20,000 to $45,000, depending on the severity of the infection and the treatment needed.[13] In 2003 it was estimated the annual cost of treating patients with infections picked up while in hospital was approximately $140 million. This does not take into account the cost to the patient and family in delayed recovery times, extra doctor visits and time off work.[14]

The Commission is leading work on infection prevention and control including hand hygiene, CLAB and surgical site infection surveillance.

Hand hygiene

Dr Joshua Freeman is clinical lead for the hand hygiene programme. He is a microbiologist at Auckland DHB.

This programme aims to improve hand hygiene compliance across all health care worker groups in order to reduce hospital-acquired infections. During 2011/12 Auckland DHB was contracted by the Commission to lead the programme. The national average rate of compliance across all hospital workers and all five hand hygiene 'moments' was reported to be less than 50 percent when the Commission was established in 2010. The programme's June 2012 report shows the compliance rate is now 63.2 percent – very close to the 2011/12 target of 64 percent. Studies have shown that significant and sustained improvements in hand hygiene rates can have major positive effects on infection rates. For example, Auckland DHB recorded significant reductions in *Staphylococcus aureus* bacteraemia rates once their hand hygiene programme was fully implemented.

The first-year review of the programme also identified that it achieved its targets for training auditors – with 120 gold auditors and six platinum auditors being in place.[15]

Central line associated bacteraemia (CLAB)

Dr Shawn Sturland is clinical lead for the CLAB programme. He is clinical leader for Intensive Care at Wellington Regional Hospital Intensive Care Services.

CLAB is a serious but preventable complication from a relatively common procedure (insertion of central lines). Ko Awatea at Counties Manukau DHB was contracted by the Commission to achieve a sustainable reduction in CLAB episodes through a national programme of leadership, training and coordination. All the key milestones in the year one plan were met. These included delivering training sessions and developing resources, analysing DHB baselines and regular updates on CLAB rates.

13 Evaluation of Middlemore Hospital ICU's implementation of the standardised checklist of interventions, 'the central line bundle' to prevent catheter-related blood stream infection.

14 The Clean Hands Chronicle – clean hands save lives. Issue three, August 2012.

15 Platinum auditors train and guide gold auditors operating at the local DHB level.

For the first time since the programme started in 2008, it reported zero CLAB incidents nationally for April. It also reported that three ICUs (Whangarei, Tauranga and Hawke's Bay) were CLAB-free for more than one year. Counties Manukau has reported that reductions in CLAB rates across a number of wards has resulted in saving 220 inpatient bed days and a saving of $520,000 since July 2011.

Surgical site infection surveillance

Surgical site infections (SSIs) are the second most common form of hospital-acquired infection, are costly to treat, are associated with increased mortality and have an impact on quality of life.

During 2011/12 we commissioned a cost-benefit analysis. This supported international evidence that a national SSI surveillance programme will improve patient outcomes as well as avoiding costs of $6.2m[16] a year. One-off costs of implementation are estimated to be around $4.4 million with annual costs of $1 million. Subsequently we identified a lead agency to develop and implement the programme. This programme will facilitate comparisons between providers and will motivate and support teams to reduce rates of SSIs by implementing evidence-based changes to surgical practice.

REDUCING PERIOPERATIVE HARM PROGRAMME

Mr Ian Civil is clinical lead for the reducing perioperative harm programme. He is a trauma surgeon at Auckland DHB where he is also Head of Surgery. He has recently ended a term as President of the Royal Australasian College of Surgeons.

The reducing perioperative harm programme aims to improve the surgical patient's journey and reduce preventable adverse events that cause harm. A key programme being supported by the Commission is the World Health Organization (WHO) surgical checklist. Internationally the reduction in avoidable complications following introduction of the checklist is around 30 percent.[17] In New Zealand we could expect a new financial benefit of $43 million over 10 years.

When implemented properly, the WHO surgical safety checklist goes beyond checking. It promotes effective teamwork and communication. It requires hospital staff to stop and think what they are doing and why. It involves checking the right people are present, that they know each other's names and are empowered to speak up if they notice something going wrong, and that they are all in agreement about why they are operating. Thinking about what could go wrong is key – for example checking for allergies to medicines is part of the checklist, and needs to be done with engaged minds. It is a simple process but one that has been shown to be profoundly effective in saving lives.

Unfortunately its use is variable[18], and often reflects little more than compliance with ticking boxes. This programme will work to increase the engaged and effective use of this powerful tool.

REDUCING FALLS RESULTING IN INJURY IN PUBLIC HOSPITALS

Sandy Blake is clinical lead for the national falls harm prevention programme. She is the Director of Nursing, Patient Safety and Quality, at Whanganui DHB.

Falls in public hospitals remain the largest category of serious events reported by hospitals. Our report *Making Our Hospitals Safer – Serious and Sentinel Events reported by District Health Boards 2010/11*, published in February 2012, reported 195 falls in the 2010/11 year. This represents 52 percent of the total number of serious and sentinel events reported by DHBs. As a result of this information, reducing the number and harm from falls in hospital inpatient settings and aged residential care has become one of the Commission's four priority programmes. It is therefore one of the four health quality and safety markers the Commission is developing for the sector at the request of the Minister of Health. During 2011/12 we started mapping falls programme activity in DHBs and worked with ACC to ensure our work (which focuses on health care settings) complements ACC's work as the lead agency for falls prevention as part of the overarching New Zealand Injury Prevention Strategy.

16 The medium scenario

17 Haynes AB, et al. 2009. A surgical safety checklist to reduce morbidity and mortality in a global population. *New England Journal of Medicine*. 360(5): 491–9.
De Vries EN, et al. 2010. Effect of a comprehensive surgical safety system on patient outcomes. *New England Journal of Medicine*. 363(20): 1928–37.
Neily J, et al. 2010. Association between implementation of a medical team training program and surgical mortality. *Journal of the American Medical Association*. 304(15): 1693–700.

18 Vogts N, et al. 2011. Compliance and quality in administration of a Surgical Safety Checklist in a tertiary New Zealand hospital. *New Zealand Medical Journal*. 124(1342): 48–58.

2.3 Output class 3: Influence quality and safety practice

Consumer and provider partnerships improve quality and safety.

Vision statement – Partners in Care framework

Developing the quality and safety capability of the sector is a key element in delivering better sector quality and safety outcomes and a more systematic and predictable quality and safety response across the system. Our health care professionals are very well trained in the science of their own fields – medicine, nursing, pharmacy and so on. However the delivery of health care is itself a science, and knowledge and expertise in this, the science of system improvement, is less well developed (in New Zealand and in most countries). Our aim is to achieve and surpass internationally accepted quality and safety outcomes for every New Zealander, and to make this a self-sustaining process. This will depend on increasing the number of people in the sector who have the capability to drive improvement effectively.

In the short term, the benefits of building capability include:

- building a critical mass of technical and leadership skills and knowledge of improvement science to facilitate the system-wide spread of our quality and safety programmes
- better delivery of key quality and safety programmes and local projects based on better access to expert knowledge in achieving effective systems improvement
- more consistent nationwide quality and safety knowledge, and use of tools and techniques to achieve key quality and safety priorities.

In the longer term, building capability will result in:

- a culture where quality and safety is inherent in everything we do
- more consistent achievement of the right standard of safety and quality across New Zealand's health and disability services
- wider engagement and participation by patients/communities in their health and disability services
- an affordable system – a high-quality system is more efficient and reduces costs.

DEVELOPING CONSUMER AND FAMILY/WHĀNAU ENGAGEMENT AND PARTNERSHIP

Patient-centred care is a fundamental element of quality in health care. One way to ensure excellent health care with limited resources lies in greater engagement of patients with decisions about their own health care. There is growing evidence demonstrating the importance of partnerships between health service organisations/health professionals, and patients, families/whānau and carers. Potential benefits have been demonstrated in improved outcomes, enhanced experience of care, lower costs per case and increased workforce satisfaction.

During 2011/12 the Commission developed a *Partners in Care* framework and action plan.

