Health Quality & Safety Commission New Zealand

Kupu Taurangi Hauora o Aotearoa

Annual Report 2012–13

For the period 1 July 2012 to 30 June 2013

Published in November 2013 by the Health Quality & Safety Commission,
PO Box 25496, Wellington 6146.

ISBN 978-0-478-38562-5 (print)
ISBN 978-0-478-38561-8 (online)

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

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

open FOR BETTER CARE
Hāpai ake te toiora

Chair's Report

Professor Alan Merry

"We are starting to see significant improvements as a result of our programmes, meaning fewer deaths, less harm and human suffering, and money saved."

It has been a very full and productive year for the Health Quality & Safety Commission. We have focused on programmes to reduce harm in four priority areas: falls in health care settings, healthcare associated infections, surgery and medication. At the same time we have used these programmes as ground-up exemplars to promote the underlying principles of quality and safety of health care more generally.

We are starting to see significant improvements as a result of our programmes, including no central line infections for six months out of 12 and hand hygiene compliance rates in hospitals well above target. This means fewer deaths, less harm and human suffering, and money saved.

These four programmes have provided leverage for the launch of the Commission's national patient safety campaign, *Open for better care*, in May 2013. The campaign pulls together many strands of the Commission's work – our programmes, measurement and evaluation functions, consumer participation and engagement, and building improvement capability.

The Commission is increasingly 'shining the light' on variation and issues impacting on health quality and safety so the most important areas for improvement are addressed. We have completed seven Atlas of Healthcare Variation domains. The Atlas is an online tool for clinicians, users and providers of health services that demonstrates variation in the health care delivered in different geographical regions. The purpose of the Atlas is to stimulate questions and debate about why variations exist and the degree to which variations align with what is considered appropriate care for specific populations. Early indications are this approach is working. For example, the district health board (DHB) with the highest rate of interventions for tonsillectomy and grommet surgical procedures is developing standardised indications for such surgery and developing clinical benchmarking with other DHBs. We have received suggestions for new Atlas domains, as clinicians and others recognise the value of measuring and discussing variation.

We are also now reporting against our full set of quality and safety indicators; we use these indicators to measure the quality and safety of the health system. The first full report on the indicators, published in June 2013, provides robust baselines for measuring future achievements. Similarly, our quality and safety markers allow the sector to measure our priority programme outcomes and are also a measure of the success of the *Open* campaign.

The ability to measure, report and manage patient experience performance has the potential to significantly improve health services. Currently, New Zealand has no consistent approach to this. During the year, the Commission developed a comprehensive national framework for measuring patient experience, which will be implemented next year. This framework complements our ongoing *Partners in Care* programme, which aims to improve consumer participation, increase health literacy and develop leadership capability so consumers and providers can work together.

So far our work has focused mainly on the hospital sector, but we have been progressively broadening the reach of our programmes into age-related residential care and primary care. Several providers outside DHBs are now reporting serious adverse events, which is positive.

The four mortality review committees published reports highlighting important areas where deaths can be avoided: deaths of children from unintentional suffocation and strangulation; deaths of mothers and babies due to pregnancy and childbirth; deaths resulting from family violence; and deaths resulting from surgery. The committees work successfully across agencies to ensure recommendations are implemented to reduce

these tragic and potentially avoidable deaths in future. I would like to thank the Chairs and members of the Mortality Review Committees for their important work.

There have been several changes to the Commission's Board this year. Our Deputy Chair, Dr Peter Foley, sadly died after a battle with cancer. Peter provided invaluable input into the Commission's work right to the end – a testament to his lifelong commitment to improving health and disability services. Dr Peter Jansen left us during the year to take up a senior position in Australia. We are grateful to Peter for his valuable contributions to the Board, especially his commitment to improving equity and his role on the finance and audit committee. Existing Board member Shelley Frost was appointed as Deputy Chair and Alison Paterson and Dr Dale Bramley were appointed as new Board members.

I would like to conclude by thanking the many agencies and individuals we work with. We could not succeed without you.

Professor Alan Merry, ONZM
Chair
Health Quality & Safety Commission

Chief Executive's Report

Dr Janice Wilson

"Good measurement, information and evaluation must underpin our conversations and engagement with the sector and inform all our quality and safety improvement work."

It is just two and a half years since our establishment and the Commission is already an important and valuable part of the health and disability sector.

As well as progress on priority areas of patient safety, we are also well on the way to establishing a robust measurement, information and evaluation function. This fundamental building block is enabling us to 'shine the light' on quality and safety issues and solutions across the sector and engage in meaningful conversations about them.

We now have robust information to underpin our four priority programmes and measure the success of the *Open for better care* campaign. Our aim is to energise people to think about measurement and how it can help them improve the quality and safety of their services. The next step is to build this function further to help us discuss quality and safety with other parts of the sector – including primary care and age-related residential care.

Information is vital for improving equity for all populations – one of the Commission's key aims, as articulated in the Triple Aim for Quality Improvement. The first step in reducing disparities is to understand the extent and nature of those disparities. Our measurement function always includes an ethnicity component so we can examine health care disparities in key areas. The next step is to understand why those disparities exist and determine which causes can be tackled successfully. The Commission is being assisted in this work by Roopu Māori, which was established to advise our Board and Chief Executive on strategic issues, priorities and frameworks for Māori and to identify key issues for Māori consumers and organisations.

Another fundamental building block for quality and safety is our work to support clinical leadership and capability in improvement science and change management. Some of our activities in this area during the year included sponsoring participation in key quality improvement conferences and professional development programmes, developing educational tools and resources, and providing clinical leadership opportunities. All of our priority programmes now have clinical leads, whose roles are critical to the progress being made. They exemplify the importance of strong, evidence-based leadership within services and in quality improvement.

Engagement of consumers with decisions about their own health care improves outcomes, enhances the experience of care and reduces costs. We have implemented year one of our *Partners in Care* programme. I would particularly like to acknowledge the success of the Commission's health literacy medication safety project. Two community pharmacies volunteered to be part of this project, recognising that good communication is the key to patients using their medicine in a safe and appropriate way. With support and training, the pharmacies put in place tools for improving health literacy over a three-month demonstration period. The results were surprising and impressive. An evaluation found that written resources are less effective than taking time to listen clearly to consumers and ensure they understand how, when and why to take their medicine. Some staff who believed they were already communicating well recognised that improvements could be made when they applied the three-step framework – find out what people know, build health literacy skills and knowledge, and check you were clear (and if not go back to the previous step). Staff were inspired by the education, training and skills development because they could see how it made a real difference to consumers. The resources developed for this pilot will be freely available on our website.

The sector has widely discussed the recent Mid Staffordshire NHS Foundation Trust Public Inquiry. The lessons identified during the inquiry highlighted the universality of themes relating to quality and safety in health care. The findings are relevant to everyone in the sector in New Zealand, and we have much to learn from them.

We were immensely saddened by news of the death of Dr Peter Foley. As Deputy Chair of the Commission since its establishment, Peter made a strong contribution to the direction of the organisation, provided strong leadership and strategic-level thinking, and promoted a particular focus on having patients at the centre of care. Peter worked tirelessly to improve health services for patients and their families/whānau. In recognition of his hard work he was appointed to the New Zealand Order of Merit in the Queen's Birthday and Diamond Jubilee Honours List 2012.

I would like to thank Commission management and staff. We set ourselves some challenging targets for 2012–13 and our successes would not have been possible without their hard work, commitment and expertise.

Dr Janice Wilson
Chief Executive, Health Quality & Safety Commission

Statement of Responsibility

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

The Board of the Health Quality & 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 & Safety Commission for the year ended 30 June 2013.

Signed on behalf of the Board:

Professor Alan Merry, ONZM
Chair

31 October 2013

Shelley Frost
Deputy Chair

31 October 2013

Contents

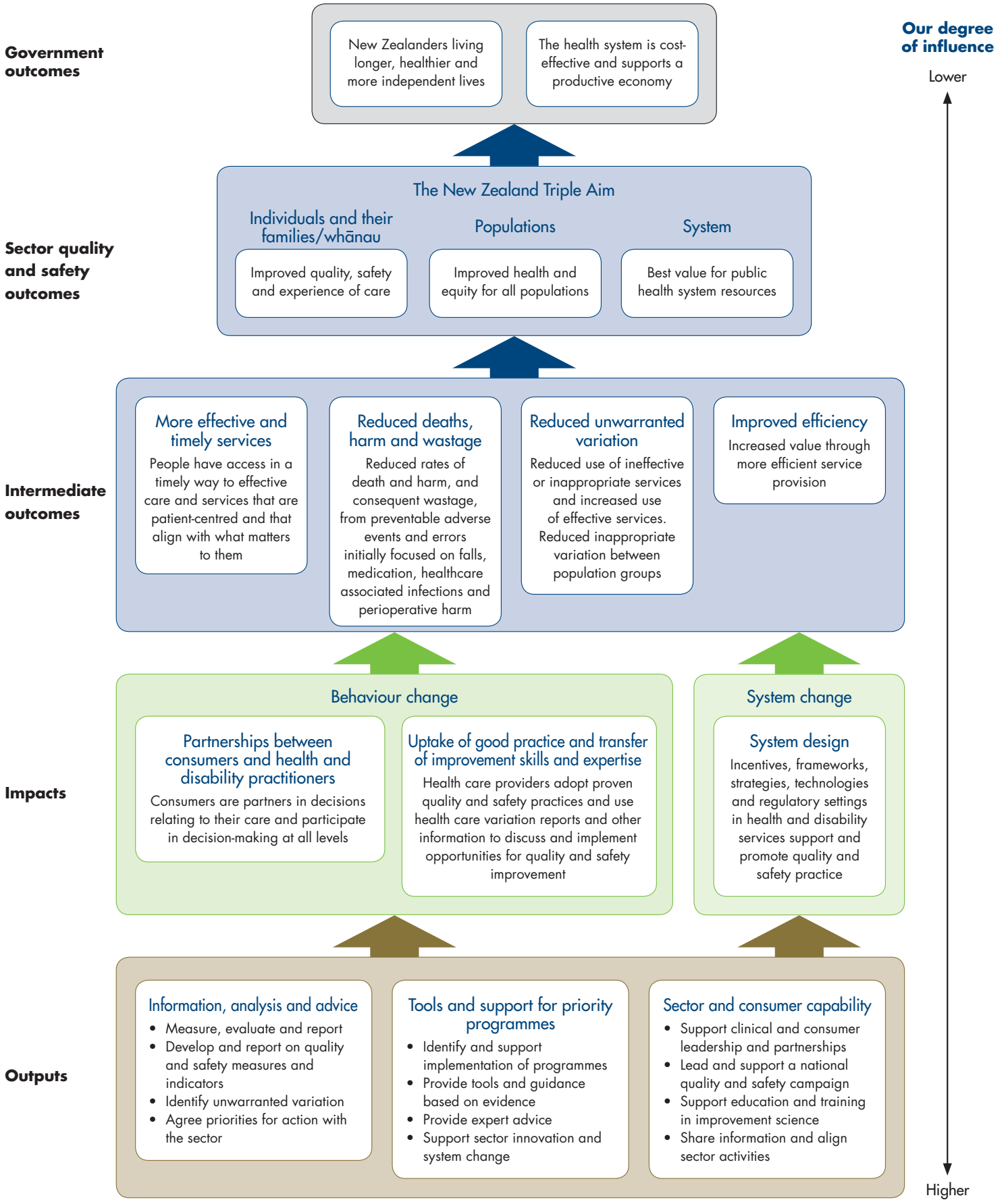
Chair's Report 1
Chief Executive's Report 3
Statement of Responsibility 4

Part 1 7
1.0 The Health Quality & Safety Commission 7
1.1 Strategic context for our work 8
1.2 Achieving Government's outcomes through the Triple Aim 8
1.3 Focusing effort on what matters most 9
1.4 Our partners 10
1.5 How we measure our achievements 11
1.6 How our work contributes to broader Government priorities 16

Operational review 2011–12 18
2.0 Output class 1: Information, analysis and advice 18
2.1 Measurement and evaluation 18
2.2 Reporting and management of health care incidents 22
2.3 Quality accounts 25
2.4 Mortality review committees 25
3.0 Output class 2: Sector tools, techniques and methodologies 29
3.1 Reducing harm from falls 29
3.2 Medication safety 31
3.3 Infection prevention and control 33
3.4 Reducing perioperative harm 36
4.0 Output class 3: Influence quality and safety practice 38
4.1 The *Open for better care* campaign 38
4.2 Supporting and building leadership and capability 39
4.3 Developing consumer and family/whānau engagement and partnership 41
4.4 Quality and Safety Challenge 43
5.0 Maintaining and developing organisational capability 44
5.1 Leadership, direction and delivery 44
5.2 External relationships 46
5.3 People development 47
5.4 Financial and resource management 47
5.5 Permission to act despite being interested in a matter 49

Part 2 50
6.0 Reporting 50
7.0 Report against the Statement of Service Performance 51
7.1 Output class 1: Information, analysis and advice 51
7.2 Output class 2: Sector tools, techniques and methodologies 57
7.3 Output class 3: Sector and consumer capability 63
8.0 Revenue/Expenses for output classes 64
9.0 Financial statements 65
9.1 Statement of comprehensive income for the year ended 30 June 2013 65
9.2 Statement of financial position as at 30 June 2013 66
9.3 Statement of changes in equity for the year ended 30 June 2013 67
9.4 Statement of cash flows for the year ended 30 June 2013 68
9.5 Notes to the financial statements 69
10.0 Auditor's report 84
Appendix 1: Board and committe membership 86

THE HEALTH QUALITY & SAFETY COMMISSION'S OUTCOMES FRAMEWORK



Part 1

1.0 The Health Quality & Safety Commission

The Health Quality & Safety Commission (the Commission) was established in 2010 in response to concern that only modest improvements in health quality and safety had been achieved at a national level over previous years. Quality experts argued that a strong mandate to drive quality-related activities, greater coordination of appropriate quality interventions at a national level and strong clinical engagement were pivotal to achieving sustainable quality gains and better value for money.

The Commission is a Crown entity under the New Zealand Public Health and Disability Act 2000 (the Act) and is categorised as a Crown agent for the purposes of the Crown Entities Act 2004.[1]

The Commission's objectives are to lead and coordinate work across the health and disability sector in order to:

- help providers across the sector to improve the quality and safety of health and disability support services
- monitor and improve the quality and safety of health and disability support services.

The legislative functions of the Commission under section 59C (1) of the Act are to:

- advise the Minister on how quality and safety in health and disability services may be improved
- advise the Minister on any matters relating to:
  - health epidemiology and quality assurance or
  - mortality
- determine quality and safety indicators (such as serious and sentinel events) for use in measuring the quality and safety of health and disability support services
- provide public reports of the quality and safety of health and disability support services as measured against:
  - the quality and safety indicators
  - any other information the HQSC considers relevant for the purpose of the report
- promote and support better quality and safety in health and disability support services
- disseminate information about the quality and safety of health and disability support services
- perform any other functions that:
  - relate to the quality and safety of health and disability support services
  - the HQSC is for the time being authorised to perform by the Minister by written notice to the HQSC after consultation with it.

The Commission's task is to add value to health quality and safety in New Zealand by measuring and identifying what needs to improve and providing expertise and advice to support improvement and spread good practice. We promote and support clinical leadership and governance as integral to high-quality, safe health care and support the engagement of consumers as partners in the health care system.

Shining the light on variation and key areas for improvement

Being an intelligent commentator and advocate for change

Lending a hand by making expert advice, guidance and tools available

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

1.1 Strategic context for our work

New Zealand's health and disability system rates reasonably well internationally, but there is room for improvement. Patients still suffer significant levels of harm from medicines, falls, surgery, healthcare associated infections and other areas of care.[2] Evidence shows that many serious adverse events that occur in health care and disability support services are avoidable and amenable to intervention. There is a growing number of examples in New Zealand of quality and safety programmes resulting in successful outcomes and process improvements. These include:

- a reduction of central line associated bacteraemia (CLAB) rates in New Zealand from an estimated 3.32 per 1000 line days before implementation of the national CLAB programme, to fewer than 1 per 1000 line days in the eight months to January 2013 – each CLAB avoided represents on average a saving of $20,000
- increased audited compliance rate (70 percent in June 2013) with good hand hygiene practice from a baseline of approximately 35 percent[3] in 2008 before implementing the national hand hygiene programme
- a reduction in rates of sudden unexpected death in infancy (SUDI), with an estimated 3000 lives saved in the past 20 years and a reduction in annual death rates from 299 to 60.

The recent Mid Staffordshire NHS Foundation Trust Public Inquiry looked at serious failings at the Trust between January 2005 and March 2009. While many of the lessons in the final report, published in February 2013, are specific to the English National Health Service (NHS), there are themes universal to all health care that we can all learn from. They are all areas in which the Commission has an active interest and include:

- consumer involvement and engagement – putting the patient at the centre of care
- a common culture, that puts patients first and encourages openness and transparency about matters of concern
- strong clinical leadership and clear lines of responsibility for quality of care
- high-quality analysis of data so risks and issues are recognised and addressed early
- clear and constructive relationships between different parts of the system – organisations need to talk to each other and share information.

1.2 Achieving Government's outcomes through the Triple Aim

The New Zealand Triple Aim for quality improvement includes:

- 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.

The Triple Aim includes a focus on improving equity for all populations. In practice, this means prioritising activities or programmes that improve the quality and safety of health and disability services across all populations.

2 Details of levels of harm, death and cost are included in section 1.5 as well in specific programme sections in Part 1, section 3.0 of this report.
3 This baseline is from 2008 at the start of the previous Ministry of Health-led National Quality Improvement Programme.

The diagram on page 6 shows the Commission's outcomes framework for improving quality and safety, and ultimately achieving the Government's outcomes for the health and disability sector:

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

1.3 Focusing effort on what matters most

There are many issues to address and opportunities for improvement across the health and disability sector, but our resources are limited. This means we are selective about where we focus our attention and investment to get the best value for money.

The Commission's prioritisation framework underpins our decisions about where we focus our efforts. We consider important factors such as:

- the size of the potential benefit in terms of improving quality and safety outcomes and reducing waste 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 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
- the extent to which the work will result in improved equity for all populations.

The Commission's prioritisation framework and work programmes align well with our 2012/13 Letter of Expectations from the Minister of Health, which identified our specific priorities. These included:

- effective and efficient delivery of only priority programmes in a manner and timeframe that maximises benefits to the sector
- setting targets in the areas of hospital acquired infection control, medication safety, falls reduction and surgical safety, and working with DHBs to ensure the early achievement of these targets
- continuing to provide evidence to underpin programmes
- monitoring and evaluating the effectiveness of those programmes, even in the initial phases of work
- playing an active role as a member of the Health Sector Forum
- maintaining a clear overview of the dependencies between the Commission's and other entities' major projects.

The Commission commissioned several reviews and cost–benefit analyses in 2012–13, including:

- evaluation of the electronic medicines management (eMM) programme and a framework for measuring medication-related harm
- the cost of falls
- use of the surgical safety checklist
- a review of mortality review committees.

These provide evidence to underpin our programmes and ensure we monitor and evaluate the effectiveness of those programmes. They also help us ensure we get the best value for money already invested. Further details are provided in this report under specific programme headings.

During 2012–13 our specific priorities were:

- reducing falls and harm from falls in care settings
- reducing healthcare associated infections
- reducing perioperative harm (ie, improving surgical safety)
- reducing medication errors (ie, improving medication safety).

These priorities will change over time, as current priorities become 'business as usual' and no longer need as much support, and as new priorities emerge from our analysis of information about quality and safety.

Three central elements underpin this work:

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

1.4 Our partners

The Minister of Health's 2012/13 Letter of Expectations clearly articulated the need to maintain clear overview of the dependencies between the Commission's and other entities' major projects.

Everyone involved in providing health and disability services has a role in ensuring quality and safety. Their roles include:

- quality and safety assurance activities, such as legislation, regulation, standards, certification, auditing and credentialing
- 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 and private and non-government organisations (NGOs)
- health and disability workers being responsible at all times for the quality and safety of their own practice
- consumers being partners in their own care.

The Commission is a relatively small agency and needs partnerships within the sector to provide expertise, implement programmes and change the quality and safety culture of health and disability services. These partnerships help us connect with people and the workface, and adapt and respond.

We emphasise the importance of collaboration and coordination between different parts of the sector, in particular our growing partnerships with clinical leaders, consumers and consumer groups, and a developing partnership with Māori. We are also building strong international links, so that we are well connected to innovation, evidence and advice from our colleagues overseas. Our links include:

- partnerships with regional DHB groups to ensure alignment between national, regional and local health and quality improvement programmes. These linkages allow the Commission and regional groups to work together, share skills and partner on specific activities as appropriate
- partnerships with regions to promote the *Open for better care* campaign

- a Memorandum of Understanding (MOU) with the Northern Regional Alliance[4] for the Northern Region Health Plan *First, Do No Harm* campaign. The Commission is now represented on the *First, Do No Harm* Steering Group. We are currently in discussions with other regional groups to identify how we can best connect our national, regional and local priorities
- an MOU with Ko Awatea, the Centre for Health System Innovation and Improvement (under the auspices of Counties Manukau DHB) to help build the capability and expertise of the health system, including all health workers, consumers and communities, to deliver improvements in health and disability services
- a developing working partnership with ACC, the Ministry of Health and the Health and Disability Commissioner to prevent serious harm to patients
- regular planned communications/meetings with the senior team of the Australian Commission on Safety and Quality in Health Care to share information and collaborate on specific programmes, eg, shared decision-making
- a collaboration with Professor Atul Gawande of the Harvard School of Public Health, focused on the reducing perioperative harm programme. The school is conducting a similar project in South Carolina, and is providing tools and advice based on that experience
- an MOU with the NHS Institute for Innovation and Improvement[5] which gave us access to the institute's knowledge of improvement practices in other countries. In return we shared our knowledge and information about health care improvement initiatives in New Zealand. The institute closed on 31 March 2013. A new entity, NHS Improving Quality, is now hosted by the NHS Commissioning Board. Our MOU has transitioned to the new agency, which is working out the nature of its relationships with international partners.

We continue to be an active member of the Health Sector Forum. The forum consists of the chairs and chief executives of key government health agencies and meets regularly to discuss common priorities and share information. The Commission Chair and Chief Executive attend and actively participate in these meetings.

The Commission Chair also attends meetings of the National Health Board and the Health and Disability Commissioner attends our Board meetings.

1.5 How we measure our achievements

It is important to measure the impact of our work on improved quality and safety to ensure we are achieving our objectives, to monitor and modify our initiatives and to identify and deal with any unintended consequences they might produce. We expect our work to result in changes in practice as well as outcomes, so we measure:

- the specific results of the Commission's work
- the achievements of the sector as a whole in improving health quality and safety.

4 The Northern Regional Alliance supports the Northern Region DHBs (Auckland, Counties Manukau, Northland and Waitemata) in their role as health and disability service funders in functional areas specifically delegated to the Northern Regional Alliance. Northland DHB utilises the services as a customer.

5 Until 31 March 2013 this was a special health authority of the NHS in England which 'supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership'.

1.5.1 Measuring the outcomes of the Commission's work

The Commission currently measures changes in practice as well as outcomes using a set of quality and safety markers for healthcare associated infections, perioperative harm and harm from falls. These are shown in Tables 1–3, along with other measures identified in our 2012–15 Statement of Intent.

Baselines against which progress will be measured in future years are highlighted in bold.

Table 1: Healthcare associated infections

Measure	Actual 2011–12	Target 2012–13	Estimated actual 2012–13[6]	Expected outcomes over the next three years	Data source
Process measures					
Percentage observed compliance with all 'Five Moments for Hand Hygiene'	**62.1% (October 2012)**	64%	70.5% (June 2013)	The target is 70%	Hand Hygiene New Zealand programme
Compliance with bundle of procedures for inserting central line catheters in intensive care units (ICUs)	**77% (April 2012)**	Longer-term target is 90%	83%[7] (December 2012)	The target is 90%	*Target CLAB Zero* programme
Outcome measures					
Rate of healthcare associated *Staphylococcus aureus* bacteraemia[8] per 1000 inpatient days	0.14 per 1000 bed days	Establish baseline	**0.11 per 1000 bed days**	Maintenance of rate between 0.07 infections and 0.11 per 1000 bed days would be consistent with literature which suggests that a reduction of between 20% and 50% should be possible[9, 10, 11]	Hand Hygiene New Zealand programme

6 The estimate is based on six months of National Minimum Dataset (NMDS) data extrapolated for a full year. Validated NMDS data for the full year is not available until at least three months after the end of the period.
7 Nearly 60 percent have reached the 90 percent target.
8 A bacterial infection that can result from poor hand hygiene practices.
9 Grayson ML et al. 2008. Significant reductions in methicillin-resistant *Staphylococcus aureus* bacteraemia and clinical isolates associated with a multi-site hand hygiene culture-change programme and subsequent successful statewide roll-out. *Medical Journal of Australia* 188(11): 6336–40.
10 Harrington G et al. 2007. Reduction in hospital wide incidence of infection and colonization with methicillin-resistant *Staphylococcus areus* with use of antimicrobial hand hygiene gel and statistical process control charts. *Infection Control and Hospital Epidemiology* 28: 837–44.
11 Achievement of reduction needs to be considered alongside implementation of actions to reduce this harm.

Measure	Actual 2011–12	Target 2012–13	Estimated actual 2012–13[6]	Expected outcomes over the next three years	Data source
Rate of central line associated bacteraemia per 1000 line days	**3.5 per 1000 line days**[12]	<1 per 1000 line days in all 24 ICUs	0.46 per 1000 central line days in the period April 2012 to March 2013 (national average)	<1 per 1000 line days	*Target CLAB Zero* programme
Rate of surgical site infection per 100 procedures for total hip and knee joint replacements		Establish baseline	1.9 infections per 100 procedures based on recorded infections in the initial four months from the eight pilot sites. The full baseline will be established in 2013–14.	Literature suggests a reduction of 25–27% should be possible[13, 14]	National Minimum Dataset (NMDS)[15]

Between April 2012 and March 2013 the cost avoided by reduced rates of CLAB was close to $2 million and the number of CLAB cases avoided was close to 100.

12 Ko Awatea. 2013. *Target CLAB Zero National Collaborative to Prevent Central Like Associated Bacteraemia: Final Report September 2011 to March 2013*. Counties Manukau: Ko Awatea.

13 Brandt C et al. 2006. Reduction of surgical site infection rates associated with active surveillance. *Infection Control and Hospital Epidemiology* 27(12): 1347–51.

14 Dellinger EP et al. 2005. Hospitals collaborate to decrease surgical site infections. *American Journal of Surgery* 190(1): 9–15.

15 The Ministry of Health has quality control processes relating to NMDS data and the Commission relies on these processes to ensure data quality. The Commission uses the data as extracted from the NMDS.

Table 2: Perioperative harm[16]

Measure	Actual 2010–11	Actual 2011–12	Target 2012–13	Estimated actual 2012–13[17]	Expected outcomes over the next three years	Data source
Process measure						
Percentage of operations where all three parts of the World Health Organization (WHO) surgical safety checklist is used			Establish baseline	**71.2**	Target is 90%	
Outcome measures						
Postoperative sepsis rate[18] per 1000 surgical episodes	8.77	9.65	Establish baselines	**9.06**	Reductions in rates of DVT and PE over two years and maintained in future years. Literature suggests that a reduction of around 30% should be possible.[19] This would equate to: • postoperative sepsis 6.3 per 1000 episodes • postoperative sepsis (elective) 3.5 per 1000 episodes • postoperative DVT/PE 2.8 per 1000 episodes.[20] Associated reduction in additional OBDs and cost will be measured.	NMDS
Postoperative sepsis rate (elective) per 1000 surgical episodes	5.58	6.19		**5.02**		NMDS
Postoperative deep vein thrombosis/pulmonary embolism (DVT/PE) rate per 1000 surgical episodes	4.24	4.21		**4.03**		NMDS
Additional occupied bed days (OBDs) associated with postoperative sepsis	854	936		**891**		NMDS
Additional OBDs associated with postoperative sepsis (elective)	172	184		**156**		NMDS
Additional OBDs associated with postoperative DVT/PE	1204	1218		**1155**		NMDS
Additional cost associated with postoperative sepsis[21]	$658,000	$721,000		**$686,000**		NMDS
Additional cost associated with postoperative sepsis (elective)	$132,000	$142,000		**$120,000**		NMDS
Additional cost associated with postoperative DVT/PE	$927,000	$938,000		**$889,000**		NMDS
Excess number of in-hospital deaths associated with sepsis	11	15		**6**		NMDS
Excess number of in-hospital deaths associated with sepsis (elective)	4	2		**2**		NMDS
Excess number of in-hospital deaths associated with DVT/PE	5	5		**2**		NMDS

16 Called 'surgical safety' in the Commission's 2012–15 Statement of Intent.
17 The estimate is based on eight months of NMDS data extrapolated for a full year. Validated NMDS data for the full year is not available until at least three months after the end of the period.
18 Calculated as a number of surgical admissions where postoperative sepsis and postoperative DVT/PE was recorded within the initial surgical episode OR where a readmission was associated with postoperative sepsis and DVT/PE and occurred within 28 days of discharge from an initial surgical episode per 1000 surgical episodes.
19 Haynes A et al. 2008. A surgical safety checklist to reduce morbidity and mortality in a global population. *New England Journal of Medicine* 360: 5.
20 Achievement of reduction needs to be considered alongside implementation of actions to reduce this harm.
21 Based on Auckland DHB estimate of $770 per OBD.

Table 3: Reducing harm from falls

Measure	Actual 2010–11	Actual 2011–12	Target 2012–13	Estimated actual 2012–13[22]	Expected outcomes over the next three years	Data source
Process measure						
Percentage of older patients given a falls risk assessment			Establish baseline	**77%**	The target is 90%	DHB audits of patient aged 75 and over between December 2012 and February 2013 to see how many had received a falls risk assessment
Outcome measures						
In-hospital fractured neck of femur (FNOF)	111	91	Establish baselines	**106**	Reduction of falls with a FNOF to 75–95 falls would be consistent with literature, which suggests that a reduction of 10–30% is possible[23, 24]	NMDS
Additional OBDs following in-hospital FNOF	4124 OBDs	3944 OBDs		**3787**		NMDS
Mortality following in hospital FNOF			Establish baseline	Numbers are too small to be reliable		N/A
Cost of additional occupied bed days associated with FNOF			Establish baseline	**$2.76 million**		NMDS/ Cost data from New Zealand Institute of Economic Research (NZIER)[25]

22 The estimate is based on six months of NMDS data extrapolated for a full year. Validated NMDS data for the full year is not available until at least three months after the end of the period.
23 Beasley B, Patatanian E. 2009. Development and implementation of a pharmacy fall prevention program. *Hospital Pharmacy* 44(12): 1095–102.
24 Achievement of reduction needs to be considered alongside implementation of actions to reduce this harm.
25 De Raad JP. 2012. *Towards a Value Proposition… Scoping the Cost of Falls. NZIER scoping report to Health Quality and Safety Commission NZ*. Wellington: NZIER.

MEDICATION SAFETY

The Commission's 2012–15 Statement of Intent indicated that we would establish the following baselines for medication safety.

Table 4: Medication safety

Percentage of high priority patients who receive medicines reconciliation at admission	While most DHBs collect local data on patients who received medicines reconciliation at admission, this information is not standardised nationally and is not able to be used as a baseline.
Percentage of audited medicine orders that are legible	Some DHBs carry out audits of the national medication chart but information is not available nationally.
Number of aged care residential providers using the standardised documentation for prescribing and administering medication in age-related residential care facilities	Seven providers piloted the standardised documentation for prescribing and administering medication in age-related residential care facilities. (See section 7.2 of this report for more information.)

A measurable set of quality and safety markers is being developed and finalised for the medication safety programme during 2013–14.

1.5.2 Measuring achievement of the sector as a whole

The Commission has developed an initial set of health quality and safety indicators for New Zealand. These indicators provide a whole-of-sector view on the quality and safety of our health and disability sector, not simply those areas where the Commission is taking a lead role.

More detail on these indicators is provided in section 2.1.

1.6 How our work contributes to broader Government priorities

The Commission's work also contributes to a number of the Government's specific priorities for the health and disability sector and wider cross-government work (see Table 5).