Partners in Care has three streams, aiming to:

1. increase health literacy
2. improve consumer participation
3. develop leadership capability for providers and consumers.

While this three-year programme starts in 2012/13, we made some important progress during 2011/12, outlined below.

Building capability of consumer organisations

The Commission continues to support the Consumer Collaborative of Aotearoa to become a self-sustaining and independent organisation, with the capacity and capability to actively facilitate consumer engagement and partnership with health and disability providers and services. A directory of consumer organisations and assessment of the needs of consumer organisations and individuals undertaking consumer representation roles was completed.[19] This is a working document and is updated as more organisations and individuals become aware of it.

Improving health literacy

It is important for New Zealanders to know about the health and disability services that are available to them and how they can access these services. It is also important they understand the choices available to them and the implications of the treatments they are receiving – why they are taking certain medications, for example, and what, if any, are the risks to look out for.

19 http://www.hqsc.govt.nz/our-programmes/consumer-engagement/projects/directory-of-consumer-organisations/

The Ministry of Health's 2010 report, *Korero Marama – Health Literacy and Māori*, found that 56 percent of adult New Zealanders had low health literacy skills. Health literacy is about making sure people understand the available information about health care services, the medications they take and the health care options and decisions they make.

We asked the New Zealand Guidelines Group to research the ways health providers and other organisations in New Zealand were working towards improving people's understanding of their health and the services available to them. It discovered that, while more information was being written in plain language, this did not go far enough to reach people with low health literacy. The report noted the majority of health providers were not aware of the detrimental effect of low health literacy, but where concerted efforts had been made to ensure patients understood their health problem and treatment, the results were both positive and rewarding. During 2012/13 the Commission will implement recommendations from the report focused on improving provider communication.

The Commission sponsored 21 people (consumers and providers) to attend the Workbase[20] health literary conference in May 2012.

Improving capability through effective forums and workshops

Beverley Johnson

The Commission sponsored Beverley Johnson, President/CEO of the Institute for Patient and Family-Centered Care (USA) as one of the keynote speakers at the Australasian conference, *The Great Healthcare Challenge 2011*. Before the conference in October 2011, we arranged workshops and forums for Beverley Johnson to discuss her work and the increasing evidence of the value of patient/consumer and family engagement in health services.

Lynne Maher

Lynne Maher, Director for Innovation and Design, NHS Institute for Innovation and Improvement, presented workshops in Auckland and Wellington in May 2012 for 33 teams of two. Consumers and clinicians paired up to take part in the eight-month programme, *Partners in Care*, designed to provide each team with the knowledge and skills to lead their particular consumer engagement project within their organisation. This approach is a world first.

The projects being implemented by the consumer/clinician teams cover a wide range of topics such as advanced care planning, improving recovery orientation in mental health services, developing resources for particular health issues and many more. The Commission will profile completed projects with a view to their broader uptake and will promote this partnership approach to innovation in the sector.

CLINICAL LEADERSHIP AND BUILDING THE QUALITY AND SAFETY CAPABILITY[21] OF THE SECTOR

The Commission has an important role to work with the sector (including with clinical leaders) to enable providers to make the changes required. Credible clinical leaders who understand the challenges of looking after patients, often in challenging circumstances and unsociable hours, are key to driving this change effectively. We started this process in 2011/12 by appointing clinical leaders who are well-respected in their fields for all our key programmes. Their role is 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.

During the year, we developed evidence-based and planned approaches to guide our future work in building quality and safety capability in the sector. We decided the most urgent area where competency development is needed is in improvement science and that we should start building this capability as part of our work in the four priority areas of reducing harm from hospital-acquired infections, surgery, medicines and patient falls. Work has commenced on developing and defining these competencies.

We signed a Memorandum of Understanding (MOU) with Ko Awatea, the Centre for Health System

20 Workbase is a charitable trust providing language, literacy and numeracy services.

21 Capability is the knowledge and skills of people. Capacity is the number and level of people.

The overriding goal of improvement science is to ensure quality improvement efforts are based as much on evidence as the best practices they seek to implement. Simply put, strategies for implementing evidence-based quality improvement need an evidence base of their own.

Shojania KG, Grimshaw JM. Evidence-based quality improvement: the state of the science. Health Aff (Millwood) 2005; 24(1):138-50.

Innovation and Improvement (under the umbrella of Counties Manukau DHB) to help build the capability and expertise of the health system for all health workers, consumers and communities to deliver improvements in health and disability services.

Learning from our international partners

Partnership with the NHS Institute for Innovation and Improvement[22]

The Commission signed an MOU with the NHS Institute in February 2012. The MOU provides the Commission with access to the Institute's knowledge of improvement practices in other countries, and in return we share knowledge and information about health care improvement initiatives in New Zealand. We are holding regular discussions on strategic and operational matters and keeping each other informed of significant upcoming events. There is potential to jointly develop quality improvement services and events.

Harvard School of Public Health

A team from the Harvard School of Public Health, led by Dr Atul Gawande, is collaborating with the Commission on the reducing perioperative harm programme. They are conducting a similar project in South Carolina, and are providing tools and advice based on that recent experience.

Dr Helen Bevan workshop – delivering value through quality improvement

Dr Bevan, Director of Service Transformation at the NHS Institute of Innovation and Improvement, has led efforts in the NHS to mobilise front-line clinicians, consumers, and clinical and managerial leaders to achieve cost reduction through quality improvement. In May 2012 she provided a workshop for senior health leaders on reducing costs and delivering value through quality improvement and innovation.

Dr Raj Behal workshop

Dr Behal, Senior Patient Safety Officer and Associate Chief Medical Officer at Rush University Medical Centre in Chicago, facilitated a well-attended workshop on hospital-based mortality.

Lynne Maher workshops – experience-based design for Partners in Care

This is covered in the section on developing consumer and family/whānau engagement and partnership.

Beverley Johnson forums and workshops

This is also covered in the section on developing consumer and family/whānau engagement and partnership.

22 A special health authority of the National Health Service in England which supports the NHS to transform health care for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership.

QUALITY AND SAFETY CHALLENGE

In 2011/12 the Commission sponsored the Quality and Safety Challenge, a programme of short-term initiatives designed to improve patient safety, foster quality improvement, and/or improve consumer engagement.

Twenty-seven initiatives were selected involving DHBs, NGOs, private providers and professional bodies. The initiatives included six consumer/*Partners in Care* initiatives, three focused on falls prevention, two on medication safety, two on Global Trigger Tools, and two on venous thromboembolism prevention. The remainder included topics such as residential care, ventilator-associated pneumonia, clinical ethics networks, and the quality of maternity care in cases of perinatal death. A number are already delivering benefits for patients and their families.

An external evaluation of the effectiveness of the challenge began in July 2012 and will document the value these initiatives have delivered to the health care sector and highlight any opportunities/recommendations for the future. Depending on the success of the current initiatives, the Commission will consider sponsoring a second round.

COMMUNICATION AND ENGAGEMENT

Our communication and engagement work aims to:

- raise our profile and promote understanding of our role and effectiveness as a catalyst for invigorating change, and our focus on four priority areas
- establish the Commission as the 'go to' body for the health sector for support and advice to improve the quality and safety of New Zealand health and disability services
- ensure stakeholders know how the role of the Commission relates to their work and interests
- promote the benefits of increasing health quality and safety to the sector and encourage the sector to 'own' health quality and safety
- ensure our publications are clear, accurate and understandable.

We launched our new website in March, with information and updates from our programme areas, news and events, and publications and resources. 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 coordinated suite of activity occurring across the sector, and it offers opportunities for direct dialogue and engagement with the Commission's stakeholders.

During 2011/12 we produced or funded 29 newsletters and factsheets. These are outlined in more detail in the Statement of Service Performance.

3.0 Maintaining and developing organisational capability

The Commission is now fully functional, fully staffed and has suitable premises and appropriate technology support. We have developed and implemented a full range of policies and controls appropriate to a Crown entity.