Table 5: Contribution to Government priorities

Priority	Commission contribution
Shorter stays in emergency departments	It is expected that the Commission's work on reducing healthcare associated infections, perioperative harm, medication errors and harm from falls will reduce length of stay in hospital for those patients who would have otherwise been affected by preventable harm. While the Commission's work programme on its own will not result in shorter stays in emergency departments, it is one of a range of actions that hospitals are taking to improve bed usage. To help hospitals improve the efficiency of their services, our quality and safety indicators measure some of the factors that result in greater use of hospital beds, including OBDs for people aged 75 and over admitted two or more times per year, day cases that turn into overnight stays, hospital readmissions and hospital days during the last six months of life. Measuring and reporting against these indicators highlights these issues publicly, provides useful information for agencies responsible for reducing stays in emergency departments and will stimulate debate about improving systems.
Improved access to elective surgery	The Commission's work on reducing preventable harm with the commensurate increased length of stay will be part of the overall action plan to improve efficiency of resource use.
Increased immunisation	The quality and safety indicators measure and report on age-appropriate vaccination for two-year-olds. This highlights the issue publicly, provides useful information for agencies responsible for increasing immunisation and will stimulate debate about improving systems.
More heart and diabetes checks	The quality and safety indicators will, in future, measure and report on cardiovascular disease (CVD) management. The Commission's recently published Atlas of Healthcare Variation domain on CVD management, which examined the use of secondary prevention medicines for all people that were hospitalised with a heart attack or stroke between 2000 and 2010, provides useful information to complement the work being done in primary care to increase heart checks. We are also using patient stories to find ways to improve insulin safety and reduce harm from insulin errors.
Mental Health and Addiction Service Development Plan 2012–2017	During 2013–14, the Commission will publish the first annual mental health serious adverse event report. This will provide useful information for agencies implementing the Mental Health and Addiction Service Development Plan 2012–2017.
Greater service integration	Through our eMM work with the Ministry of Health, we are working towards an electronic system that will give health care providers access to all New Zealanders' medicine information. It is the cornerstone of the wider e-health programme.
Health of older people	Many Commission programmes are being widened to include the aged care sector. In particular, some aged care providers are now using the Commission's national reportable events policy and reporting serious adverse events. The medication safety programme is developing a medication chart for aged care facilities. The programme to reduce harm from falls has older people as its key focus. Information from the Commission's quality and safety indicators, markers and Atlas are stratified across population groups. This provides useful data across the different age groups and ethnicities (including older people to inform the work of policy-makers and providers).
Cross-government work programmes such as the Children's Action Plan[26]	The Commission's Child and Youth Mortality Review Committee (CYMRC), Perinatal and Maternal Mortality Review Committee (PMMRC) and Family Violence Death Review Committee (FVDRC) identify and address systemic issues relating to any type of death or adverse event. Their work relates specifically to infants, children and young people and, in particular, to those most vulnerable. The committees provide information and advice, and work across government agencies to improve systematic issues that will result in a reduction in death and harm. Information from the Commission's quality and safety indicators, markers and Atlas are stratified across population groups. This provides useful data across the different age groups and ethnicities (including children), which can inform the work of policy-makers and providers.

26 Ministry of Social Development. 2012. *Children's Action Plan. Identifying, supporting and protecting vulnerable children*. Wellington: Ministry of Social Development.

Operational review 2011–12

The Commission groups its activities into three output classes.

Output class 1: Information, analysis and advice
Output class 2: Sector tools, techniques and methodologies
Output class 3: Sector and consumer capability

2.0 Output class 1: Information, analysis 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 various ways and settings stimulates 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, our reports encourage discussion and promote learning.

2.1 Measurement and evaluation

We have a responsibility to report on the overall quality of health care, and to monitor and drive improvement. During 2012–13 this included:

- measuring and reporting quality and safety markers in the areas of healthcare associated infections, falls and surgery
- measuring and reporting quality and safety indicators
- measuring and reporting health care variation
- reporting and management of health care incidents
- reviewing mortality
- supporting implementation of quality accounts.

NEW ZEALAND QUALITY AND SAFETY MARKERS

In February 2012, Minister of Health Hon Tony Ryall and Associate Minister of Health Hon Jo Goodhew asked the Commission to develop quality and safety markers for the sector, focused on reducing harm from in-patient falls, healthcare associated infections, surgery and medication. The markers are a mix of process and outcomes measures, designed to track progress and, through public reporting, stimulate debate and improvement.

The markers for healthcare associated infections, falls and surgery were developed and sent to key stakeholders in December 2012. The first report with baseline information was published in June 2013. A supplementary document was also published in which DHBs that performed particularly well in each of the measures explained how they achieved their results.

The development of markers for medication-related harm is a priority for the Commission. A framework for measuring medication safety was developed during 2012–13 and markers are expected to be introduced as part of the *Open for better care* national patient safety campaign.

NEW ZEALAND ATLAS OF HEALTHCARE VARIATION

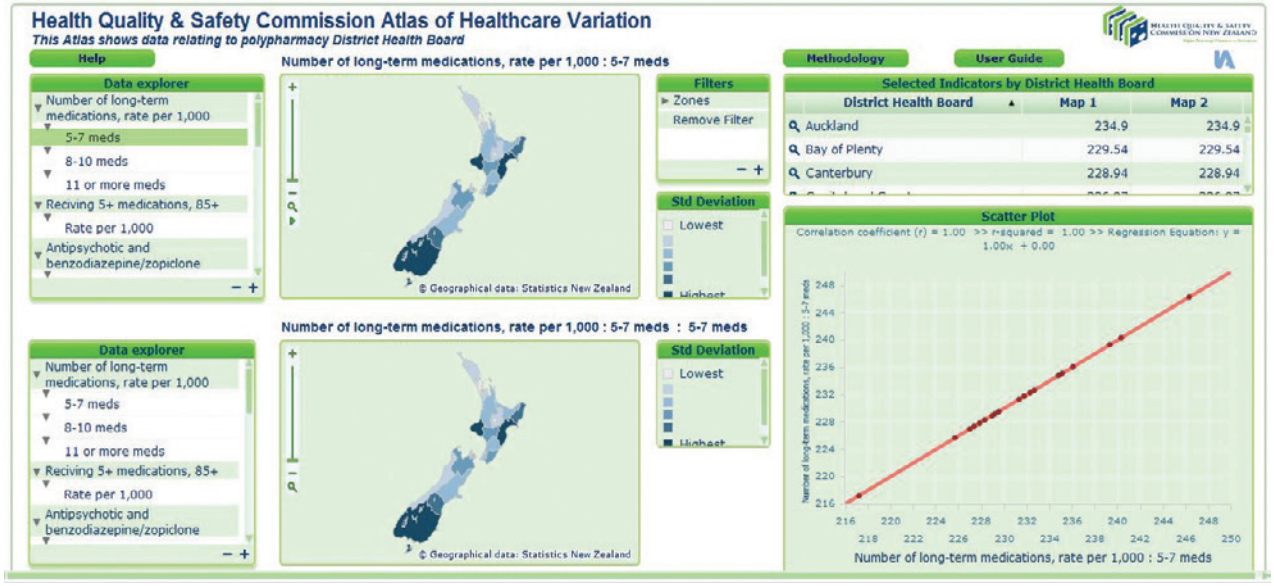
Health care variation reporting has been shown internationally to be a powerful tool for improving appropriateness of care through highlighting overuse, underuse and misuse of interventions.

Seven Atlas domains were published in 2013–14. Four were made available on the Commission's website[27] and three ambulatory sensitive hospitalisation domains were sent to DHBs and PHOs. The interactive web tool displays easy-to-use maps, graphs, tables and commentary highlighting variations by geographic area in the provision and use of specific health services and outcomes. Further domains will be published each year, with a further 6–10 planned for 2013–14.

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 and improvement in practice through this debate. Atlas domains can be used to facilitate open discussion between clinicians, managers, policy-makers and the public, and highlight opportunities for improvement. The clear focus of this reporting is to encourage dialogue, as well as stimulating improved performance. An example from the Atlas investigating the management of gout suggests that long-term treatment results in better outcomes for an individual with gout, including fewer hospital admissions and lower use of other medications.

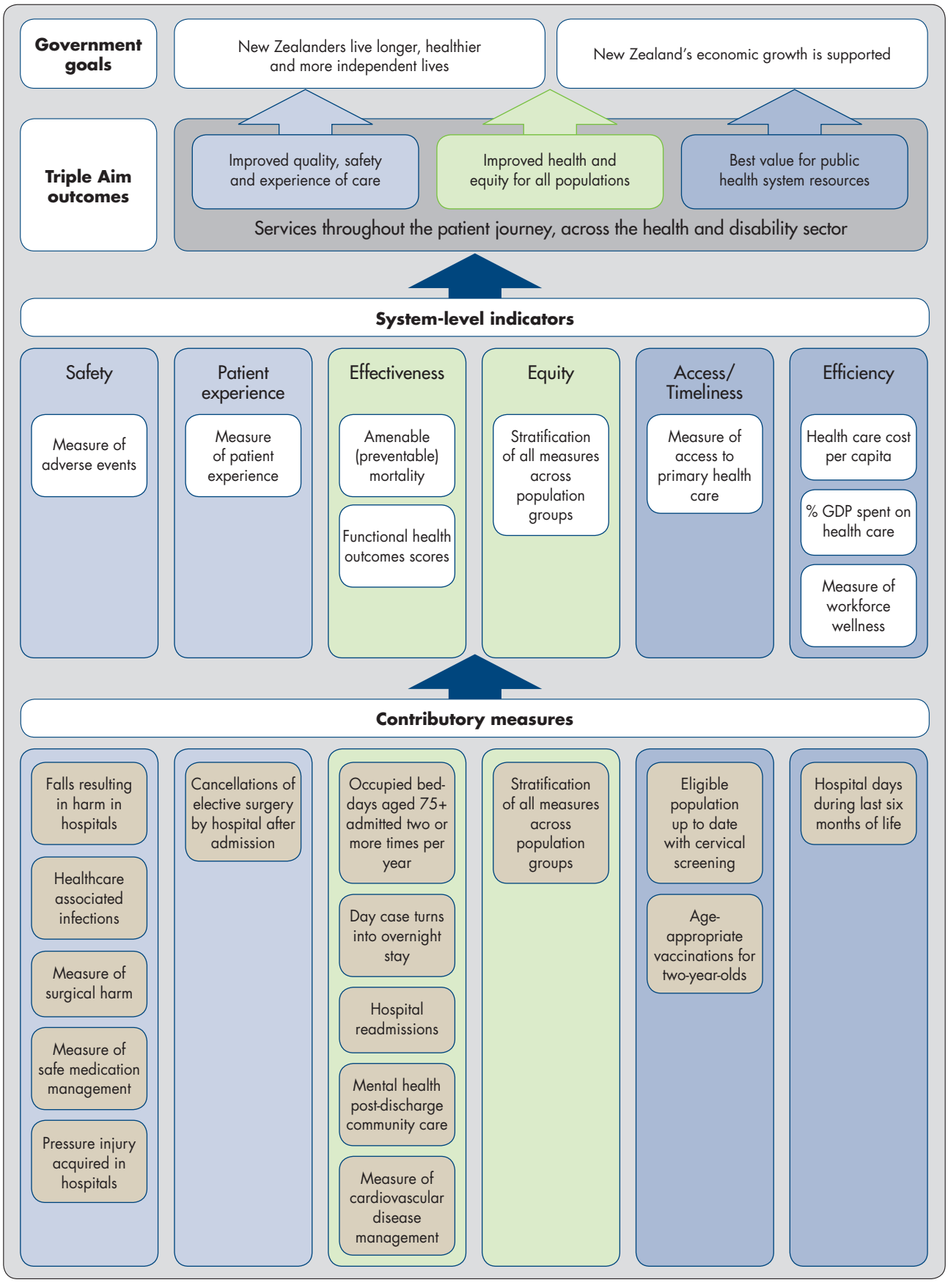
To increase the likelihood of the Atlas resulting in change and improvement, the Commission has contracted for the development of resources to help DHBs, primary care providers, clinicians and managers analyse and interpret local variation. As part of this work, a tool is being developed for primary care providers which will enable them to identify more easily patients in their patient management systems who may benefit from findings in the Atlas reviews. It is anticipated these tools and resources will promote national consistency.

The Atlas is also a powerful tool for improving equity. All Atlas domains reflect variation by ethnicity, and the expert advisory group for each Atlas domain has Māori representation. More information about variation by ethnicity is provided on page 21 under 'Measuring and improving equity'.



27 CVD, polypharmacy in older people, management of gout, and surgical rates for tonsillectomy/adenoidectomy and otitis media (grommet insertion).

HEALTH QUALITY AND SAFETY INDICATORS



HEALTH QUALITY AND SAFETY INDICATORS

The quality and safety indicators are a small set of summary indicators that give the public and the sector 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 overarching goal of reporting against the indicators is to provide robust information to support achievement and measure progress against delivery of the Triple Aim outcomes.

The indicators also:

- inform the 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 areas for service improvement
- support improved equity by breaking down results by population group.

In December 2012 the Commission published the first report against national and international indicators *Describing the quality of New Zealand's health and disability services*.[28] The report included information on nine of the suite of 24 indicators. During 2012–13 the Commission completed development work on the full set of indicators, which includes consumer experience indicators, and will publish them from 2013–14.

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

Over time, we expect that the indicator set will change as:

- definitions for existing indicators are refined
- new indicators are added, reflecting priorities identified by the sector or determined through the Commission's work programme
- others are 'retired' as they become less relevant.

Measuring consumer experience: Consumer experience is a good indicator of the quality of health services. By integrating the learnings from consumer experiences in a quality improvement programme, the chance of service improvement is increased. During 2012–13, the Commission contracted the development of measures of patient experience that can be used:

- as part of our national quality and safety indicator set
- as part of DHB accountability requirements
- for DHBs to plan and monitor improvements in patient experience of individual services.

This work continues and we plan to finalise a tool for the consistent collection of data across DHBs by the end of December 2013, for implementation in 2014–15.

MEASURING AND IMPROVING EQUITY

A key aim of the Commission, as articulated in the Triple Aim, is 'improved… equity for all populations'. Outcomes of treatment are not yet distributed equally in New Zealand. For example, nearly 50 percent more Māori than non-Māori/non-Pacific patients suffer an in-hospital preventable serious adverse event (after controlling for age, deprivation, admission type, length of stay and gender).[29]

28 Health Quality & Safety Commission. 2012. *Describing the quality of New Zealand's health and disability services*. Wellington: Health Quality & Safety Commission. URL: http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/742/.

29 Davis P et al. 2006. Quality of hospital care for Māori patients in New Zealand: retrospective cross-sectional assessment. *The Lancet* 367: 1920–5.

International research shows that, even when access to care is equal, ethnic minority patients tend to receive lower-quality care than other patients. We also know that, even when quality improvement efforts improve outcomes across the entire patient population, disparities between racial/ethnic groups can remain or even worsen.[30]

Equitable care does not mean the same care for everyone. High-quality care – doing the right thing at the right time – varies for different people. However, varied care must never mean that lesser-quality care is provided because of someone's race, gender, income or location.

The first step in improving equity is to understand the extent and nature of disparities. During 2012–13, the quality and safety marker reports, the Atlas domains and the quality and safety indicator reports specifically linked ethnicity with quality and safety information. This allows us to examine any health care disparities in key areas. The next step is to understand why disparities exist and determine which causes can be tackled successfully. The Commission is being assisted in this work by Roopu Māori.

The analysis of this data has raised questions for DHBs. For example the Atlas domain on management of gout identified that although Māori and Pacific populations have a higher prevalence of gout, they are less likely to receive the recommended medication for long-term management of their condition.

LIBRARY OF QUALITY MEASURES

The Commission has supported the ongoing development of the library of quality measures held by Health Quality Measures NZ. This online tool, based on research, provides definitions of how to use, interpret and contribute to a range of measures within the health sector. It now houses the Commission's national quality and safety indicator set. The library is hosted by Patients First, which is governed by the Royal New Zealand College of General Practitioners and General Practice New Zealand, and can be accessed via the Patients First website.[31]

2.2 Reporting and management of health care incidents

Dr David Sage is clinical lead for the Commission's reportable events programme. He is an experienced clinician with a long-standing interest in health system performance. He spent nine years as the chief medical officer at Auckland DHB.

REPORTABLE EVENTS

To increase safety, there needs to be a system to identify when things go wrong and improve the response. This includes open disclosure, conducting root-cause analysis and sharing information so other providers can improve systems and prevent similar events.

Since 1 July 2012 organisations have been required to report key findings and recommendations of reviews of serious adverse events to the Commission. This means that in future the Commission will be able to report in greater detail issues such as contributory causes and what has been learnt from the events. During the year, the Commission worked with the sector to develop two web-based learning packages,[32] which provide guidance to health care staff on:

- serious incident review
- open disclosure.

The Commission was assisted in producing these packages by staff from primary care, disability services, age-related residential care, hospices and home and community services.

30 Orsi JM et al. 2012. Black-white health disparities in the United States and Chicago: a 15-year progress analysis. *American Journal of Public Health* 100(2): 349–56.
31 www.patientsfirst.org.nz
32 The programmes are hosted on the Ministry of Health's LearnOnline vocational training resource hub at http://learnonline.health.nz/.

SERIOUS AND SENTINEL EVENTS REPORTED BY DISTRICT HEALTH BOARDS IN 2011–12

The Commission reports at least annually on the serious adverse events[33] (previously called serious and sentinel events) that occur in public hospitals. The reports provide an impetus for the health system to learn from the events and take steps to prevent them in future. They also continue to inform the Commission's programmes.

The report for events that occurred in 2011–12 was published in November 2012.[34] A total of 360 events in DHB hospitals were reported. Not all the events described in the report were preventable, but many involved errors that should not have happened.

Falls in hospitals accounted for 47 percent of all events in 2011–12. As the highest category of serious adverse events, it is clear the Commission must continue its work in this area. The increased number of cases of delayed treatment also flagged the need for the sector to focus on breakdowns in hospital systems. The Commission is looking at measures that can be put in place to reduce the likelihood of these types of events occurring, for example, making sure patients are full partners in the management of their care so they too are aware if there needs to be a further test, result from a specimen or referral to another specialist.