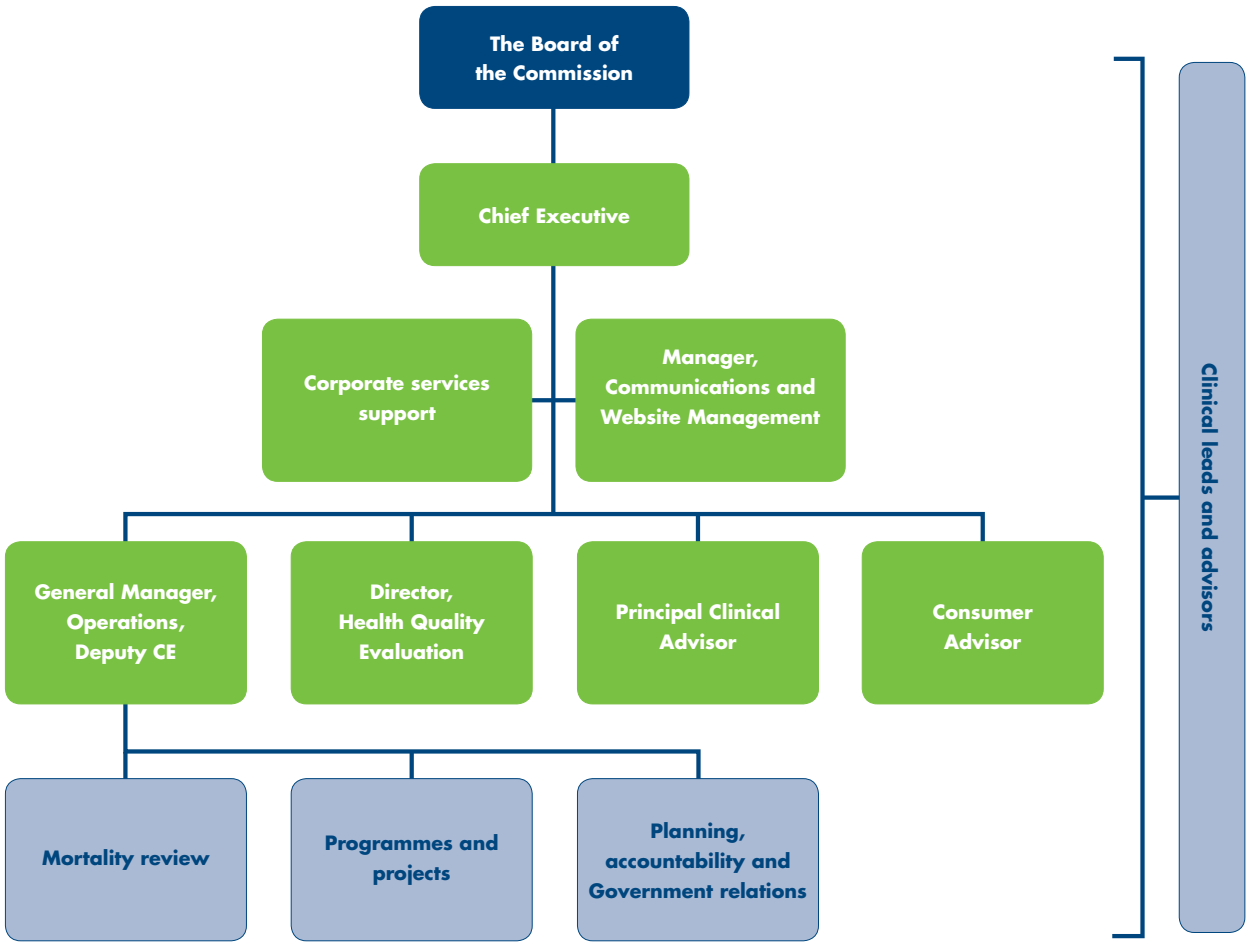
3.1 The Commission's progress against the targets for organisational capability in the 2011–2014 Statement of Intent

This section reports progress against the targets that we set for ourselves as an organisation. They are included in our 2011–14 Statement of Intent but are not part of the Statement of Service Performance.

BUILD CAPACITY AND CAPABILITY OF THE COMMISSION

Performance measure and standard	Achievements
Structure of the Commission finalised by 31 July 2011.	The structure of the Commission has been finalised (see diagram below).
All key positions filled by permanent staff by 30 September 2011.	By 30 September 2011 all key senior positions were filled (one had been appointed but not yet commenced).

Structure of the Commission



Our aim is to be role model for lean, cost effective, high-quality organisations.

Professor Alan Merry, Chair of the Commission

EXPERT ADVICE AND LEADERSHIP

During 2011/12 the Commission established 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. Initially the group will focus on measurement and evaluation work and public reporting.

SHARED SERVICES

Performance measure and standard	Achievements
By 30 December 2011 opportunities for shared back-office services among relevant agencies will be identified and implemented.	The Commission has in place all the back-office support it currently requires. IT infrastructure is contracted via a syndicated procurement process. The Commission remains involved in the Ministry of Social Development and Department of Internal Affairs 'all of government' (AOG) procurement processes and will look to use these contracting processes for IT 'infrastructure as a service', legal support, travel, and media as these are further developed. AOG contracts are in place for print solutions and were used for the purchase of computer hardware. Payroll functions and payments to Committee members have been outsourced to a third-party specialist payroll provider who is able to provide services more economically than the Commission could provide in-house. Human resource services were tendered for on the Government Electronic Tenders Service (GETS) and contracts are in place on a fee-for-services basis. Financial services remain in-house. The Commission will continue to look for opportunities to improve the cost-effectiveness of back-office services.

FINANCIAL MANAGEMENT

Performance measure and standard	Achievements
Management of the Commission's finances will be consistent with relevant requirements under the State Sector and Public Finance Acts and applicable Crown entity legislation to maintain sound management of public funding. Audit New Zealand's 2011/12 audit grading of performance in each area of financial service performance will provide a baseline for future improvement.	Audit New Zealand undertook an interim audit of the Commission in May 2012. It noted the Commission continues to 'maintain an effective control environment' and that we have 'made good progress in developing policies, establishing procedures and bedding-in systems of control'. It noted the Commission has taken action on the Audit New Zealand recommendations from the 2011/12 audit. A final audit for 2011/12 occurred in October 2012.

INFORMATION MANAGEMENT

Performance measure and standard	Achievements
By 30 June 2012 the Commission will have determined its information requirements and commenced putting these in place.	The Commission has access to national collections to populate the New Zealand Atlas of Healthcare Variation and the quality and safety indicators and markers. We have also established relationships to enable us to access a variety of other data as required.

GOVERNANCE DEVELOPMENT

Performance measure and standard	Achievements
By 30 June 2012 there will be appropriate consumer involvement at board level.	After consultation with the Minister, it has been agreed that a person able to represent a consumer perspective will be brought onto the Commission's Board at the next opportunity. Our *Partners in Care* framework and action plan was finalised and is focused on building partnerships with consumers at all levels (including governance), both in the sector and in the Commission itself.

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

The Commission is committed to providing a work environment in which 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 generations.

These practices are reflected in our formal policies on flexible work practices and equality and diversity.

Our policy on equality and diversity includes a firm commitment to the principles of equal employment opportunities and to ensuring no discriminatory policies or practices exist in any aspect of employment. The policy notes that equal employment opportunities/diversity practices include hiring based on merit, fairness at work, flexible working options and promotion based on talent. These principles relate to all aspects of employment including recruitment, pay and other rewards, career development and work conditions.

Understanding, appreciating and realising the benefits of individual differences will not only enhance the quality of our work environment but will enable the Commission to better reflect the diversity of the community we serve.

3.3 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 occasions.