An increasing number of non-DHB providers are reporting serious adverse events to the Commission, including ambulance services (St John and Wellington Free), the National Screening Unit and the Department of Corrections. Serious adverse events relating to disability services (residential and home-based) have been reported to the Commission since 1 July 2012 and members of the New Zealand Home Health Association are expected to follow (47 organisations).

Other agencies also collect information on serious adverse events, and we have been working with ACC, the Ministry of Health and the Health and Disability Commissioner to develop a working partnership to prevent serious harm to patients.

MENTAL HEALTH AND ADDICTIONS SERVICES REPORTING OF SERIOUS ADVERSE EVENTS

Incidents involving mental health patients were included in public reporting of serious adverse events up to and including 2009–10. These events, particularly the suspected suicides of mental health outpatients, are, however, considered to be different from, for example, a wrong-sided operation or harm to a patient from a fall. The Commission has removed these events from the general reporting process and worked with a group of experts from the mental health sector to develop a more appropriate system of reviewing these cases.

Information using this new approach was collected from DHBs during 2012–13 and the first mental health and addictions services serious adverse events report was published in late September 2013.[35] A total of 177 events were reported involving actual, or potential, serious harm to patients including death by suspected suicide, serious self-harm, serious adverse behaviour and going missing from an inpatient facility. Based on the experience of serious adverse event reporting in non-mental health and addictions services, it is expected that DHB reporting will improve over the next 2–3 years, and the number of events reported will increase.

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

34 Health Quality & Safety Commission. 2012. *Making Our Hospitals Safer: Serious and Sentinel Events Reported by District Health Boards in 2011/12*. Wellington: Health Quality & Safety Commission. URL: http://www.hqsc.govt.nz/our-programmes/reportable-events/publications-and-resources/publication/695/

35 Health Quality & Safety Commission. 2013. District health board mental health and addictions services: serious adverse events reported to the Health Quality & Safety Commission 1 July 2012 to 30 June 2013. Wellington. Health Quality & Safety Commission.

TRIGGER TOOL SURVEILLANCE

Gillian Robb is clinical lead for the Commission's global trigger tool work. She is a professional teaching fellow at the University of Auckland, and a senior quality manager at Counties Manukau DHB.

The global trigger tool (GTT) is an internationally recognised tool for measuring patient harm, developed by the Institute for Healthcare Improvement. It provides a simple, validated and cost-effective methodology that complements other reporting systems for patient harm.

The Commission's GTT programme aims to engage all DHBs to achieve a more coherent national approach to using information about patient harm to inform patient safety initiatives.

This year has seen an increasing interest in the process. From an initial group of six DHBs over 2011–12, a further eight have taken up either the adverse drug event trigger tool (which is a component of the GTT) or the full tool as part of their suite of tools to measure and understand the extent and nature of patient harm.

During 2012–13, the Commission conducted site visits to eight DHBs in order to focus on supporting and sustaining the process by working with individual teams. There were also presentations to senior leadership teams and at grand rounds. Visits are planned with a further four DHBs later in 2013.

In November 2012 the Commission produced a guide for DHBs on how to use the tool to help reduce patient harm in hospitals.[36] This guide provides useful information on managing data, standard operating procedures, reporting, triggers, performance indicators and identifying opportunities for improvement.

In April 2013, in conjunction with the *First, Do No Harm* patient safety campaign, the Commission held a national GTT workshop attended by participants from 16 DHBs. This focused on building capacity within individual DHBs and among regional groups to enhance the sustainability of the GTT process and to develop knowledge and skills around using the data for improvement. A visiting speaker from Melbourne Health shared her expertise and experience of using the trigger tool data for improvement, further building on international links established at the Asia Pacific (APAC) Forum on Quality Improvement in Health Care in 2012.

A comprehensive evidence review of the GTT was commissioned and will be made available on the Commission's website in late 2013. This will be a valuable resource for New Zealand and international GTT communities.

A national GTT network has been established to support the sustainability of the programme further. In the near future a secure portal will be added to the Commission's website to allow DHBs to have discussions and share learnings.

36 Health Quality & Safety Commission. 2012. *The Global Trigger Tool: A Practical Implementation Guide for New Zealand District Health Boards.* Wellington: Health Quality & Safety Commission.

2.3 Quality accounts

Quality accounts reinforce the importance of quality of care by placing quality reporting 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
- show the public where improvements are needed and planned
- receive feedback from the public and wider sector on what each provider is trying to achieve
- be held to account by the public and local stakeholders for delivering quality improvements.

> "The introduction of Quality Accounts to all health and disability service providers within New Zealand marks an important step in putting quality at the heart of all healthcare activity."
>
> *Quality Accounts: Maintaining Momentum* (a report to the Commission from PwC New Zealand)

Quality accounts are being adopted in New Zealand. While responsibility for their delivery sits with health and disability service providers, the Commission is supporting this delivery by providing guidance on their content and style.

The first phase of this work programme was completed in June 2012, with the publication of a best practice advisory guidance manual. This provided a practical, step-by-step approach to preparing, documenting and publishing a quality account. The second phase focused on knowledge transfer to nominated staff from each DHB via regional workshops in September and October 2012. The third phase, launched in March 2013, focused on maintaining the momentum of the programme and providing support packages tailored to individual DHBs. With this support, the intent is that all DHBs will publish their 2012–13 quality accounts by the end of December 2013.

2.4 Mortality review committees[37]

Mortality review is an applied research process used to identify and address systemic issues relating to any type of death or adverse event with the aim of improving systems and practice within health and disability services. While one unexpected, preventable death may be seen as a tragedy, deaths occurring in a pattern are usually an indication of larger system failures.

There are four mortality review committees operating under the umbrella of the Commission. They review particular deaths or the deaths of particular groups of people to learn how best to prevent such deaths and harm in future.

The committees report at least annually and work across agencies to ensure recommendations from their reports can be implemented. Because the committees focus intensively on specific events, they are a powerful tool for improving the quality and safety of services and systems.

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

During the year a review of mortality review committees was undertaken by MartinJenkins and Professor Gregor Coster, to identify recommendations to maximise the benefit from our investment in mortality review.[38]

37 Section 59E(3) 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. Each such report must be included in the Commission's next annual report. This section of the annual report fulfils that obligation.

38 Review of the National Mortality Review Programme March 2013 (unpublished).

It included looking at expected and actual outcomes from the current approach and alternatives to improve the effectiveness, efficiency and ongoing sustainability of the programme. Implementation of the recommendations is underway and will result in better coordination across all mortality review functions, reduced duplication and the ability to increase investment in newer committees such as the Perioperative Mortality Review Committee (POMRC).

CHILD AND YOUTH MORTALITY REVIEW COMMITTEE

Dr Nick Baker is chair of the Child and Youth Mortality Review Committee (CYMRC). He has been the general and community paediatrician in the Nelson area since 1993 and is also a senior lecturer on community and child health for the University of Otago. He has been president of the Paediatric Society of New Zealand for two terms.

The CYMRC reviews deaths of children and young people aged 28 days to 24 years.

In March 2013, the committee released its *Special Report: Unintentional suffocation, foreign body inhalation and strangulation*.[39] The report showed that while infant deaths and the infant mortality rate were at record lows in 2012, more needs to be done to keep the most vulnerable members of New Zealand's communities safe from harm. The report noted that death from traumatic asphyxia caused by suffocation is one of the three leading causes of unintentional injury deaths in New Zealand. It looked at three main types of death: suffocation in the place of sleep, inhalation of food or foreign bodies, and external pressure on the neck or face. Of the 79 deaths the report looked at, 50 arose from unintentional suffocation in bed, underlining the need to provide babies and young children with safe places to sleep.

> "Each number in this report represents a tragic loss for families and whānau around New Zealand, and we hope that our investigations of infant and child mortality, and our support for actions which aim to keep children safe, will help to prevent further deaths of these types."
>
> Dr Nick Baker, CYMRC chair

The CYMRC report recommendations align with current government initiatives to improve support for vulnerable children, enhance smoking cessation programmes, put in place better systems to engage across the health system, increase the availability of safe sleeping spaces, encourage policies and staff training in DHBs, and place greater emphasis on the safety of cots and bassinettes.

Information collected for the CYMRC report has already been used to influence new Ministry of Health choking guidelines, and is contributing to the development of training resources and safe-sleep programmes around New Zealand.

Local committees: The CYMRC process of data collection relies on information and support from the DHB of each deceased child or youth. To gather and review information, there is a local child and youth mortality review group in every DHB, funded by the Commission.

39 CYMRC. 2013. *Special Report: Unintentional suffocation, foreign body inhalation and strangulation*. Wellington: Health Quality & Safety Commission. URL: http://www.hqsc.govt.nz/publications-and-resources/publication/805/.

PERINATAL AND MATERNAL MORTALITY REVIEW COMMITTEE

Professor Cynthia Farquhar (left) was chair of the Perinatal and Maternal Mortality Review Committee (PMMRC) until 12 June 2013. She is the postgraduate professor of obstetrics and gynaecology at the University of Auckland.

Dr Sue Belgrave (right) has been chair of the PMMRC since 12 June 2013. Dr Belgrave is an obstetrician and gynaecologist, a Royal Australian and New Zealand College of Obstetricians and Gynaecologists training supervisor and chair of the Auckland training committee.

The PMMRC reviews the deaths of babies and mothers in New Zealand and advises on how to reduce the number of deaths.

In June 2013 the *Seventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting Mortality 2011*[40] was published. The report found a downward trend in maternal mortality and a significant reduction in several measures of perinatal mortality including a reduction from 3.6 deaths per 1000 births in 2007 to 3 deaths per 1000 births in 2011.[41] Māori, Pacific and Indian mothers, and women from areas of socioeconomic deprivation, were significantly more likely to experience a perinatal death.

Nineteen percent of all perinatal-related deaths were identified as potentially avoidable in 2011. The most common contributing factors to these deaths were barriers to access or engagement with care, most commonly late or infrequent access to antenatal care. These were followed by personnel factors, most commonly failure to follow recommended best practice. The risks of losing a baby from potentially avoidable causes were higher for Māori and Pacific mothers, and for women from areas of socioeconomic deprivation.

Report recommendations focused on improving the standard of neonatal resuscitation, offering single embryos to all women having assisted reproduction, improved antenatal screening and fortifying bread with folic acid.

The sector has a record of responding well to the recommendations in the PMMRC reports. This includes increased funding for perinatal and maternal mental health services, greater access to better maternity data to assist in policy development, a new website service to help pregnant women find a midwife (Find your midwife, www.findyourmidwife.co.nz), and development of national guidelines for areas such as postpartum haemorrhage, diabetes, observation of the newborn and referral.

FAMILY VIOLENCE DEATH REVIEW COMMITTEE

Associate Professor Julia Tolmie is chair of the Family Violence Death Review Committee (FVDRC). Professor Tolmie is an associate professor in law at the University of Auckland and has researched and published for more than 20 years on family violence issues.

The FVDRC reviews deaths resulting from family violence in New Zealand and advises on how to reduce the number of family violence deaths.

In June 2013, the FVDRC published its *Third Annual Report: December 2011 to December 2012*.[42] The FVDRC analysed deaths that occurred in family violence

40 PMMRC. 2013. *Seventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2011*. Wellington: Health Quality & Safety Commission. URL: http://www.hqsc.govt.nz/publications-and-resources/publication/958/.

41 Using the WHO's international measure of perinatal mortality.

42 FVDRC. 2013. *Third Annual Report: December 2011 to December 2012*. Wellington: Health Quality & Safety Commission. URL: http://www.hqsc.govt.nz/publications-and-resources/publication/992/.

incidents in New Zealand during 2009 and 2010, and conducted in-depth, qualitative reviews on nine deaths that occurred during 2010 and 2011. Of the 72 family violence deaths considered by the FVDRC, 20 were associated with child abuse and neglect, 35 were intimate partner homicides and 17 involved other family members.

Report recommendations focused on better inter-agency collaboration and information sharing, strengthening stopping violence programmes and better care for victims after a family violence homicide. Some recommendations are already being acted upon.

PERIOPERATIVE MORTALITY REVIEW COMMITTEE

Dr Leona Wilson, ONZM, is chair of the Perioperative Mortality Review Committee (POMRC). Dr Wilson is a specialist anaesthetist and has also completed a Masters of Public Health and is a Fellow of the Australian Institute of Company Directors.

The POMRC reviews all deaths related to surgery and anaesthesia that occur within 30 days of an operative procedure and advises on how to reduce such deaths. In March 2013, *Perioperative Mortality in New Zealand 2012: Second report of the Perioperative Mortality Review Committee* was published.[43]

The report drew on data from the National Mortality Collection and the NMDS to examine death rates in four clinically important areas:

- cholecystectomy (surgical removal of the gall-bladder) – the report found a death rate of 1 percent for acute admissions and 0.16 percent for elective admissions within 30 days
- pulmonary embolism – the report found a death rate of 0.05 percent for acute admissions and 0.008 percent for elective patients who had surgery/anaesthesia and developed pulmonary embolism
- patients aged 80 or over (a high-risk group) – the report found a death rate of 9 percent within 30 days post-emergency surgery. Where the surgery was planned, the death rate dropped significantly to 1.2 percent
- elective patients, categorised as low risk – the report found a death rate of 0.07 percent within 30 days post-surgery for all ages, although for those aged 0–24 years, for example, there was a death rate of 0.01 percent within 30 days post-surgery.

These figures are comparable with what is happening overseas.

> "We're hoping these findings will help patients and their doctors and nurses make the best possible decisions about their care." Dr Leona Wilson, POMRC chair

The report made a number of recommendations, including:

- formal assessment of all patients pre-operatively for risk of VTE
- active participation by all health care professionals in the WHO surgical safety checklist
- ensuring information is available to patients about the risks of dying within 30 days of any procedure with a significant risk of mortality
- further development of non-operative care pathways, and use of these when surgical procedures are considered too risky.

Reducing perioperative harm is one of the Commission's four priority areas and work is underway to support use of the WHO surgical safety checklist and other tools for improving teamwork and communication in multidisciplinary surgical teams (see page 36).

43 POMRC. 2013. *Perioperative Mortality in New Zealand: Second report of the Perioperative Mortality Review Committee*. Wellington: Health Quality & Safety Commission. URL: http://www.hqsc.govt.nz/publications-and-resources/publication/813/.

3.0 Output class 2: Sector tools, techniques and methodologies

One of the Commission's key roles is to 'lend a hand' to enable the sector to improve the quality and safety of services. This includes developing evidence-based guidance and toolkits, providing advice and building networks of clinicians and consumers to champion and lead quality improvement.

We do not need to reinvent the wheel. There is already considerable expertise and innovative quality and safety practice in the sector and overseas, and it is important the Commission taps into this, as it supports the implementation of priority quality and safety programmes.

Our view across the sector allows 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 allows us to identify international best practices and work to introduce those relevant to New Zealand.

3.1 Reducing harm from falls

Sandy Blake is clinical lead for the Commission's national reducing harm from falls programme. She is the director of nursing, patient safety and quality at Whanganui DHB.

The falls programme is a national multi-agency programme led by the Commission to:

- reduce personal costs faced by individuals who fall and harm themselves, such as pain, anxiety, short-term or long-term disability, decrease in quality of life (including a loss of confidence) and, in some cases, an early death
- reduce the costs of treatment, rehabilitation and care, including premature admission to age-related residential care.

It is supported by an expert advisory group that brings together individuals from a broad base representing service, practice, professional, research and consumer perspectives.

Hazel was in hospital for a scheduled hip replacement operation in September 2012, and was returning to her bed from the bathroom during the night, when her crutches slipped and she fell. She cracked a bone in the hip she'd just had surgery on, and needed to have further surgery. This turned a week-long stay in hospital into a three-week stay and had a major impact on Hazel and her family.

During the year, the Commission engaged NZIER to identify where falls occur, how age relates to the risk of falling and where costs lie.[44] Its report informed the development of the programme and priorities within it. It identified that inpatient falls add up to $5 million a year to treatment costs. It also identified there are five times as many hospital discharges related to falls in residential care, and 18 times as many from falls in the community in general, compared with inpatient falls. There are a total of 47,000 fall-related discharges per annum – accounting for 5 percent of all discharges in a year and costing public hospitals $205 million. As a result of the report, the Commission is taking a broader focus to its work in reducing harm from falls, particularly in the *Open for better care* campaign.

44 De Raad JP. 2012. *Towards a Value Proposition… Scoping the Cost of Falls. NZIER scoping report to Health Quality and Safety Commission NZ.* Wellington: NZIER.

Highlights of our falls programme during the year included:

- the 'April Falls' promotion, where the Commission supported DHB activities
- the May launch of the *Open for better care* campaign, with falls prevention as the first topic of focus.

The April Falls promotion: The Commission ran the inaugural April Falls quiz, which attracted nearly 1500 entries and was an engaging way for people to test their knowledge about falls, while measuring sector knowledge of falls risks and prevention. The findings provided the Commission with a baseline for comparison in subsequent years. Over 700 participants signed up to receive alerts to the specific information packages on falls prevention ('the 10 topics').

Open for better care *campaign:* The first focus of the *Open for better care* campaign, reducing harm from falls, got off to a great start in May with a suite of activities and resources aimed at encouraging the use of evidence-based interventions to prevent falls and strareduce harm from falls. These included:

- the first two of four audio-visual resources – *Preventing falls in hospitals* and *Staying safe on your feet at home*
- a patient information compendium, containing information about how to stay safe and avoid falls while in hospital, an ACC home safety checklist and ACC vitamin D card for the patient's prescriber
- *The facts* – the case for change in the hospital setting.

June and July saw the first of 10 topics on reducing harm from falls published on the Commission's website as interactive learning activities equivalent to 60 minutes of professional development. The first topics included an overview of falls in older people, the *Ask, assess, act* initiative and a focus on risk assessment and care planning.

The Commission's clinical lead, Sandy Blake, co-authored a discussion document on falls risk assessment and care plans.[45] Findings in the discussion document and evidence about common risk factors have been used to develop a falls risk assessment menu in TrendCare (a patient acuity tool in use in 16 of the 20 DHBs). This has supported DHBs in reporting against the quality and safety markers for falls, which are focused on risk assessment and individualised care planning. The baseline data was released in June 2013 and provides a baseline to measure the success of parts of the campaign as well as the ongoing falls programme.

Falls in hospitals accounted for 47 percent of all serious adverse events in 2011–12. The Commission is undertaking a project to look at what we learn from these reported patient falls and make recommendations for better reporting and reviewing of falls.

An important development during the year was expanding support for falls prevention to age-related residential care and, in particular, our agreement on collaboration with Capital & Coast, Hutt Valley and Wairarapa DHBs, and ACC. We are also, in partnership with ACC, preparing an initiative to promote prescribing of vitamin D in the community for those at risk of vitamin D deficiency (extending ACC's programme of vitamin D prescribing in age-related residential care).

The falls prevention topic of the campaign continues until November 2013.

45 Blake S, Westrate J. 2013. *Falls risk assessment tools and care plans in New Zealand district health boards: A review and discussion document.* Wellington: Health Quality & Safety Commission. URL: http://www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/publications-and-resources/publication/1079/.

3.2 Medication safety

Medicines are one of the most common interventions in the health system and impact on the lives of every New Zealander at some point. The medicines management process is complex and open to medication errors, which can result in adverse drug events (ADEs). Between March 2010 and February 2011, a study of 1210 charts in three large DHB hospitals using GTT methodology showed that 30 percent of patients suffered some medication-related harm. Five percent of these were serious, and five people died.[46] While the total incidence of ADEs caused by high-risk medicines in New Zealand is unknown, this study found that opioids (32.9 percent) and anticoagulants (10 percent) were most commonly implicated for causing an ADE. Of the 19 ADEs identified in the study as contributing to severe harm or death, 50 percent were related to opioids and anticoagulant use. Around 60 percent of ADEs are thought to be preventable.

The national medication safety programme is a partnership between the Commission and the National Health Board/National Health IT Board. It aims to produce a safer and more informed environment for the use of medicines in New Zealand, to reduce harm and cost from medication errors and to increase the efficiency and integration of medication management systems. Our aim is to ensure that 'the right patient gets the right medicine in the right dose at the right time, by the right route and correctly recorded'.

Key elements of the programme are:

- the suite of national medication charts
- medicine reconciliation
- electronic medicines management (eMM)
- high-risk medicines and/or situations
- provision of expert advice.

NATIONAL MEDICATION CHART

The standardised paper-based national medication chart is a simple but effective way of reducing medication errors. Standardising practice is a recognised safety initiative in many industries. The standardised chart reduces medication errors that happen when clinicians are unfamiliar with a chart or with a hospital or other health care facility's unique systems.

By the end of June 2013, 17 DHBs (up from 15 at June 2012) and some hospices and private hospitals had introduced the national medication chart. A short-stay medication chart was also developed and sector feedback incorporated into the design. The short-stay chart will be tested in seven different situations to inform the final design. In addition, a medication chart for use in aged residential care services is being piloted at seven facilities. The outcome of these pilots will be used to determine the next steps in developing a standardised process for prescribing and administering medication in aged residential care.

New versions of the medicine reconciliation and medication charting standards were released in October 2012. These standards define materials, practices or outcomes expected with the medicine reconciliation and medication charting processes. Greater emphasis has been placed on ensuring that there are appropriate requirements and guidance for different health care sectors such as primary and secondary. The standards have been endorsed by the Health Information Standards Organisation.

46 Seddon ME et al. 2013. The Adverse Drug Collaborative: a joint venture to measure medication-related harm. *New Zealand Medical Journal* 126(1368).

MEDICINE RECONCILIATION

Medicine reconciliation ensures patient medicines are checked at critical handover times, such as when patients are admitted to or discharged from hospital. A study on the impact of medicine reconciliation on the rates of medication error in cardiac care in the USA has been published recently. Results indicate significant reductions in medication errors from implementation of medicine reconciliation.[47]

By the end of June 2013, all DHBs were using medicine reconciliation. Six chose to provide medicine reconciliation to all admitted patients within 24 hours. The other 14 DHBs use their own prioritisation criteria to decide which patients have their medicines reconciled. The spread of medicine reconciliation at all transition points (including discharge) has continued, as has work to validate prioritisation criteria to help the spread of medicine reconciliation further.

ELECTRONIC MEDICINES MANAGEMENT

Information technology (IT) has the potential to transform the way medicines are managed in the sector. Through our joint work with the National Health Board/National Health IT Board on the eMM programme, we are working towards an electronic system that will give all health care providers access to every New Zealander's medication information and will enable people to manage their medicines more effectively. This includes prescribing, administering, reconciling, dispensing and tracking medicines. An important component of this sector-wide work involves shared electronic care records.

During 2012–13, the Commission continued to support the three DHBs who are implementing phase 2 of the eMM programme as well as those establishing an eMM programme. This included:

- a business case toolkit to provide DHBs with a standardised way to assess costs and estimate benefits of ePrescribing and Administration (ePA) implementation
- one-pager briefing notes for clinical groups (doctors, nurses, pharmacists), IT representatives and implementation team stakeholders, which give an overview of eMM projects, what to consider and how to get involved
- implementation roadmaps with an estimate of each DHB's progress with eMM adoption up until 30 June 2016
- the MOH electronic signature waiver application
- agreeing with clinical leads and DHBs the most critical enhancements to be developed by the software provider
- establishing an eMM sector engagement forum
- establishing a trans-Tasman alliance with major MedChart sites in Australia to align development requests and jointly prioritise product development.

The Commission contracted Sapere Research Group[48] to provide the Commission with information that would:

- guide decisions on future regional and national roll-out of the eMM initiatives, by providing advice on implementation lessons and the change process
- provide a framework for the sustainable, ongoing measurement and evaluation of medication-related harm for the medication safety programme
- enable us to form a judgement on the relative value of the current eMM initiatives, in terms of the likely impact on patient safety and cost effectiveness.

Overall the results showed a strong sense of common purpose and support for the implementation of the eMM solutions. The roll-out plan is becoming better established, and the project is clinically led and supported by the IT solutions. A number of challenges were, however, identified and these are being addressed in partnership with the National Health Board/National Health IT Board.

47 Benson JM, Snow G. 2012. Impact of medication reconciliation on medication error rates in community hospital cardiac care units. *Hospital Pharmacy* 47(12): 927–32.

48 With contributing partners the National Institute for Health Innovatoin (NIHI) and the University of Otago.

A framework for measuring medication-related harm was proposed but many issues need to be resolved before it can be applied, including significant changes and standardisation of data systems, codes and definitions.

HIGH-RISK MEDICINES AND/OR SITUATIONS

The Commission issued four *Medication Safety Watch* bulletins during the year. These included timely information about medicine-related incidents, errors and adverse drug events and their implications, and recommendations on how to improve medication safety. The sector directly contributes information to the bulletins.

We also issued two alerts:

- Error-prone abbreviations, symbols and dose designations NOT TO USE
- Safety signal: Oral metoprolol administration.

Alerts include recommendations relating to either internationally recognised or locally identified high-risk medicines or situations. They are sent to relevant health care providers with the latest information and advice on particular topics or concern.

The Commission also produced two National Medication Safety Programme Updates (August and December 2012) and a leaflet for patients, *Taking your medicine safely*.[49]

A New Zealand Tall Man Lettering list was developed based on the Australian Tall Man Lettering list with the inclusion of New Zealand-identified high-risk pairs of similar medicine names. When published, the list will be recommended for use in electronic systems to reduce the risk of clinicians picking the wrong medicine name from drop-down lists.

High-risk medicines and situations will be topic four of the *Open for better care* campaign.

3.3 Infection prevention and control

Dr Sally Roberts is clinical lead for the infection prevention and control programme. She is an infectious diseases physician and clinical head of microbiology at Auckland DHB.

The infection prevention and control programme aims to significantly reduce the harm and cost associated with preventable healthcare associated infections. International and local studies show that these infections prolong hospital admissions, use up valuable health care resources and can cause considerable harm to patients, some of whom die as a result.

Healthcare associated infections are some of the most frequent adverse events in health care worldwide.[50] Up to 10 percent of patients admitted to modern hospitals in the developed world acquire one or more of these infections. Each case of healthcare associated bloodstream infection in New Zealand can cost an additional $20,000 or more depending on the severity of the infection and the treatment needed.[51] In 2003, it was estimated the annual cost of treating patients with infections picked up while in hospital was approximately $140 million.[52] This did not take into account the cost to the patient and family in delayed recovery time, extra doctor visits and time off work.[53]

49 http://www.hqsc.govt.nz/assets/Medication-Safety/Other-PR/brochure-Taking-Your-Medicine-Safely-WEB.pdf
50 World Health Organization. 2009. *Report on the Burden of Endemic Health-Care Associated Infection Worldwide*. Geneva. World Health Organization.
51 Evaluation of Middlemore Hospital ICU's implementation of the standardised checklist of interventions 'The Central Line Bundle'- to prevent catheter-related blood-stream infection.
52 Graves N et al. 2003. Modeling the costs of hospital-acquired infections in New Zealand. *Infect Control Hosp Epidemiol* 24(3): 214–23.
53 Health Quality & Safety Commission. 2012. *The Clean Hands Chronicle: Clean hands save lives*. Issue Three, August 2012. Wellington: Health Quality & Safety Commission.

The Commission is leading national quality improvement initiatives, including:

- improving the hand hygiene practice of DHB health care workers
- reducing CLAB
- reducing surgical site infections (SSIs).

Our programmes have had an initial focus on hospital-level care where vulnerable patients have a higher risk of infection.

HAND HYGIENE PROGRAMME

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

This programme aims to improve hand hygiene best practice across all DHB health care worker groups in order to reduce healthcare associated infections. The programme is based on the WHO *Guidelines on Hand Hygiene in Health Care*. Auckland DHB has been contracted by the Commission to lead a three-year programme to be completed in July 2014 that is leading a culture change and improving hand hygiene compliance among health care workers.

"Good hand hygiene is one of the most significant actions any health professional can take to protect the safety of their patients. It is quick and easy and has an impact far in excess of its cost in terms of both time and money. In many ways not caring about good hand hygiene means you don't care what happens to your patient."

Gary Lees, director of nursing and midwifery, Lakes DHB

The auditing process indicates that national compliance with best-practice guidelines in public hospitals improved from 62.1 percent in October 2012 to 70.5 percent in June 2013, just exceeding the 64 percent target. Before the programme started in 2009 the rate was 35 percent.

The Commission and Auckland DHB are working to raise hand hygiene compliance rates to at least 80 percent in the next two years, which would make New Zealand's compliance among the best in the world. Importantly, it would significantly reduce the number and impact of healthcare associated infections.

The year two review of the programme identified that it was establishing a sustainable local and regional process for training auditors, with 196 gold auditors in place in July 2013.[54]

CENTRAL LINE ASSOCIATED BACTERAEMIA (CLAB) PROGRAMME

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

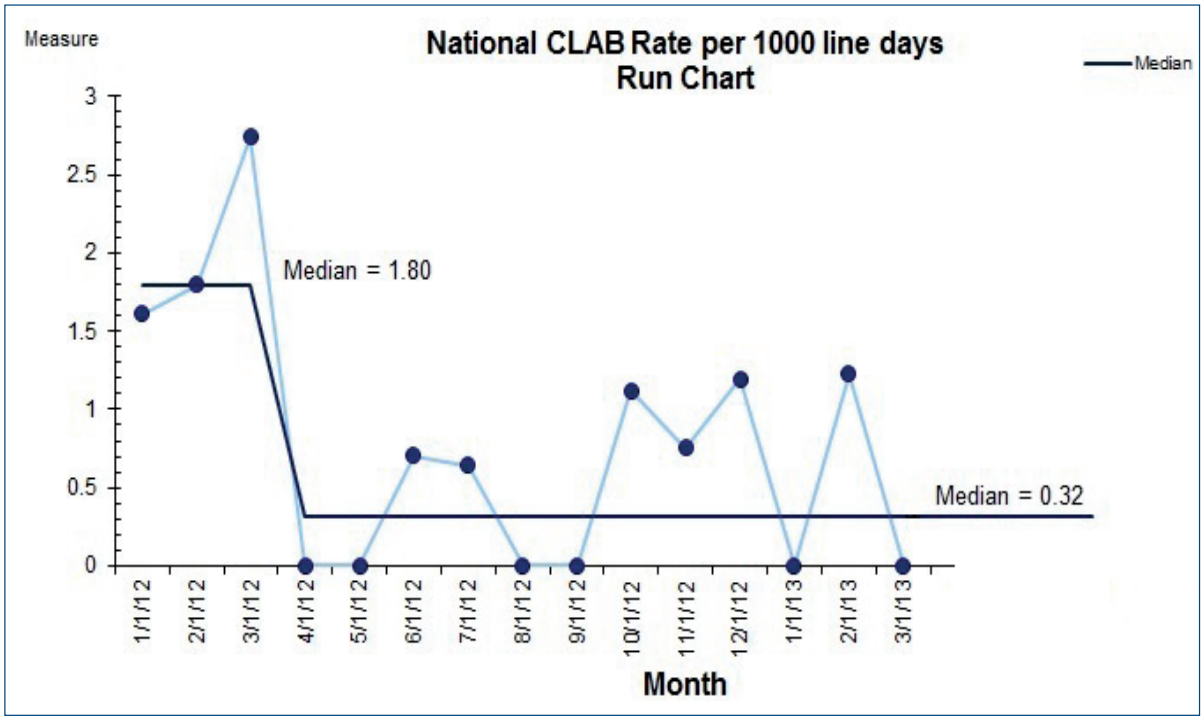
In 2011 Ko Awatea at Counties Manukau DHB was contracted by the Commission to achieve a sustainable reduction in CLAB episodes in intensive care units (ICUs) through a national programme of leadership, training and coordination.

54 Hand Hygiene New Zealand. 2013. *Year Two: Annual Summary Report 2012/2013*. Auckland: Hand Hygiene New Zealand.

CLAB is a serious but preventable complication from a relatively common procedure (insertion of central lines). There is compelling international[55] and local[56] evidence to show the effectiveness of initiatives to reduce incidence of CLAB.

In New Zealand, the national CLAB programme has had significant success, with ICU CLAB rates reducing from an estimated 3.32 per 1000 central line days prior to implementation to 0.46 per 1000 central line days in the period April 2012 to March 2013. This is well within the 2012–13 target of less than 1 per 1000 line days. New Zealand was CLAB infection free for six non-consecutive months of out 12 during this period.

CLAB rates



The CLAB insertion and maintenance process has been implemented in all ICUs and high dependency units (HDUs) and rolled out to 52 other clinical areas (eg, operating theatres and radiology departments).

The Commission has contracted Ko Awatea to the end of 2013 to develop a sustainability model that will enable the programme to become 'business as usual' in the sector and continue to maintain an infection rate of less than 1 per 1000 line days in ICUs nationally.