Board member having interest	Item under discussion and date	Particulars of interest	Board action/resolution
Shelley Frost	Library of Clinical Measures: Proposal for funding for implementation of a governance and operational framework for Health Quality Measures NZ (HQMNZ), a programme established by the Patients First Programme 27 July 2011 and 23 August 2011	Mrs Frost declared her interest as a member of the Patients First Steering Group and Deputy Chair, GPNZ	Unanimous agreement that Mrs Frost remain for the discussion but abstain from voting
Peter Jansen	Appointment of members to Roopu Māori Group 23 August 2011	Dr Jansen declared a conflict of interest as all the potential candidates identified were known personally to him	Unanimous agreement that Dr Jansen remain in the meeting but abstain from voting
Geraint Martin	Medication Safety 1 November 2011 and 19/20 December 2011	Mr Martin declared a conflict as CEO of Counties Manukau DHB	Unanimous agreement that Mr Martin remain in the meeting for discussion but abstain from voting
Geraint Martin	Phase 2 e-Medication Funding 8 March 2012	Mr Martin declared his interest as CEO of Counties Manukau DHB	Unanimous agreement that Mr Martin remain in the meeting but be excluded from discussions and abstain from voting
David Galler	Asia Pacific Forum 13 April 2011	Dr Galler declared his interest as Director of Leadership, Ko Awatea which is co-hosting the Forum with IHI	Unanimous agreement that Dr Galler remain in the meeting but be excluded from discussions and abstain from voting

Part Two

4.0 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. Each of the mortality review committee reports includes a report on the progress of that committee and links to each of the reports are included in this annual report.

5.0 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 2011/12 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.

5.1 Output class 1: Information, analysis and advice

PUBLIC REPORTS ON QUALITY AND SAFETY

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
Quality of reports	All reports include priorities for action	Achieved	The following reports published during 2011/12 included priorities for action: • Fifth and Sixth Perinatal and Maternal Mortality Review Committee Reports • Low Speed Run Over Mortality Report • The involvement of alcohol consumption in the deaths of children and young people in New Zealand during the years 2005–2007 Report • Inaugural Perioperative Mortality Review Committee Report (third quarter) • Second Family Violence Death Review Committee Report • Child and Youth Mortality Review Committee Activities Report. The 2010/11 Serious and Sentinel Events report deliberately does not have recommendations, and instead includes examples of how improvements have been made in DHBs. The Atlas of Healthcare Variation does not have recommendations as it is a tool for comparison, discussion and self-improvement.

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
Quality of reports	• Within 12 months of publication, stakeholder feedback indicates that 80% found the report user-friendly • Within 12 months of publication, stakeholder feedback indicates that, where the report has recommendations relevant to the organisation, 80% have used them to either confirm current practice or make service improvements	Not due until 2012/13	The performance measure requires stakeholder feedback within 12 months of publication. No surveys were due during 2011/12. The surveys will be completed for each of the reports under this output class as follows: • first report against national and international measures of quality and safety – survey to be completed by July 2013 • first healthcare variation report – survey to be completed by June 2013 • The 2010/11 Serious and Sentinel Events report – survey to be completed by February 2013 • Low Speed Run Over Mortality report – survey to be completed by August 2012 • Report on Involvement of alcohol consumption in the deaths of children and young people in New Zealand during the years 2005–2007 – survey to be completed by September 2012 • Sixth Perinatal and Maternal Mortality Review Committee Report – survey to be completed by June 2013 • Family Violence Death Review Committee Report – survey to be completed by January 2013 • Perioperative Mortality Review Committee Report – survey to be completed by February 2013. To prepare for the process of eliciting stakeholder feedback we established a survey tool and process. This was successfully trialled on the Commission's March 2012 newsletter and will now be used to survey stakeholders in relation to relevant 2011/12 publications. The mortality review committee reports are being used to inform improvements in a number of important areas as outlined on the next page.

Fifth Perinatal and Maternal Mortality Review Committee Annual Report

- Counties Manukau DHB has set up a panel of experts to look at the result in the report which indicates that more mothers and babies are at risk in the Counties Manukau DHB area than other DHBs. It will report back on how maternity care could be improved or delivered differently.
- The Ministry of Health has indicated support for establishing a mother and baby unit in the North Island.

Low Speed Run Over Mortality Report (Child and Youth Mortality Review Committee)

- The Safekids campaign focused on this issue, using the information as the basis for awareness campaigns across New Zealand.
- Housing New Zealand agrees with the recommendations that it should:
  - over time, modify its current stock so they have safe play areas for children, separated from driveways
  - ensure all new developments are constructed so they have safe play areas for children, separated from driveways.

  Housing New Zealand is currently in the process of developing guidelines that incorporate this into new builds, new acquisitions, infill housing and existing stand-alone properties.
- The Chair of the Child and Youth Mortality Review Committee is currently discussing the recommendation about systematic data collection on all low-speed child run-over injuries and mortalities with the New Zealand Transport Agency (NZTA). The NZTA appears to be interested in taking on the data collection responsibility, since it manages the national (on-road) crash database.
- The report contains a recommendation that driveway safety should be part of all Well Child care, with special emphasis given at the Well Child nine-month child health assessment. We understand the Ministry of Health appreciates the importance of this recommendation and has agreed to incorporate it into the Well Child programme. The exact details are not yet known.

Second Family Violence Death Review Committee Report

Two of the three recommendations have already been taken up by:

- the New Zealand Police, which has increased first-responder domestic violence training
- the Department of Corrections, which is making changes to its home detention planning.

The involvement of alcohol consumption in the deaths of children and young people in New Zealand during the years 2005–2007 Report (Child and Youth Mortality Review Committee)

- The Land Transport (Road Safety and Other Matters) Amendment Act 2011 incorporated elements of two key recommendations of this report (which were first publicised by the Committee in 2010 when it did the preliminary analysis for the report):
  - enforcement of the zero blood alcohol concentration with all drivers under 20 years of age
  - raised penalties for dangerous driving behaviours and easier procedures for Police to charge drivers in breach of their licensing conditions.
- The Commissioner of Police has indicated a willingness to work with the Commission on the recommendations relating to Police.
- Whanganui DHB has considered how it could implement the recommendation relating to its paediatric and emergency services.

Perioperative Mortality Review Committee Report

- The Private Surgical Association supports the recommendation that there be whole-of-system data reporting on perioperative deaths, including private hospitals.

FIRST REPORT AGAINST NATIONAL AND INTERNATIONAL MEASURES AND INDICATORS OF QUALITY AND SAFETY

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
Timeliness of report	Published by 30 June 2012	Partially achieved (published in July 2012)	By 30 June the draft set of measures and indicators had been developed. After Board consideration in July, they were published and feedback sought from the sector.

FIRST HEALTHCARE VARIATION REPORT

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
Timeliness of report	Published by 30 June 2012	Achieved	The first Healthcare Variation Report (the Atlas of Healthcare Variation) was launched on 29 June. It can be accessed at http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-health-care-variation/

2010/11 SERIOUS AND SENTINEL EVENTS REPORT

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
Timeliness of report	Published by 30 December 2011	Partially achieved (published in February 2012)	The report was delayed because of the quality of the data provided and the variation in application of the reporting policy around the country. However, when released in February 2012, it had extensive media coverage and was welcomed positively by the public and health professionals. The report can be viewed at: http://www.hqsc.govt.nz/publications-and-resources/publication/333/

CHILD AND YOUTH MORTALITY REVIEW COMMITTEE TOPIC REPORTS

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
Timeliness of report	One topic report published by 31 July 2011	Partially achieved (published in August 2012)	Low Speed Run Over Mortality was published in August 2012. It can be viewed at http://www.hqsc.govt.nz/assets/CYMRC/Publications/low-speed-report.pdf
	At least one further topic report published by 30 June 2012	Achieved	The second topic report, The involvement of alcohol consumption in the deaths of children and young people in New Zealand during the years 2005–2007 was published in September 2011. It can be viewed at http://www.hqsc.govt.nz/assets/CYMRC/Publications/Alcohol-report.pdf

PERINATAL AND MATERNAL MORTALITY REVIEW COMMITTEE FIFTH ANNUAL REPORT

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
Timeliness of report	Published by 31 October 2011	Achieved	• The Fifth Perinatal and Maternal Mortality Review Committee Report was published in September 2011 and can be viewed at http://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/30/ • The Sixth Perinatal and Maternal Mortality Review Committee Report was published in June 2012. Both reports can be viewed at http://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/479/