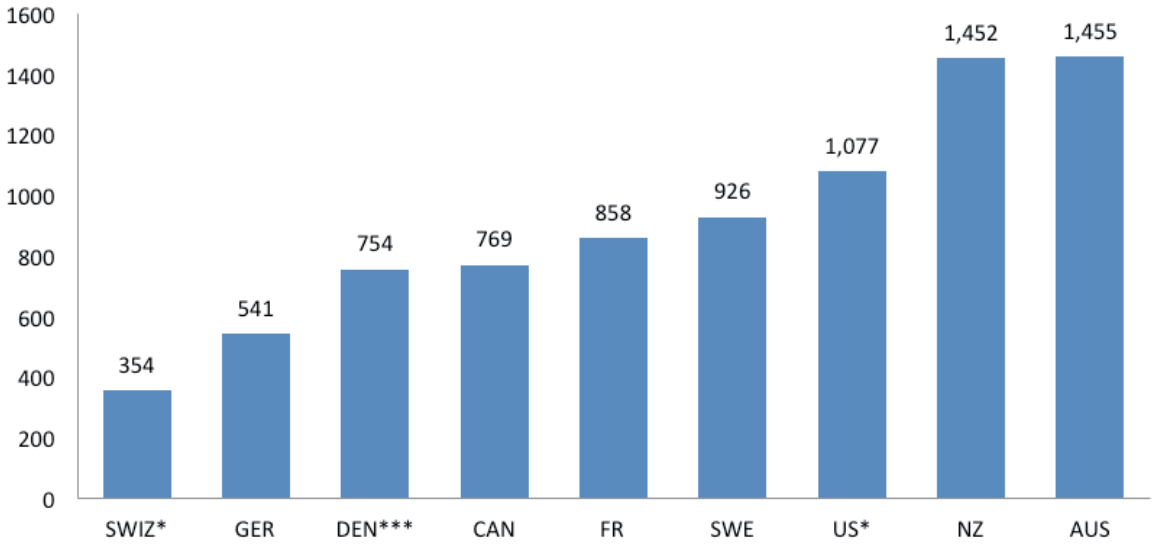
REDUCING SURGICAL SITE INFECTIONS

Surgical site infections[57] (SSIs) are the second most common form of healthcare associated infection. They are costly to treat, are associated with increased mortality and can have a significant impact on quality of life. Of all healthcare associated infections, SSIs have the most impact on length of stay – by an average of 23 days for SSIs following hip and knee replacements and 32 days for SSIs after coronary artery bypass grafts.

In New Zealand in 2009, there were 1452 cases of postoperative sepsis[58] per 100,000 hospital discharges, one of the highest rates in the OECD.[59]

55 Pronovost P et al. 2006. An intervention to decrease catheter-related bloodstream infections in the ICU. *The New England Journal of Medicine* 355: 2725–32.
56 Seddon ME et al. 2011. Aiming for zero: decreasing central line associated bacteraemia in the intensive care unit. *NZMJ* 124(1339).
57 Development of an infection of a surgical wound.
58 The definition of postoperative sepsis is wider than that of SSI, but it was viewed as a potentially useful proxy given that there is no direct coding of isolated SSIs in the NMDS.
59 OECD Health Care Data 2012.

Postoperative sepsis per 100,000 hospital discharges



Nationally coordinated SSI improvement programmes have been shown internationally and through a cost–benefit analysis for the New Zealand situation to improve patient outcomes and generate savings for the health sector. The cost–benefit analysis estimated that benefits from the programme would build steadily until, by year 10, savings from SSIs avoided would be around $4.4 million per year on an ongoing basis and that a reduction in SSI rates of some 8 percent (+/- 4 percent) per year could be expected.[60]

During 2012–13, the Commission established a programme to support implementation of a sustainable national SSI quality improvement programme for DHB-funded surgery (including within the private sector). A lead agency (a joint venture between Auckland and Canterbury DHBs) was appointed and a national software programme purchased to provide a standardised infrastructure for collection of robust, reliable and relevant information and local and national reporting of data. The initial focus of the programme is on infections as a result of operations for hip and knee prostheses.

DHBs are enthusiastic about the programme and initial uptake exceeded expectations, with eight DHBs participating as development sites during 2012–13 to test, refine and improve processes and procedures. National roll-out will begin in July 2013 with 19 DHBs engaged in the programme. Analysis of the preliminary data from the development sites will be reported in December 2013, with national reporting of the SSI quality and safety markers to commence in March 2014.

Reducing harm from SSIs will be the second topic of the *Open for better care* campaign and is planned to run from October 2013 to March 2014.

3.4 Reducing perioperative harm

Ian Civil is clinical lead of the reducing perioperative harm programme. He is a trauma surgeon at Auckland DHB where he is also director of surgery. He has recently ended a term as president of the Royal Australasian College of Surgeons.

Over 300,000 publicly funded surgical operations are performed in New Zealand each year. Even routine surgery requires the complex coordination of surgeons, anaesthetists, nurses and support staff to provide timely and effective care. Effective teamwork and communication lie at the heart of providing safe surgical care.

60 Sapere Research Group. May 2011. *Cost benefit analysis of the proposed national surgical site surveillance and response programme*. Wellington: Sapere Research Group. See also: Sapere Research Group. 2013. *Surgical site infection surveillance in New Zealand - the case for investment*. Wellington: Sapere Research Group.

Patients undergoing surgical intervention are at increased risk of complications and death. A systematic review of studies suggests that about 1 in 10 hospital patients in developed countries experiences an adverse event and that about 60 percent of these are surgical patients.

In New Zealand:

- for the six-year period from 2005–06 to 2010–11, ACC accepted a total of 205 claims for retained equipment and wrong-site surgery[61]
- retained instruments or swabs made up 2 percent of the serious adverse events reported to the Commission in 2011–12[62]
- on the basis of 2009 administrative data and the rates per 100,000 hospital discharges:
  - the average for foreign bodies left in during a procedure was 8.7 compared with the OECD rate of 5.7[63]
  - for accidental puncture or laceration, the average was 405 compared with 220 in the OECD[64]
- in 2012, 759 people had a DVT or PE while still in hospital following a procedure, or were readmitted with one within 28 days of a procedure. A total of 531 people had sepsis following a procedure.

A number of interventions to improve safety practices have been shown to reduce complications significantly, including the use of checklists and improvements to teamwork and communication.

A recent cost–benefit analysis produced for the Commission by Sapere Research Group indicated that potentially preventable complications arise in 10–15 percent of all New Zealand surgical procedures. The same analysis estimated that there is scope for more consistent use of the checklist within the New Zealand health system and that the cost of this improvement is likely to be low. We could expect a net financial benefit of $43 million over a 10-year period from systematic use of the WHO surgical safety checklist.[65] The benefits arise from avoided complications of surgical care leading to reduced hospital costs.

During 2012–13 the Commission collected data on the percentage of operations where all three phases of the checklist were used, establishing a baseline for the next phase of the programme. In addition, a study prepared for the Commission[66] concluded that, while personnel report routinely using components of the checklist, in general, there is a lack of understanding of the overall intent of the checklist. Most see it as a compliance document rather than a team tool to ensure patient safety and facilitate teamwork and communication.

The Commission is now seeking proposals for the development and piloting of an education series to improve teamwork and communication within multidisciplinary surgical teams through the full implementation of specific structured communication tools (including briefings, the WHO surgical safety checklist and debriefings).

Reducing perioperative harm will be the third topic of the *Open for better care* campaign.

61 Sapere Research Group. 2012. *Cost benefit analysis of the surgical safety checklist*. Wellington: Sapere Research Group.
62 Health Quality & Safety Commission. 2012. *Making Our Hospitals Safer: Serious and Sentinel Events reported by District Health Boards 2011/2012*. Wellington. Health Quality & Safety Commission.
63 OECD. 2011. *Health at a Glance: OECD Indicators*. OECD Publishing. URL: http://dx.doi.org/10.1787/health_glance-2011-en.
64 Op. cit.
65 Sapere Research Group. 2012. *Cost benefit analysis of the surgical safety checklist*. Wellington: Sapere Research Group.
66 Litmus. 2012. *Attitudes towards the surgical safety checklist and its use in New Zealand operating theatres*. Wellington: Litmus.

4.0 Output class 3: Influence quality and safety practice

Improving the quality and safety capability of the sector is a key element in delivering better quality and safety outcomes and a more systematic and predictable quality and safety response across the sector. 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 most other 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.

The need has been identified to build health improvement science capability across New Zealand. The Commission has a leadership role in helping health and disability service providers achieve this.

4.1 The *Open for better care* campaign

The *Open for better care* national patient safety campaign is coordinated by the Commission and is being implemented regionally by the health sector. DHBs and other providers are using campaign resources according to their local needs. The aim is for DHBs and regions to 'own' the campaign, the challenges that will be encountered and the leadership needed to bring about change. A campaign advisory group made up of external experts advises on the campaign's design and implementation. The campaign focuses on reducing harm in the areas of falls, surgery, healthcare associated infections (particularly SSIs) and medication.

The campaign has an overarching aim:

'To inform and mobilise the New Zealand population to ensure safety and quality improvement in health care by preventing harm, avoiding waste and getting better value from resources.'

The campaign also promotes a number of generic principles, ie, the need to:

- increase patient involvement in care and quality improvement approaches
- increase capability within the health and disability workforce (and consumers) to ensure quality improvement becomes business as usual
- support and encourage respect and teamwork
- inform and mobilise the population to assist in preventing harm
- promote sharing of good practice
- support and encourage good communication.

The campaign was launched on 17 May 2013 by the Associate Minister of Health, Hon Jo Goodhew.

The campaign is a call to action for all health professionals, asking them to make a commitment to continually improving patient safety. It identifies simple changes in practice that can make a big difference to patient safety. Tools, interventions, networks, collaborations, promotions, resources and workforce development opportunities will make it easier to do the right thing.

In the first few weeks of the campaign (to 30 June 2013), campaign promotions included media releases about the campaign launch, the release of the quality and safety baseline data (which will be one measure of the success of the campaign), DHB signings of the campaign pledge certificate, articles provided to various sector media, presence at conferences, newsletters and distribution of a number of campaign resources. There was considerable stakeholder engagement.

"Waikato DHB is pleased to be one of the first DHBs to profile our involvement in the national patient safety campaign. *Open for better care* has allowed us to bring a focus to the great patient safety work already underway in our DHB, and provides us with an opportunity to build on that work.

"The Midland DHBs are working together on the campaign which includes all the region's DHBs, and we are fully committed to improving outcomes for patients and communities across the region."

Jan Adams, Waikato DHB chief operating officer and campaign lead for the Midland region

The first area of focus for the campaign is falls prevention (details are included in the falls prevention section of this annual report). Development work has also been undertaken on the three other topics.

It is essential to evaluate the success of the campaign, and evaluation has been integral to its design. The Commission is interested in the answers to four questions:

- Did the desired change in safety practice occur?
- Did a reduction in harm and cost occur?
- How successful was the process of effecting change through the campaign?
- Has the campaign resulted in sustainable improvement?

Measurements to answer the first two questions will be provided by the quality and safety markers (see section 2.1). The first report on the markers was published in June 2013 and provides baseline data that will be both one measure of the success of the campaign and a measure of the success of our ongoing programme work.

The second two questions are an evaluation of the specific value added by the campaign approach. This evaluation will be a separate activity, drawing on a broader range of evaluative methods including qualitative and economic evaluations.

4.2 Supporting and building leadership and capability

EDUCATION AND TRAINING

The Commission plays an important role in providing the education and training required to achieve system and clinical practice changes. During 2012–13, we:

- sponsored around 100 frontline staff in the health and disability sector to attend the APAC Forum in Auckland in September 2012. World leaders and specialists in innovation and health care improvement shared their learnings and successes, showcased new ideas and stimulated discussions on innovation in health care. The programme also included:
    - educational site visits designed for delegates to understand how markets outside of the health sector are applying quality improvement methodology and innovation to meet the challenges they are facing
    - intensive sessions led by known professionals to provide a greater understanding and actionable ideas for delegates to take back to their organisation
    - sponsorship of 32 people to attend the four-day International Healthcare Initiative (IHI) patient safety professional development course run by Ko Awatea in May 2013. Participants learned how to:
        - describe the skills, theory and practical tools critical to developing a successful patient safety programme

  - participate in an ongoing patient safety professional networks
  - use diagnostics and measures to determine the safety of systems
  - develop and implement a plan to improve safety at a systems level
- sponsored 16 people to attend the 10-week Improvement Advisor course run by IHI which started in June 2013. This was the first time the improvement advisor programme was held in New Zealand. It is designed to create a network of skilled and experienced improvement advisors who will be able to identify, plan and execute improvement projects throughout the organisation, deliver successful results and spread changes throughout the system. Participants commit to spending at least one day a week completing course work and supporting improvement projects, including the *Open for better care* campaign. The Commission plans to develop a national network of improvement experts (focused initially on improvement advisors) to support the update and spread of improved system performance
- provided web-based learning packages, videos, interactive PDFs, tools and links to a variety of learning resources produced by the Commission and by other agencies on issues such as serious incident review, open disclosure, health literacy in pharmacies, GTTs, falls reduction and others.

CLINICAL LEADERSHIP

Clinical leadership is fundamental to improving patient safety and service quality, workforce satisfaction and effectiveness, and, ultimately, clinical and financial stability.

All Commission programmes now have clinical leads who are well respected in their fields. 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. To support this role, meetings of the clinical leads were held to support their work in leading change. We also hosted a joint meeting of clinical leads and regional *Open for better care* leads to ensure everyone had a full understanding of the campaign and to provide tools and methods to support implementation of the campaign.

The Commission partnered with DHB Shared Services and the National Health Board to assess the progress New Zealand is making in improving clinical governance and leadership in our public health services – and how we are doing in engaging frontline clinicians in the running of the public health service. The study was carried out by the University of Otago's Centre for Health Systems. Its report[67] was published in November 2012 and launched in December by the Minister of Health, Hon Tony Ryall.

The report noted that good progress has been made since the early days of 'In Good Hands', a programme established in 2009 to give DHBs strong guidance about engaging doctors, nurses and other health professionals in the running of frontline health services. However, there is more to do to promote and embed clinical governance and leadership. The survey data showed positive development around several issues including partnerships with management, shared decision-making, responsibility and accountability as well as support for the development of clinical leadership.

A companion report[68] contained more detailed analysis of three specific quality and safety survey questions. It found that:

- 57 percent of those surveyed believed health professionals in the DHB work together in well-coordinated teams
- 70 percent agreed that health professionals involve patients and families in efforts to improve patient care
- 69 percent agreed that it is easy to speak up when they see problems with patient care.

67 Gauld R, Horsburgh S. 2012. *Clinical Governance Assessment Project: Final Report on a National Health Professional Survey and Site Visits to 19 New Zealand DHBs.* Dunedin: Centre for Health Systems, University of Otago.

68 Gauld R, Horsburgh S. 2012. *Clinical Governance Assessment Project: Analysis of Three Quality and Safety Questions in a National Survey of New Zealand Health Professionals.* Dunedin: Centre for Health Systems, University of Otago.

The Commission has also supported Ministry of Health work on the productive series. This has two programmes: *The Productive Ward: Releasing Time to Care* and *The Productive Operating Theatre*. The series supports organisations to redesign and streamline how they work. It also aims to enable frontline staff, with the support and commitment of the executive management team, to systematically identify and resolve day-to-day issues and frustrations using proven improvement methodology. During 2012–13 the Commission contracted an independent assessment of the implementation of the productive series. The report recommended decisions be made about whether the programmes should be supported at a national level (including support for DHBs to fully implement and spread the programmes). It also recommended a core set of national measures across both programmes that would demonstrate the impact of the programmes on the quality and efficiency of care.

Subsequently, a decision was made to reinvigorate and enhance the productive series with an initial focus on productive wards. Management of the productive series will remain with the Ministry of Health but will continue to align very closely with the work of the Commission.

CORE COMPETENCIES

During the year, we commissioned a report to provide guidance on the critical competencies required in the sector to build health improvement science capability, the highest priority areas or needs, and the resources available locally and globally for developing these skills. A group of experts in improvement science met three times to inform the development of the core competencies, and a literature review and survey of key stakeholders were undertaken.

The report, which was received in July 2013, will form the basis of further work during 2013–14 to finalise core competencies and inform future decisions on the provision and funding of capability building in improvement science.

4.3 Developing consumer and family/whānau engagement and partnership

Our health and disability services exist for the patients and consumers they serve. Growing evidence demonstrates the importance of partnerships between health service organisations/health professionals and patients, families/whānau and carers. Potential benefits include improved outcomes, enhanced experience of care, lower costs per case and increased workforce satisfaction. One way to ensure excellent health care with limited resource lies in greater engagement of patients with decisions about their own care. We are particularly interested in promoting values-based decision-making. For example, one-third of patients with accepted indications for knee replacement will choose not to have this procedure if fully informed about the risks, the time associated with recovery and the extent of potential benefit.[69] In essence, patients who participate more in decision-making make choices that are more consistent with what is important to them as individuals. The question 'What is the matter with you?' must become 'What matters to you?' and all the risks and benefits associated with available options must be described.

Consumer representation is mandatory in all Commission work programmes. We have an active consumer network that supports and guides the Commission's work. The network met for the first time in September 2012. Members represent a variety of health, disability and community groups.

The Commission's three-year *Partners in Care* programme started in 2012–13. It has three streams, which aim to:

- improve health literacy
- increase consumer participation
- develop leadership capability for providers and consumers.