FAMILY VIOLENCE DEATH REVIEW COMMITTEE SECOND REPORT

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
Timeliness of report	Published by 31 July 2011	Partially achieved (published in January 2012)	The Family Violence Death Review Committee Second Report was released in January 2012. It can be viewed at: http://www.hqsc.govt.nz/our-programmes/mrc/fvdrc/publications-and-resources/publication/288/

PERIOPERATIVE MORTALITY REVIEW COMMITTEE FIRST ANNUAL REPORT

Performance measure	Standard 2011/121	Status (achieved, not achieved)	Further information
Timeliness of report	Published by 31 August 2011	Partially achieved (published in February 2012)	The inaugural Perioperative Mortality Review Committee Report required additional epidemiological analysis, which delayed progress. The report was published in February 2012. It can be viewed at: http://www.hqsc.govt.nz/our-programmes/mrc/pomrc/publications-and-resources/publication/321/

A NATIONAL ALL-SECTOR APPROACH TO REPORTING AND MANAGING INCIDENTS AND EVENTS

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
A national policy for the management of health care incidents with operational guidelines will be promulgated across the health and disability sector	Policy promulgated by 30 December 2011	Partially achieved (published in February 2012)	The New Zealand Health and Disability Services National Reportable Events Policy was promulgated on the Commission's website in February 2012. It can be viewed at: http://www.hqsc.govt.nz/our-programmes/reportable-events/national-reportable-events-policy/
Central repository to collect, analyse and report incidents that meet the threshold for inclusion	Repository fully operational by 30 June 2012	Achieved	A database used to collect, analyse and report incidents was established during the second quarter. This is working well as a fully operational interim repository. We have now purchased a software package that is tailor-made for this purpose.
Train-the trainer education and training programmes to support implementation of the national policy and operational guidelines delivered to trainers from the public, private and NGO sector	At least one train-the-trainer programme will be delivered by 30 June 2012	Changed approach achieved	The Commission and DHB quality and safety managers decided on a more direct approach to training rather than a train-the-trainer approach. A web-based training document was published on the Commission's website in June. It provides advice on how to manage the root cause analysis (RCA) process for severity assessment code 1 and 2 incidents to assist RCA teams. This is being actively promoted by DHB quality and safety managers within their organisations. The training document can be found on http://www.hqsc.govt.nz/our-programmes/reportable-events/publications-and-resources/publication/478/

SUPPORTING AND FACILITATING DEVELOPMENT OF METHODS FOR MEASURING THE CONSUMER EXPERIENCE

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
DHBs and the Commission complete the new consumer satisfaction survey and have it included in the DHB operational policy framework (OPF) for 2012/13 The new measures are considered by consumers to be relevant	The new measures are included in the DHB OPF by 30 June 2012 By 31 December 2011 testing demonstrates consumers consider the new measures to be relevant	Not achieved	The DHB quality and safety managers, facilitated by the Commission, developed a 'how to guide' and a toolkit for measuring the consumer experience. The next step is to incorporate this into a nationally consistent set of measures. These are now expected to be in the OPF for 2013/14. As a new national set of measures has not been finalised, it has not been possible to test them with consumers. However, the project team which developed tools and methods for measuring consumer experience included consumer representation and consultation with consumers.

5.2 Output class 2: Sector tools, techniques and methodologies

NATIONAL MEDICATION SAFETY PROGRAMME

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
The national medication chart will be implemented in all DHBs	Implemented by 1 January 2012	Not achieved	By 1 January 2012, 15 DHBs had implemented the national medication chart. By 30 June 2012, this number was still 15, although the remaining DHBs are further down the implementation track. Canterbury, Taranaki, Southern, Auckland and Northland DHBs did not commence implementation because of a variety of factors. These range from environmental impacts of the Canterbury earthquakes, to resource constraints and integration of the chart into scannable operating solutions. The Commission has engaged with these DHBs to identify and address barriers to implementation. In Auckland, for example, we piloted a scannable version of the chart. Northland is expected to implement the chart by November 2012.
Targets for 2011/12 and out-years for implementation of the national standard paper-based medicine reconciliation process for priority patients will be agreed with each DHB	Targets agreed by 31 December 2011 Targets for 2011/12 are met by 90% of DHBs by 30 June 2012	Not achieved	Targets have not been agreed. A national prioritisation tool needed to be developed first to identify high-risk patient groups, before targets could be set. A measure relating to implementation and evaluation of the prioritisation tool has been included in the 2012–2015 Statement of Intent. However, 19 DHBs have commenced implementation of medicine reconciliation. This is a very good result and reflects a considerable effort by both the Commission (training and support) and the DHBs.

PROGRAMME LEAD FOR THE NATIONAL HAND HYGIENE PROGRAMME

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
Percentage of health care providers compliant with the hand hygiene programme (as shown by regular auditing)	64% overall compliance with the hand hygiene programme achieved by 30 June 2012	Substantially achieved	The June 2012 audit showed average compliance across all workers and all five hand hygiene 'moments' was 62.3% with 17 DHBs submitting data. This is a very good result considering compliance was reported to be less than 50% when the Commission was established in 2010.

PROGRAMME LEAD FOR THE CENTRAL LINE ASSOCIATED BACTERAEMIA (CLAB) PROGRAMME

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
A plan for implementation of CLAB programmes in ICUs, surgical and neonatal units will be complete	Implementation plan by 30 July 2011	Achieved	The business case and request for proposal for the delivery of a national CLAB programme were completed by the end of July 2011. The contract was awarded in September 2011 to Counties Manukau DHB/Ko Awatea.
Deliverables in the above plan will have been met	Deliverables met by 30 June 2012	Achieved	All key deliverables in the plan agreed with Ko Awatea were met by 30 June 2012.[23] This included appointment of staff to the project, establishment of a steering group, delivering training sessions and developing resources, analysis of DHB baselines and regular updates on CLAB rates. Good progress is being made in reducing CLAB rates. The June CLAB report notes there were zero CLAB incidents reported nationally for April. The report also highlights 431 days CLAB-free at the Whangarei ICU at 19 April, 730 at Tauranga ICU at 18 May and 365 at Hawke's Bay ICU at 11 May. Counties Manukau demonstrated the gains that can be achieved when spreading the CLAB programme to multiple clinical areas – a reduction of approximately 220 inpatient bed days and savings of $520,000 from July 2011.

FACILITATE USE OF WHO SAFE SURGERY CHECKLIST

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
An assessment of the percentage of all surgical procedures in New Zealand public hospitals using the WHO Safe Surgery Checklist appropriately will be complete	Assessment complete by 30 June 2012	Not achieved	This performance measure has now been included in the 2012–2015 Statement of Intent, with a delivery date of 30 December 2012. Since appointing a clinical lead, the programme to improve surgical safety has gathered momentum. A cost-benefit analysis of the surgical safety checklist has been completed, showing that more systematic use of the checklist is likely to lead to reductions in avoidable complications resulting from surgery and that a net financial benefit could be expected for minimal cost. Focus group meetings are being held to assess the attitudes among clinicians and patients towards use of the checklist.

23 Some of the dates for individual deliverables varied from the plan, but were achieved by 30 June 2012.

5.3 Output class 3: Influence 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 2011/12	Status (achieved, not achieved)	Further information
A register of consumer organisations, groups and individuals undertaking advisory and/or representative roles in the health and disability sector will be published	Published by 30 June 2012	Achieved	The register was published on the Commission's website on 2 December 2011. It can be viewed at: http://www.hqsc.govt.nz/our-programmes/consumer-engagement/projects/directory-of-consumer-organisations/

HEALTH QUALITY AND SAFETY CLINICAL LEADERSHIP GROUP

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
Clinical leadership group established and at least one face-to-face meeting held	Meeting held by 31 December 2011	Not achieved	Clinical leaders are now in place for all the Commission's key programmes. The first joint meeting of the Commission's clinical leads took place on 16 July 2012. Leadership networks have been (or are being) established for our key programmes and the Commission's expert advisory groups and steering groups also include leading clinicians.