69 Arterburn et al. 2012. Introducing decision aids at Group Health was linked to sharply lower hip and knee surgery rates and costs. *Health Affairs* 31(9): 2094–104.

HEALTH LITERACY

It is important for New Zealanders to know about the health and disability services available to them and how they can access those services. It is also important that they understand the choices available to them and the implications of the treatments they are receiving, for example, why they are on certain drugs and what risks there are, if any.

During the year, two community pharmacies volunteered to be part of the Commission's health literacy medication safety project. They recognised that their communication is the key to making sure that their patients used their medicine in a safe and appropriate way.

Workbase was contracted to deliver a literature review and a suite of education, training and tools for the project (developed in conjunction with the volunteer pharmacists and consumer representatives). The pharmacists received a full day's training and were asked to apply the resources using a train-the-trainer model. The exercise became a professional development opportunity for pharmacy staff around the topic of health literacy. The Commission's medication safety specialists, consumer team and Workbase provided further support to the pharmacist trainers and their teams throughout the demonstration period. The project was evaluated by Malatest International and resulted in some surprising and impressive findings.[70] The evaluation found that written resources are not as effective as taking the time to listen clearly to consumers and ensure they understand how, when and why to take their medicine. Some staff who believed they were already communicating well came to recognise that improvements could be made when they applied the three-step framework – find out what people know, build health literacy skills and knowledge, and check you were clear (and if not go back to the previous step). Staff were inspired by the education and training and skills development because they could see how it made a real difference for consumers. This in turn gave pharmacy staff improved job satisfaction.

The education, training, tools and resources developed for the pilot were designed to be applied across the entire health and disability sector. The Commission will upload these onto the health literacy section of its website so others can use them freely.

CONSUMER PARTICIPATION

Partners in Care: Dr Lynne Maher, director for innovation and design, NHS Institute for Innovation and Improvement, provided a series of workshops and web-based learning to support an eight-month programme, *Partners in Care*. Consumers and clinicians paired up to take part in the programme, which was designed to provide each team with the knowledge and skills to lead their particular consumer engagement project within their organisation. The projects covered a wide range of topics such as advanced care planning, improving recovery orientation in mental health services and developing resources for particular health issues.

Consumer narratives: Consumer narratives were placed on the Commission's consumer engagement webpage. These narratives are a powerful tool to help consumers, patients and providers work collaboratively. There are now 22 videos on the webpage.[71]

Supporting the Consumer Collaboration of Aotearoa (CCA): The CCA brings together organisations and individuals representing health and disability service users. The Commission provided financial support to the CCA during 2012–13. Further support is being provided for the first half of 2013–14 while the CCA develops its capacity to become a viable membership-based organisation.

70 See: http://www.hqsc.govt.nz/our-programmes/consumer-engagement/publications-and-resources/publication/1073/.
71 See: http://www.hqsc.govt.nz/our-programmes/consumer-engagement/video-library/.

LEADERSHIP CAPABILITY FOR PROVIDERS AND CONSUMERS

Consumers provided first-hand accounts of their experiences of the health and disability sector at a conference held by the Royal New Zealand College of General Practitioners and General Practice New Zealand in Auckland in September 2012. The conference theme was 'Through Patients' Eyes'. The Commission chaired a panel of patients and consumers. Their stories provided the 500 attendees with unique insights into the experience of health care and the importance of supportive, effective relationships between consumers and health professionals.

The Commission provided sponsorship for consumers to attend a number of quality and safety conferences, workshops and courses, including the:

- third annual Health and Disability Commissioner conference
- APAC Forum
- Commission/NHS eight-month co-design course
- consumer and providers leaders forum.

In May 2013, the Commission hosted a leaders' forum to address the question, 'How can we co-create a national leadership pathway?' Twelve leaders in their field attended (half providers, half consumers). As a result, an email interest group was established to network about leadership by sharing materials and resources, and innovative leadership activities. The Commission is facilitating contact between members of the interest group.

MEASURING FOR IMPROVEMENT – CONSUMER EXPERIENCE

The Commission and the Ministry of Health are working on an approach to measure consumer experience in health and disability services. It will allow comparability and be focused on stimulating improvements at a local level. The approach centres on four domains: communication, participation, coordination, and physical and emotional needs. It is being developed in consultation with consumers and the sector.

4.4 Quality and Safety Challenge

An external evaluation of the effectiveness of the Quality and Safety Challenge was completed in October 2012. This was a 2011–12 programme of short-term initiatives, sponsored by the Commission and designed to improve patient safety, foster quality improvement and/or improve consumer engagement. The evaluation found that the 27 selected projects contributed to establishing new knowledge, identifying system improvements and creating a culture of quality improvement. It also noted that there were fewer outcomes in relation to contributing to capacity and capability building, and developing leadership (although some gains were noted). The evaluation found the Challenge offered a unique funding opportunity in targeting smaller but strategically important quality improvement initiatives. Seed funding also enabled health organisations to overcome barriers to action and identified quality improvement needs.

On 25 September 2012, the Commission held a Quality and Safety Challenge forum. This brought together 21 of the 27 project teams to give a high-level overview of their projects' objectives, successes and findings. The full project reports and video clips of the forum presentations are available on the Commission's website.[72]

72 See: http://www.hqsc.govt.nz/our-programmes/other-topics/quality-and-safety-challenge-2012/projects/.

5.0 Maintaining and developing organisational capability

To achieve our outcomes and outputs we need a solid foundation of skilled people working together in a well-run organisation and strong partnerships with others in the sector.

This annual report uses the four key elements of the Performance Improvement Framework developed by the State Services Commission, the Treasury and the Department of the Prime Minister and Cabinet to provide an overview of how the Commission has positioned itself to deliver now and in the future. These are:

- leadership, direction and delivery
- external relationships
- people development
- financial and resource management.

5.1 Leadership, direction and delivery

The Commission is led by a Board of seven members appointed by the Minister of Health. There were eight board meetings during the year in addition to meetings related to strategic planning, governance development and the Commission's *Open for better care* campaign.

Three board committees support the work of the Board.

The Finance and Audit Committee provides independent assurance and assistance to the Board on:

- the Commission's risk, control and compliance framework, and its external accountability responsibilities
- the Commission's financial statements and adequacy of systems of internal controls.

The Capability Committee provides advice to the Board on how the Commission can develop quality improvement capability in the sector and support clinical and consumer leadership.

The Communication and Engagement Committee provides strategic-level advice on the communication and stakeholder engagement being undertaken by the Commission.

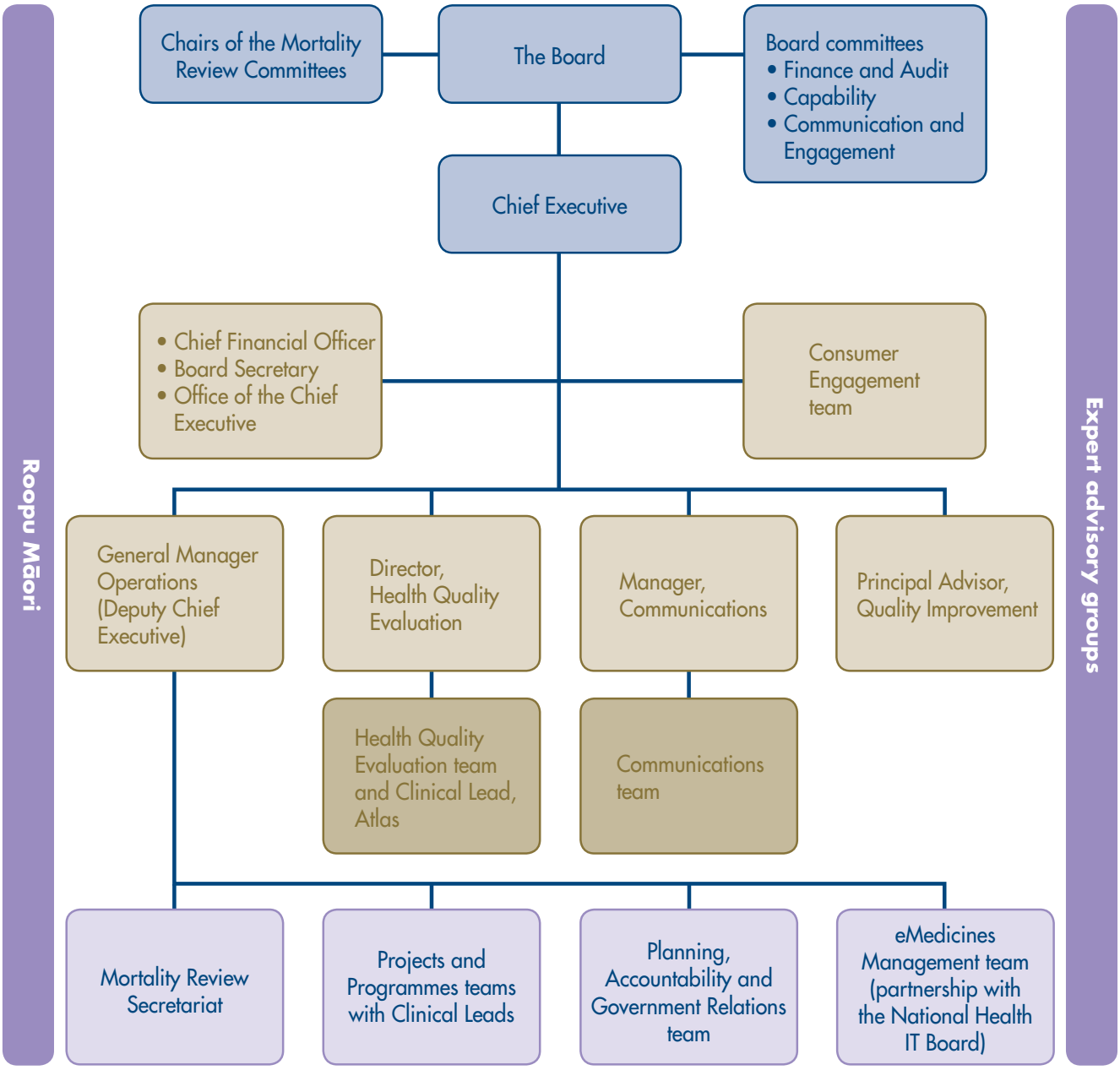
Roopu Māori provides advice to the Board and Chief Executive of the Commission on strategic issues, priorities and frameworks from a Māori world view and identifies key quality and safety issues for Māori patients and organisations. Advice from this group assists in the gathering and interpretation of data on quality and safety, and helps to prioritise or shape new programmes to ensure the Commission's aim to improve health and equity for all populations can be achieved.

The work of the Commission is carried out by around 35 staff. In addition we have sector-based clinical leads for each programme area and a number of expert advisory committees (see our structure chart on page 45).

One of the key roles of a Crown entity board is to develop a strong strategic direction for the organisation. During 2012–13 the Commission Board and staff jointly developed and published a three-year strategic plan.[73] The plan articulates the Commission's vision, mission and values and, at a high level, our role, purpose and strategic priorities. These are embodied in this annual report.

73 Health Quality & Safety Commission. 2013. *Strategic Plan 2013–16*. Wellington: Health Quality & Safety Commission. URL: http://www.hqsc.govt.nz/publications-and-resources/publication/837/.

STRUCTURE OF THE COMMISSION



The following values guide all Board members and staff in the way we engage with each other, with government and with the sector.

- **Person-centred:** By having the patient/consumer at the heart of everything we do, we support individual and family/whānau participation and decision-making about health and disability services at every level.
- **Evidence-informed:** By basing our programmes and initiatives on strong evidence, and evaluating their effectiveness to inform our priorities, we demonstrate the value of quality improvement in reducing harm and costs.
- **Partnership:** By working alongside stakeholders we improve health quality and safety. We value the views of others and respect diversity of culture and opinion.
- **Open and transparent:** We encourage sharing of ideas and knowledge. We communicate in clear language for all to understand. We encourage sharing of information in a just culture, so we can identify best practice, learn from mistakes and make health services better and safer.
- **Leadership:** By showing leadership, we set the direction for health quality and safety in New Zealand and encourage innovation and change to achieve our shared vision.

There is also an expectation that the Board should complete an annual self-assessment, formally reviewing the performance of individual members, the Chair and the Board as a whole against meaningful, good practice standards of Board performance.

An independent review to assess the effectiveness and performance of the Board identified particular areas where it could focus to ensure continuing improvement. An ongoing annual self-assessment process is planned. Board members also continue to attend director training provided by the New Zealand Institute of Directors.

During 2012–13 an independent review provided advice to the Commission on the development of board papers that would enhance decision-making by the Board at an appropriate level. The advice has been implemented and continues to inform Board papers. This includes ensuring that the link to relevant Statement of Intent deliverables is included in all papers.

5.2 External relationships

ENGAGEMENT WITH THE MINISTER(S) AND MINISTRY OF HEALTH

As a Crown entity, we are expected to work productively with the Minister(s) and Ministry of Health. During 2012–13 the Commission provided monthly update reports to the Minister with delegated responsibility for the Commission. We also provided timely quarterly update reports on performance against the Statement of Intent to the Minister through the Ministry of Health and met with Ministers on a regular and as-needed basis. We take seriously our responsibility to work with the Ministers and Ministry in an environment of 'no surprises'.

COLLABORATION AND PARTNERSHIPS WITH STAKEHOLDERS

As noted earlier in this report, the Commission puts a great deal of emphasis on collaboration and coordination between different parts of the sector – New Zealand is a small country and we all have to work together to reach our common goals. Of particular importance are our growing partnerships with clinical leaders from the sector, consumers and consumer groups, and our developing partnership with Māori. We are also establishing strong international links so we are well connected to innovation, evidence and advice from our colleagues overseas. These links are identified in section 1.4 of this report.

COMMUNICATION WITH STAKEHOLDERS AND THE PUBLIC

As a small organisation that relies on partnerships, we have a strong communications function to:

- raise the profile of the Commission and promote understanding of its role as a catalyst for invigorating change and its focus on four priority areas
- ensure the Commission has consistent and continued visibility in the sector
- help establish the Commission as the 'go-to' body for the health sector for support and advice on improving the quality and safety of New Zealand health and disability services
- ensure stakeholders are familiar with and understand the role of the Commission and how it 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.

Our communications team ensures that:

- the Commission has an up-to-date website that is useful to the sector
- our publications, such as reports and newsletters, are of a high standard and mindful of health literacy requirements
- the Commission has a professional and recognisable presence at conferences and events
- media issues are managed and the Commission's key messages are proactively promoted through the media
- communications risks are identified and managed.

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 allows the Commission to present its work as part of a coordinated suite of activity occurring across the sector, and offers opportunities for direct dialogue and engagement with stakeholders. During 2012–13 the hits on our website increased to 55,331 unique visits and 409,996 page views, up from 15,672 unique visits and 121,802 page views in 2011–12 (when the website was established).

During 2012–13 significant communications effort was focused on supporting the *Open for better care* campaign.

5.3 People development

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

All positions have competency requirements, and staff are encouraged to identify future training needs and undertake relevant training. The Commission has a dedicated staff training budget and all staff have a personal development plan that is reviewed annually. All staff have agreed competencies, goals and objectives. During the year we implemented an online performance review and development system.

GOOD EMPLOYER OBLIGATIONS (INCLUDING OUR EQUAL EMPLOYMENT OPPORTUNITIES PROGRAMME)

The Commission wishes to ensure it attracts and retains productive, talented staff. It is committed to providing a work environment in which equality and diversity are valued and actively practised. In recruiting staff, we seek 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 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 enhance the quality of our work environment and allow the Commission to better reflect the diversity of the community we serve.

5.4 Financial and resource management

FINANCIAL MANAGEMENT

We maintain sound management of public funding through our compliance with relevant requirements under the State Sector and Public Finance Acts and applicable Crown entity legislation. During 2012–13 we built on the recommendations of the 2011–12 audit review by Audit New Zealand. This was overseen by the Commission's Finance and Audit Committee.

Audit New Zealand undertook an interim audit of the Commission in May 2013. They noted that 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'. They noted that the Commission has taken action on the Audit New Zealand recommendations from the 2011–12 audit. The final audit results are included in section 10.0 of this report.

IMPROVING EFFICIENCY

The Commission uses the All of Government procurement processes and contracting unless there is a good reason not to. All of Government processes are used for most of our office and IT purchases, communications, print services and travel. During the year the Commission joined the All of Government infrastructure service contract for data storage. We continue to tender for services on GETS, the Government Electronic Tenders Service. We have implemented the ComplyWith legislative compliance information, monitoring and reporting programme, which is used by over 60 Crown-owned or funded entities, departments, companies and the Office of the Auditor-General. Financial services remain in-house.

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.

We keep abreast of, and participate in the sector-wide functional leadership programme. As part of this programme we have developed a property strategy and participated in the Ministry of Health process for benchmarking administrative and support services across like Crown entities (BASS).

The Commission continues to look for ongoing opportunities to improve the cost-effectiveness of back-office services.