COMMUNICATION AND ENGAGEMENT WITH THE BROADER SECTOR

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
Number and distribution of newsletters and factsheets	Six factsheets and six newsletters produced annually and distributed to the sector including frontline staff	Achieved	The Commission produced or funded 29 newsletters and factsheets during 2011/12. They are all available on the Commission's website. Newsletters produced directly by the Commission: • 5x Commission newsletters (July 2011, September 2011, December 2011, March 2012, June 2012) • 7x Commission e-updates • Perinatal and Maternal Mortality Review Committee newsletter (September 2011) • 2x National Medication Safety Programme updates (December 2011 and April 2012). Newsletters produced on the Commission's behalf by contracted organisations: • 2x Target CLAB ZERO newsletters (March 2012, June 2012) • 4x Hand Hygiene New Zealand eBulletins (December 2011, March 2012, April 2012, June 2012). Factsheets: • Infection Prevention and Control factsheet (August 2011) • Making Our Hospitals Safer – Serious and Sentinel Events 2010/11 factsheet (February 2012) • 2 x Medication Safety Watch (February 2012, May 2012) • Error-prone abbreviations, symbols and dose designations not to use poster (May 2012) • Perinatal and Maternal Mortality Review Committee's Pānui for Post-Mortem Examination (update and reprint) • Information about the Perinatal and Maternal Mortality Review Committee • Information about Child and Youth Mortality Review Committee. Distribution: We provide email copies of all our publications to the stakeholders on our database (currently around 2,000) and all are available on our website. Hard copies are distributed at conferences and events. The Serious and Sentinel Events factsheet went to 60,000 frontline health professionals either in hard copy or electronically.

Performance measure	Standard 2011/12	Status (achieved, not achieved)	Further information
Usefulness of factsheets and newsletters	Formal stakeholder feedback shows that at least 80% of respondents use and value factsheets and newsletters	Partially achieved	The first survey seeking stakeholder views was trialled using the Commission's March newsletter. The response rate was 20.4% (161/790). The survey found that: • 89% of respondents rated the newsletter as • either quite user-friendly or very user-friendly • 88.8% rated the information as either relevant or completely relevant to their organisation • 80.7% rated it as very or quite helpful to understand new concepts • 70.2% rated it as very or quite helpful for planning improvements in services. • We did not survey the factsheets as we are unlikely to continue producing these in future (as they have been replaced by more focused publications such as *Medication Safety Watch*).

6.0 Revenue/expenses for output classes

	Output class 1 Information, analysis, and advice		Output class 2 Sector tools, techniques and methodologies		Output class 3 Influence quality and safety practice		Total	
	Actual $000	**Budget $000**	**Actual $000**	**Budget $000**	**Actual $000**	**Budget $000**	**Actual $000**	**Budget $000**
Crown and other revenue	4,227	4,217	7,722	7,307	2,939	2,951	14,888	14,476
Interest income	70	11	121	26	48	10	239	47
Total income	4,297	4,228	7,843	7,333	2,987	2,961	15,127	14,523
Operating expenditure	2,055	1,768	3,089	2,787	1,034	821	6,178	5,377
Programme expenditure	2,307	2,460	4,396	5,534	2,312	2,140	9,015	10,134
Total expenditure	**4,362**	**4,228**	**7,485**	**8,321**	**3,346**	**2,961**	**15,193**	**15,511**
Surplus/(deficit)	**(65)**	**0**	**358**	**(988)**	**(359)**	**0**	**(66)**	**(988)**

7.0 Financial statements

7.1 Statement of comprehensive income for the year ended 30 June 2012

Actual 8 Months to 30 June 2011 $000		Notes	Actual 12 Months to 30 June 2012 $000	Budget 12 Months to 30 June 2012 $000
	Income			
7,730	Revenue from Crown	2	14,476	14,476
42	Interest income		239	47
346	Other income	3	412	0
8,118	**Total income**		**15,127**	**14,523**
	Expenditure			
671	Personnel costs	4	3,008	3,318
0	Depreciation and amortisation	12,13	105	87
1,519	Other expenses	6	3,065	1,972
1,341	Quality and Safety Programmes		6,815	7,886
1,490	Mortality Programmes		2,200	2,248
5,021	**Total expenditure**		**15,193**	**15,511**
3,097	**Surplus/(deficit)**		**(66)**	**(988)**
0	Other comprehensive income		0	0
3,097	**Total comprehensive income**		**(66)**	**(988)**

Explanations of major variances against budget are provided in note 27.

The accompanying notes form part of these financial statements.

7.2 Statement of financial position as at 30 June 2012

Actual 8 Months to 30 June 2011 $000		Notes	Actual 12 Months to 30 June 2012 $000	Budget 12 Months to 30 June 2012 $000
	Assets			
	Current assets			
6,607	Cash and cash equivalents	7	4,724	1,993
209	GST receivable		314	197
397	Debtors and other receivables	8	8	0
49	Prepayments		31	0
7,262	**Total current assets**		**5,077**	**2,190**
	Non-current assets			
0	Property, plant and equipment	12	306	280
0	Intangible assets	13	76	34
0	**Total non-current assets**		**382**	**314**
7,262	**Total assets**		**5,459**	**2,504**
	Liabilities			
	Current liabilities			
4,104	Creditors and other payables	14	1,755	801
61	Employee entitlements	16	173	113
0	**Non-current liabilities**		**1,928**	**914**
4,165	**Total liabilities**		**1,928**	**914**
3,097	**Net assets**		**3,531**	**1,590**
	Equity	17		
0	General funds July		3,097	2,578
0	Contributed capital		500	0
3,097	Surplus/(deficit)		(66)	(988)
3,097	**Total equity**		**3,531**	**1,590**

Explanations of major variances against budget are provided in note 27.

The accompanying notes form part of these financial statements.

7.3 Statement of changes in equity for the year ended 30 June 2012

Actual 8 Months to 30 June 2011 $000		Notes	Actual 12 Months to 30 June 2012 $000	Budget 12 Months to 30 June 2012 $000
0	Balance at 1 July		3,097	2,578
	Comprehensive income			
3,097	Surplus/(deficit)		(66)	(988)
0	Other comprehensive income		0	0
3,097	**Total comprehensive income**		**(66)**	**(988)**
	Owner transactions			
0	Capital contribution		500	0
3,097	**Balance at 30 June**	17	**3,531**	**1,590**

Explanations of major variances against budget are provided in note 27.

The accompanying notes form part of these financial statements.

7.4 Statement of cash flows for the year ended 30 June 2012

Actual 8 Months to 30 June 2011 $000		Notes	Actual 12 Months to 30 June 2012 $000	Budget 12 Months to 30 June 2012 $000
	Cash flows from operating activities			
7,730	Receipts from Crown		14,476	14,476
	Revenue		801	0
0	Other revenue			
42	Interest received		239	47
(405)	Payments to suppliers		(14,187)	(11,445)
(671)	Payments to employees		(3,120)	(3,408)
(89)	Goods and Services Tax (net)		(105)	(161)
6,607	**Net cash flow from operating activities**	18	**(1,896)**	**(492)**
	Cash flows from investing activities			
0	Purchase of property, plant and equipment		(387)	0
0	Purchase of intangible assets		(100)	0
0	**Net cash flow from investing activities**		**(487)**	**0**
	Capital flows from financing activities			
0	Capital contribution		500	0
0	**Net cash flows from financing activities**	17	**500**	**0**
6,607	Net (decrease)/increase in cash and cash equivalents		(1,883)	(492)
0	Cash and cash equivalents at the beginning of the year		6,607	2,485
6,607	**Cash and cash equivalents at the end of the year**	7	**4,724**	**1,993**

Explanations of major variances against budget are provided in note 27.

The accompanying notes form part of these financial statements.

7.5 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 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 2012, and were approved by the Board on 18 October 2012.

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).

These financial statements have been prepared in accordance with NZ GAAP as appropriate for public benefit entities and they comply with NZ IFRS.

Measurement base

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

Functional and presentation currency

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

Changes in accounting policies

There have been no changes in accounting policies. The Commission has adopted the following revision to accounting standards during the financial year, which has had only a presentational effect:

- Amendments to NZ IAS 1 Presentation of Financial Statements. The amendments introduce a requirement to present, either in the statement of changes in equity or in the notes, for each component of equity, an analysis of other comprehensive income by item. The Commission has decided to present this analysis in its statement of changes in equity.

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 have not been early adopted, and which are relevant to the CSE, are:

- 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 has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 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 assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the Commission is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the Commission expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still

under development, the Commission is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

SIGNIFICANT ACCOUNTING POLICIES

Revenue

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

Revenue from the Crown

The Commission is primarily funded through revenue received from the Crown, which is restricted in its use for the purpose of the Commission meeting its objectives as specified in its Statement of Intent. 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.

Foreign currency transactions

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

Operating leases

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

Cash and cash equivalents

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

Debtors and other receivables

Debtors and other receivables are measured at face value less any provision for impairment. There are no provisions for impairment in 2011/12.

Bank deposits

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

Inventories

Inventories held for sale are measured at the lower of cost (calculated using the First In First Out basis) and net realisable value. There are no inventories held for sale in 2011/12.

Property, plant and equipment

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

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

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

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

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

The costs of day-to-day servicing of property, plant and equipment are recognised in the prospective statement of comprehensive income as they are incurred.

Depreciation

Depreciation is provided using the straight line (SL) basis at rates that will write off the cost (or valuation) of

the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

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

Intangibles

Software acquisition

Acquired computer software 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.

Costs associated with staff training are recognised as an expense when incurred.

Amortisation

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

The amortisation charge for each period is recognised in the surplus or deficit.

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

Acquired computer software	3 years	33% SL

Impairment of property, plant and equipment, and intangible assets

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.

Goods and services tax

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

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

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Creditors and other payables

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

Employee entitlements

Short-term employee entitlements

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

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

Obligations for contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector

Retirement Savings Scheme are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Note 2: Revenue from the Crown

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

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

Note 3: Other income

The only other income was an additional $0.41m, received from the Ministry of Health associated with the Medication Safety Programme wash-up from Hutt Valley DHB.

Note 4: Personnel costs

	Actual 2010/11 (8 months) $000	Actual 2011/12 $000
Salaries and wages	472	2,583
Recruitment	114	175
Temporary personnel	0	44
Membership, professional fees and staff	0	84
Training and development		
Defined contribution plan employer contributions	24	71
Increase/(decrease) in employee entitlements	61	51
Total personnel costs	**671**	**3,008**

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

Note 5: Capital charge

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

Note 6: Other expenses

	Actual 2010/11 (8 months) $000	Actual 2011/12 $000
Audit fees to Audit New Zealand for financial audit	18	29
Staff travel and accommodation	106	295
Printing/communications	84	306
Consultants and contractors	626	1,208
Board costs/mortality review committees	355	560
Outsourced corporate services and overhead	318	654
Other expenses	12	13
Total other expenses	**1,519**	**3,065**

Note 7: Cash and equivalents

	Actual 2010/11 $000	Actual 2011/12 $000
Cash at bank and on hand	6,607	4,724
Term deposits with maturities less than three months	0	0
Total cash and cash equivalents	**6,607**	**4,724**

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	Actual 2011/12 $000
Debtors and other receivables	397	8
Less: provision for impairment	0	0
Total debtors and other receivables	**397**	**8**

Fair value

The carrying value of receivables approximates their fair value.

Impairment

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

Note 9: Investments

The Commission has no term deposit or equity investments in 2011/12.

Note 10: Inventories

The Commission has no inventories for sale in 2011/12.

Note 11: Non-current assets held for sale

The Commission has no current or non-current assets held for sale in 2011/12.

Note 12: Property, plant and equipment

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

	Computer	Furniture and office equipment $000	Leasehold improvements $000	Total $000
Cost or valuation				
Balance at 1 July 2010	0	0	0	0
Additions	0	0	0	0
Balance at 30 June 2011	0	0	0	0
Balance at 1 July 2011	0	0	0	0
Additions	143	129	115	387
Balance at 30 June 2012	143	129	115	387
Accumulated depreciation and impairment losses				
Balance at 1 July 2011	0	0	0	0
Depreciation expense	0	0	0	0
Balance at 30 June 2011	0	0	0	0
Balance at 1 July 2011	0	0	0	0
Depreciation expense	46	24	11	81
Balance at 30 June 2012	97	105	104	306
Carrying amounts				
At 1 July 2010	0	0	0	0
At 30 June and 1 July 2011	0	0	0	0
At 30 June 2012	97	105	104	306

The Commission does not own any buildings or motor vehicles.

Note 13: Intangible assets

Movements for each class of intangible asset are as follows.

	Acquired software $000
Cost	
Balance at 1 July 2010	0
Additions	0
Balance at 30 June 2011/1 July 2011	0
Additions	100
Balance at 30 June 2012	100
Accumulated amortisation and impairment losses	
Balance at 1 July 2010	0
Balance at 30 June 2011/1 July 2011	0
Amortisation expenses	24
Balance at 30 June 2012	76
Carrying amounts	
At 1 July 2010	0
At 30 June and 1 July 2011	0
At 30 June 2012	76

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

Note 14: Creditors and other payables

	Actual 2010/11 $000	Actual 2011/12 $000
Creditors	1,313	749
Accrued expenses	2,719	1,006
Other payables	0	0
Total creditors and other payables	**4,104**	**1,755**

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.

Note 15: Borrowings (NZ IAS 1.77)

The Commission does not have any borrowings.

Note 16: Employee entitlements

	Actual 2010/11 $000	Actual 2011/12 $000
Current portion		
Accrued salaries and wages	51	101
Annual leave	10	72
Total current portion	**61**	**173**
Non-current portion	0	0
Total employee entitlements	**61**	**173**

No provisions for sick leave, retirement or long service have been made in 2011/12.

Note 17: Equity

	Actual 2010/11 $000	Actual 2011/12 $000
General funds		
Balance at 1 July	0	3,097
Surplus/(deficit) for the year	3,097	(66)
Capital contributions	0	500
Balance at 30 June	**3,097**	**3,531**

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

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

	Actual 2010/11 $000	Actual 2011/12 $000
Net surplus/(deficit)	3,097	(66)
Add/(less) movements in statement of financial position items		
Debtors and other receivables	(655)	389
Creditors and other payables	4,104	(2,454)
Depreciation	0	105
Prepayments	0	18
Employee entitlements	61	112
Net movements in working capital		
Net cash flow from operating activities	**6,607**	**(1,896)**

Note 19: Capital commitments and operating leases

Capital commitments

There were no capital commitments at balance date.

Operating leases as lessee

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

	Actual 2010/11 $000	Actual 2011/12 $000
Not later than one year	0	120
Later than one year and not later than five years	0	249
Later than five years	0	0
Total non-cancellable operating leases	**0**	**369**

The Commission leases a property (from 1 August 2011) at Level 6, Classic House, Thorndon, Wellington. The lease expires in July 2015 with an option for two rights of renewal of two years each. The Commission does not have the option to purchase the asset at the end of the lease term.

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

Note 20: Contingencies

Contingent liabilities

The Commission has no contingent liabilities

Contingent assets

The Commission has no contingent assets.

Note 21: Related-party transactions

All related-party transactions have been entered into on an arms' length basis.

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

Significant transactions with government-related entities

The Commission has been provided with funding from the Crown of $14.5m for specific purposes as set out in its founding legislation and the scope of relevant government appropriations. The Commission purchased goods or services from a number of DHBs and universities. Significant transactions were: Auckland DHB ($0.76m, $0.02m 2010/11), Counties Manukau DHB ($0.98m, $0.2m 2010/11), Southern DHB ($0.60m, $0.0m 2010/11), Taranaki DHB ($0.94m, $0.01m 2010/11), UniServices Limited ($0.59m, $0.05m 2010/11), The University of Otago ($0.64m, $0.35m 2010/11) and Waitemata DHB ($0.43m, $0.03m 2010/11).

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. Purchases from these government-related entities for the year ended 30 June 2012 totalled $1.9m included DHBs (additional to those noted above), Air New Zealand, universities and other government crown entities and departments.

Key management personnel

Salaries and other short-term employee benefits to key management personnel[24] totalled $0.84m 2011/12.

The Commission contracted with Counties Manukau DHB, a Crown entity where two Commission board members hold senior positions. The value of the contract/work was $0.98m. ($0.2m 2010/11). The Commission also contracted for $0.18m ($0.28m 2010/11) with General Practice New Zealand where a board member is a member of the Patients First Steering Group.

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

The total value of remuneration paid or payable to each Board member (or their employing organisation*) during the full 2011/12 year was:

	Actual 2010/11 (8 months) $000	Actual 2011/12 $000
Professor Alan Merry* (chair)	35	29
Dr Peter Foley	13	18
Mrs Shelley Frost*	10	16
Dr David Galler*	11	15
Dr Peter Jansen*	11	15
Mr Geraint Martin*	11	15
Mrs Anthea Penny	12	15
Total Board member remuneration	**103**	**123**

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.

24 Key management personnel for 2011/12 include the CEO, General Manager, Director of Measurement and Evaluation, and Chief Financial Officer. Board Members have been reported separately.

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

Note 23: Employee remuneration

Total remuneration paid or payable:

	Employees 2010/11 (8 months)	Employees 2011/12
$120,000 - $129,999	1[25]	2
$130,000 - $139,999		3
$180,000 - $189,999		1
$200,000 - $209,999		1
$360,000 - $369,999		1
Total employees	**1**	**8**

During the year ended 30 June 2012 no employees received compensation and other benefits in relation to cessation.

Note 24: Events after the balance date

There were no significant events after the balance date.

Note 25: Financial instruments

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

Note 26: Capital management

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

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

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

Note 27: Explanation of major variances against budget

Explanations for major variances from the Commission's budgeted figures in the 2011/12 Statement of Intent are as follows:

Statement of comprehensive income

The year-end results show a near breakeven result ($0.066m deficit) against a planned SOI deficit of $0.988m. Cash and cash equivalents of $4.7m and net assets of $3.5m remain high due to planning programme activity for 2011/12 now to occur in 2012/13. This will be shown as a planned budgeted deficit as outlined within the 2012–2015 SOI.

25 The period February 2011 to 30 June 2011.

The main drivers of year-end results are as follows.

- Crown revenue matches budget expectations. Interest revenue is higher than budget by $0.2m due to interest being earned on the retained earnings and programmes underspend.
- Budgets are as per the SOI prospective financial statements which do not include $0.4m of revenue received in July 2011 for completion of the phase one national electronic medicines management programme.
- Personnel costs are $0.3m below budget but are offset by an additional $0.56m for contractors covering staff vacancies, completing programme activity in-house and additional communications costs (reported under 'Other Expenses').
- Travel is $0.15m above budget. Initial travel budgets were set too low in relation the amount of in-house programme activity and project management, and the amount of relationship and stakeholder involvement activity the Commission has completed during 2011/12.
- Overhead and other operational costs are over budget by $0.3m mainly due to the final month hosting occupancy costs from the Ministry of Health in July 2012 of $0.1m and the IT implementation costs planned for the end of 2010/11 materialising in the first quarter of 2011/12. These additional costs offset favourable variances from 2010/11 where the activity was originally planned to occur.

Quality, safety, and mortality review programme expenditure of $9.0m is $1.1m underspent YTD against a budget of $10.1m.

The main drivers of the programme variation within 2011/12 relate to:

- $0.4m for the Surgical Site Surveillance programme which will now occur in 2012/13
- $0.1m for the Surgical Checklist programme which was not spent in 2011/12
- $0.1m for those Health Quality Challenge milestones which will now be completed and paid for in 2012/13
- $0.2m less than budgeted on website development
- $0.3m for other programme activity now budgeted now occur in 2012/13.

Statement of financial position

The variance to budget for both the purchase of assets and the $0.5m equity injection (as shown in the statements of financial position, movement of equity, and cash flows) is due to both of these items being originally budgeted in 2010/11. As the Commission was being hosted by the Ministry of Health until August 2011, this funding was received and recorded in the 2011/12 accounts.

The statement of financial position shows net non-current assets of $0.38m and relates to the purchase of computer hardware, software, and fit-out of the Wellington office.

Creditors are above budgeted expectations as a significant number of programme delivery milestones occurred in June 2012 with payment to be made in July 2012.

Statement of changes in cashflow

The variance to budget for both the purchase of assets and the $0.5m equity injection (as shown in the statements of financial position, movement of equity, and cash flows) is due to both of these items being originally budgeted in 2010/11. As the Commission was being hosted by the Ministry of Health until August 2011, this funding was received and recorded in the 2011/12 accounts.

Note 28: Acquisition of shares

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

8.0 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 2012

The Auditor-General is the auditor of the 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 33 to 48, that comprise the statement of financial position as at 30 June 2012, 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 21 to 32.

Opinion

In our opinion:

- the financial statements of the Commission on pages 33 to 48.
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Commission's:
    - financial position as at 30 June 2012; and
    - financial performance and cash flows for the year ended on that date.

- the statement of service performance of the Commission on pages 21 to 32:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects, for each class of outputs for the year ended 30 June 2012, 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 18 October 2012. 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 preparation of the Commission's 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.

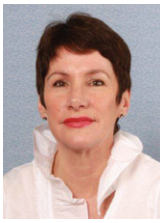
Other than the audit, we have no relationship with or interests in the Commission.

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

Appendix One: Board members

Professor Alan Merry
(Chair)

Dr Peter Foley
(Deputy Chair)



Mrs Shelley Frost

Dr David Galler

Dr Peter Jansen

Mr Geraint Martin

Mrs Anthea Penny

Appendix Two: 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 (Cindy) Farquhar (Chair) 	Professor Iain Martin (Chair) (until 29 Feb 2012) 	Dr Nicholas Baker (Chair) 	Ms Wendy Davis (Chair) (until 30 Nov 2011) 
Professor Lesley McCowan (until 31 March 2012)	Dr Leona Wilson (Chair) (from 29 Feb 2012) 	Dr Anganette Hall (until 1 July 2012)	Assoc. Professor Julia Tolmie (Chair) (from 1 Dec 2011) 
Dr Vicki Culling (until 31 March 2012)	Dr Jonathan Koea	Professor Edwin Mitchell	Ms Brenda Hynes (until 30 Nov 2011)
Dr Stephanie Palmer (until 31 March 2012)	Ms Teena Robinson	Dr Sharon Wong	Dr Alison Towns (until 30 Nov 2011)
Mrs Anja Hale (until 31 March 2012)	Dr Philip Hider	Ms Susan Matthews	Mrs Vaoga Mary Watts (until 30 Nov 2011)
Dr Beverley Lawton	Dr Catherine (Cathy) Ferguson	Ms Anthea Simcock	Ms Ngaroma Grant
Ms Susan Bree	Dr Digby Ngan Kee	Mr Erunui George (until 1 July 2012)	Associate Professor Dawn Elder (from 1 Dec 2011)
Dr Alec Ekeroma (until 26 June 2012)	Dr Anthony Williams	Mr Paul Nixon	Ms Miranda Ritchie (from 1 Dec 2011)
Dr Margaret Meeks	Ms Rosaleen Robertson	Dr Pat Tuohy (from 28 May 2012)	Professor Barry Taylor (from 1 Dec 2011)
Dr Graham Sharpe		Dr Terryann Clark (from 1 July 2012)	Ms Fia Turner-Tupou (from 1 Dec 2011)
Dr Sue Belgrave (from 14 May 2012)		Dr. Stuart Dalziel (from 1 July 2012)	Judge Paul von Dadelszen (from 1 Dec 2011)
Dr Suzanne Crengle (from 14 May 2012)			Associate Professor Denise Wilson (from 1 Dec 2011)
Ms Gail McIver (from 14 May 2012)			
Ms Linda Penlington (from 14 May 2012)			
Ms Alison Eddy (from 14 May 2012)			

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Health Quality and Safety Commission

New Zealand Government