IMPROVING EFFECTIVENESS: DEMONSTRATING OUR VALUE

Every project has a clear focus on its value proposition, both human and economic. Further detail on this is included in the description of each of the Commission's programmes.

As part of contract discussions with Victoria University of Wellington/University of Otago, the Commission has agreed a programme of work that will give us access to university staff resources and technical advice to inform our work. This will:

- include an evaluation of the effectiveness of the *Open for better care* campaign and the value of the work of improvement advisors in the sector
- include writing and publishing papers on specified topics
- help to influence the research agenda to have a greater focus on quality improvement and patient safety work.

MEETING OUR LEGAL RESPONSIBILITIES

We ensure we meet our good employer requirements, the Public Finance, Public Records, State Services and Crown Entities Acts and other applicable Crown entity legislation through our governance, operational and business rules.

We undertake regular ComplyWith surveys (six-monthly for staff and annually for board members). These continue to show a high level of overall legislative compliance. During 2012–13 an Archives New Zealand audit was completed. As a relatively new organisation it is timely for us to be working toward improving our archiving system and processes, and we continue to do so.

RISK MANAGEMENT

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

5.5 Permission to act despite being interested in a matter

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
Geraint Martin and David Galler	Counties Manukau DHB business case 30 November 2013	Both G Martin and D Galler are employees of Counties Manukau DHB and the business case is around Counties Manukau DHB	Unanimous agreement that G Martin and D Galler could remain in the meeting and be part of the discussion but not if there were any decisions to be made
Geraint Martin and David Galler	Ko Awatea's invitation to the Commission to become a partner in hosting the APAC Forum 2013 20 March 2013	Both G Martin and D Galler are involved in the organisation of the APAC Forum 2013, as it is being hosted by Ko Awatea	Unanimous agreement that G Martin and D Galler should be excluded from the discussion
Geraint Martin	Integration of the productive series and the Commission's work programme 8 April 2013	G Martin's wife is the national portfolio manager for the productive series	Unanimous agreement that G Martin should be excluded from the discussion

Part 2

6.0 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 59E(3) of the New Zealand Public Health and Disability Act 2000 requires the Commission to, at least annually, provide the Minister of Health with a report on the progress of mortality review committees; and must include each such report in the Commission's next annual report. The report on the progress of the mortality review committees is included in this report in section 2.4.

7.0 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 2012–13 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.

7.1 Output class 1: Information, analysis and advice

QUALITY AND SAFETY MARKERS FOR THE SECTOR – ACHIEVED

2011–12 performance		Measure	2012–13 performance
New measure for 2012–13	Quantity	Finalised set of measures and thresholds for patient falls, hospital-acquired infections and surgical harm	The finalised set of measures and thresholds for patient falls, hospital-acquired infections and surgical harm was completed. Details of the markers were published on the Commission's website www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers/
	Timeliness	Finalised with the sector by 30 December 2012	A letter was sent to the sector with the finalised set of measures on 19 December 2012
		Report published by 30 June 2013	The report on quality and safety markers for the sector was published on the Commission's website on 26 June 2013
	Quality	Measures are tested internally in DHBs, the clinical community and the Ministry of Health	Feasibility testing of the measures has been completed. For each group of measures the external advisory group for that workstream has been involved. Each expert advisory group includes expert frontline staff

QUALITY AND SAFETY INDICATORS – ACHIEVED

2011–12 performance		Measure	2012–13 performance
First report against national and international measures of quality and safety published in July 2012	Quantity	At least one report against national and international measures of quality and safety	*Describing the quality of New Zealand's health and disability services: December 2012 report on the New Zealand health quality and safety indicators* was published in December 2012. This was updated on 28 June 2013 and included additional indicators. http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/741/ The Commission held five workshops around New Zealand in October 2012 to introduce and explain the indicators. Sector feedback has been positive.
	Timeliness	By 30 June 2013	Published on 19 December 2012 and updated on 28 June 2013
	Quality	Within six months of the report being published a survey of stakeholders shows that at least 80 percent consider that the report was useful and well presented. This will relate to the 2011–12 report	A survey of stakeholders was completed in July 2013 on the report published in December 2012. Twenty-nine surveys were completed, a response rate of 18 percent. Although this is in line with expected online response rates generally, due to the small number of completed responses the results are indicative only. All respondents thought the report was useful and 86 percent would recommend the report to others. All thought that the report was helpful for improving knowledge and raising awareness about indicators in New Zealand and 85 percent thought it was helpful for influencing change. A further 71 percent thought the report helpful for informing practice and 65 percent thought that it was helpful as a research report. Eighty-two percent of people who had read the report thought it was well presented.

ATLAS OF HEALTHCARE VARIATION – ACHIEVED

2011–12 performance		Measure	2012–13 performance
The first Atlas domain was launched in June 2012	Quantity	At least six new Atlas domains are published	Seven new Atlas domains were published by 30 June 2013. Four were made available on the Commission's website: • cardiovascular disease • management of gout • polypharmacy in older people • surgical rates for tonsillectomy/adenoidectomy and otitis media (grommet insertion). http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/ Three ambulatory sensitive hospitalisation domains were sent to DHBs and PHOs on 28 June 2013.
	Timeliness	By 30 June 2013	Seven domains published by 30 June 2013
	Quality	Within six months of the report being published a survey of stakeholders shows that at least 80 percent consider that the report was useful and well presented. This will relate to the 2011–12 report	A survey of stakeholders was completed in May 2013. Nineteen surveys were completed, a response rate of 12 percent. Although this is in line with expected online response rates, the results need to be viewed in the context of the small number of respondents. The survey found that 89 percent of respondents would recommend the report to others with an interest in a particular Atlas domain or to those with an interest in variation/public health. The information was most helpful in terms of raising awareness about aspects of health care variation, with 90 percent of respondents stating that the information was very or quite helpful in doing this. Seventy-four percent of respondents agreed that the information was very or quite helpful in improving knowledge about health and health care variation. Eighty-four percent thought that the information was well presented. The comments provided by respondents also provided useful insights into the use of the Atlas.

SERIOUS AND SENTINEL EVENTS REPORT – ACHIEVED

2011–12 performance		Measure	2012–13 performance
Making Our Hospitals Safer: 2010/11 Serious and Sentinel Events was published in February 2012	Quantity	One serious and sentinel events report published	*Making Our Hospitals Safer: Serious and Sentinel Events reported by District Health Boards in 2011/12* was published http://www.hqsc.govt.nz/our-programmes/reportable-events/publications-and-resources/publication/695/
	Timeliness	By 30 December 2012	Published on 21 November 2012
	Quality	Within six months of the report being published a survey of stakeholders shows that at least 80 percent consider that the report was useful and well presented	A survey of the 2011–12 serious and sentinel events report was completed in January 2013. Forthy-seven surveys were completed, a response rate of 28 percent. Ninety-five percent of respondents rated the report helpful in raising awareness about serious and sentinel events. Eighty-seven percent rated the report helpful in improving knowledge about serious and sentinel events and 71 percent rated the report helpful as a tool to influence change. Seventy-seven percent found the report user-friendly/well presented.

CHILD AND YOUTH MORTALITY REVIEW – ACHIEVED

2011–12 performance		Measure	2012–13 performance
Two topic reports were published in 2011–12	Quantity	At least one review of child and youth mortality published	The child and youth mortality review *Special Report: Unintentional suffocation, foreign body inhalation and strangulation* was published http://www.hqsc.govt.nz/publications-and-resources/publication/805/
	Timeliness	31 March 2013	Published on 8 March 2013
	Quality	Report includes priorities for action	The report included priorities for action. Key stakeholders were consulted during the drafting of the report to ensure achievable, realistic recommendations were developed
		Within six months of publication stakeholder feedback indicates that at least 80 percent consider that the report was useful and well presented	A survey of stakeholders was completed in October 2013. Twenty-seven surveys were completed, a response rate of 22 percent. Of the respondents that had read the report 91 percent found the report quite useful or very useful to their work. Eighty-six percent would recommend the report to others with an interest in child and youth health and safety. Eighty-two percent considered the report well presented. Eighty-one percent felt that it was either likely or highly likely that child and youth suffocation, foreign body inhalation and strangulation would reduce following implementation of the recommendations.

PERINATAL AND MATERNAL MORTALITY REVIEW – ACHIEVED

2011–12 Performance		Measure	2012–13 performance
The fifth and sixth annual reports of the Perinatal and Maternal Mortality Review Committee were published in September 2011 and June 2012 respectively	Quantity	Review of perinatal and maternal mortality published	*The Seventh Annual Report of the Perinatal and Maternal Mortality Review Committee* was published http://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/958/
	Timeliness	30 June 2013	The report was published on 10 June 2013
	Quality	Report includes priorities for action	The report included priorities for action
		Within six months of publication stakeholder feedback indicates that at least 80 percent consider that the report was useful and well presented	Survey not due until December 2013. The results will be included in the 2013–14 annual report

FAMILY VIOLENCE DEATH REVIEW – PARTIALLY ACHIEVED (Report published three months later than planned)

2011–12 performance		Measure	2012–13 performance
The second report of the Family Violence Death Review Committee was published in January 2012	Quantity	Review of family violence deaths published	The Family Violence Death Review Committee *Third Annual Report: December 2011 to December 2012* was published http://www.hqsc.govt.nz/publications-and-resources/publication/992/
	Timeliness	31 March 2013	The report was published on 27 June 2013, three months later than planned
	Quality	Report includes priorities for action	The report included priorities for action
		Within six months of publication stakeholder feedback indicates that at least 80 percent consider that the report was useful and well presented	Survey not due until December 2013. The results will be included in the 2013–14 annual report

PERIOPERATIVE DEATH REVIEW – ACHIEVED

2011–12 performance		Measure	2012–13 performance
The inaugural Perioperative Mortality Review Committee Report was published in February 2012	Quantity	Review of perioperative deaths published	*Perioperative Mortality in New Zealand: Second report of the Perioperative Mortality Review Committee* was published http://www.hqsc.govt.nz/publications-and-resources/publication/813/
	Timeliness	31 March 2013	The report was published on 27 March 2013
	Quality	Report includes priorities for action	The report included priorities for action
		Within six months of publication stakeholder feedback indicates that at least 80 percent consider that the report was useful and well presented	A survey of stakeholders was completed in September 2013. Thirty-one surveys were completed, a good response rate of 33 percent. The survey found that 96 percent found the report quite or very helpful for raising awareness and 86 percent for improving knowledge. Eighty-five percent found the report quite or very helpful as a tool to inform practice and 81 percent as a research report. Ninety-three percent felt that the recommendations were relevant to their organisation's work or their work as individuals and half stated that the report had assisted in improving practice and service. Ninety-three percent found the report well presented and 96 percent would recommend the report to others with an interest in perioperative safety and quality.

REVIEW OF NATIONAL MORTALITY REVIEW COMMITTEES – ACHIEVED

2011–12 performance		Measure	2012–13 performance
New measure for 2012–13	Quantity	Review of the national mortality review committees completed	Consultants MartinJenkins and Professor Gregor Coster completed a review of the national mortality review committees
	Timeliness	30 June 2013	A final report was delivered in March 2013
	Quality	The review identifies how outcomes for mortality review can be maximised locally, regionally and nationally	To maximise outcomes, the report recommended changes in the following areas: • strategic operation, governance, expert advice and leadership • improved efficiency and enhanced operational support • integrated data capture and analysis • local level review inputs • monitoring implementation of review recommendations

7.2 Output class 2: Sector tools, techniques and methodologies

MEDICINE RECONCILIATION – SUBSTANTIALLY ACHIEVED
(The timeframe for evaluation of the tool was delayed by one month)

2011–12 performance		Measure	2012–13 performance
The 2011–12 measure relating to establishing targets for implementing a national standard paper-based medicine reconciliation process for priority patients was not able to be achieved as a national prioritisation tool needed to be developed first. Development of this tool became the 2012–13 measure.	Quantity	Prioritisation tool[74] implemented in at least four DHBs	Six DHBs chose to provide medicine reconciliation to all admitted patients within 24 hours (ie, not just prioritised patients). The other 14 DHBs currently use their own prioritisation criteria to decide which patients have their medicines reconciled. Of these, four DHBs use the same set of criteria and obtain information about which patients meet the set electronically. Counties Manukau DHB's prioritisation criteria are being used as a guide
	Timeliness	30 June 2013	By 30 June 2013 at least four DHBs had implemented prioritisation tools. The independent evaluation was received by the end of July
	Quality	Tool is independently evaluated to ensure high-risk patients are identified	Counties Manukau DHB completed an independent validation of its own criteria. The results of this work will be used as a guide for all other DHBs who use prioritisation criteria. A draft report of the results was provided to the Commission at the end of June 2013 and a final report received in July

74 Instead of a prioritisation tool, the programme is producing prioritisation criteria, because it became clear that many DHBs lacked the required technical infrastructure for a prioritisation tool. For example, very few DHBs will be able to obtain the full Counties Manukau DHB prioritisation criteria information electronically, because of differences in IT systems across DHBs. Some information can be obtained manually but this is time-consuming and will not be advocated.

AGED RESIDENTIAL CARE MEDICATION CHART – SUBSTANTIALLY ACHIEVED
(The pilot was completed and an interim report provided, but the timeframe for the final report on findings of the pilot was delayed by three months)

2011–12 performance		Measure	2012–13 performance
New measure for 2012–13	Quantity	Standardised process for prescribing and administering medication in aged residential care medication chart finalised	The intent of this measure was to have a standardised chart and process piloted with a report on findings by 30 June 2013. A chart and process was piloted at seven aged residential care facilities. One of these sites completed a three-month medicine review cycle by 30 June 2013 and the others will be completed by the end of July 2013. The contractor, PharmacyPartners, provided an interim report containing preliminary findings from the pilot and two sector feedback exercises. Once the final report is received, it will be reviewed and next steps will be considered. A number of factors impacted on this project. There are complex relationships between those providing medicine-related care to residents who often have complex medication management needs. In addition to the complexity of the sector, there are also significant and competing demands upon the sector such as implementing InterRAI and the new Community Pharmacy Services agreement.
	Timeliness	30 June 2013	The interim report was received by 30 June 2013. The final report is expected at the end of September 2013
	Quality	Developed in partnership with a representative cross-section of the aged care sector	A representative cross-section of the aged care sector was involved in the development of the chart. The project team met with a range of stakeholders and analysed 16 different aged residential care charts before preparing a draft design for sector feedback. A wide range of organisations were invited to respond and 162 responses were received, including 103 from aged residential care facilities. A second sector feedback exercise began on 15 May on the draft medication chart for the aged residential care sector. Fewer responses were received but, as with the first feedback exercise, there was still significant variation in opinion. A clinical advisory group has met throughout the project. Membership is made up of stakeholders from aged care facilities, GPs and community pharmacies.

ELECTRONIC MEDICINES MANAGEMENT (eMM) – PARTIALLY ACHIEVED
(Achieved in two of the three DHBs within the timeframe)

2011–12 performance		Measure	2012–13 performance
New measure for 2012–13	Quantity	Milestones in the Commission's contracts with the three DHBs implementing phase 2 of the eMM programme are met	*Waitemata DHB* – achieved. All the milestones in the contract were achieved by 30 June 2013. *Southern DHB* – achieved. All the milestones in the contract were achieved by 30 June 2013. *Taranaki DHB* – not achieved. A contract variation was finalised with Taranaki DHB to: • implement non-integrated ePrescribing and Administration (ePA) and eMedicines Reconciliation (eMR) • bring the total number of beds delivering ePA to 120 • bring the total number of beds delivering eMR to 120. The timeframe for implementation is now early 2014. The delay has been due to vendor difficulties in developing the electronic systems.
	Timeliness	30 June 2013	Achieved in two of the three DHBs by 30 June 2013. The third DHB will achieve the measure in early 2014
	Quality	A formal evaluation is undertaken with results available for the next phase of development of the programme	The report from the contractor, Sapere Research Group, was finalised and contains two sections: • the future for measuring framework for medication safety • evaluation of eMM initiatives. The evaluation of the eMM initiatives will be used to inform the next phase of development of the programme.

HAND HYGIENE – ACHIEVED

2011–12 performance		Measure	2012–13 performance
National compliance rate of 62.3 percent with 17 DHBs submitting data	Quantity	One hundred percent of DHBs enrolled and involved in implementing the hand hygiene programme	All 20 DHBs are now enrolled and involved in implementing the programme. All DHBs are submitting compliance data
	Timeliness	30 June 2013	All DHB were enrolled and involved by 30 June 2013
	Quality	Increase in audited compliance rate with the hand hygiene programme in public hospitals to 64 percent	The most recent national figures from the audit period from 1 April to 30 June 2013 show the national average compliance rate for that period was 70.5 percent, well above the target of 64 percent. Twelve DHBs achieved improvement in hand hygiene compliance to 70 percent and above

CENTRAL LINE ASSOCIATED BACTERAEMIA (CLAB) – ACHIEVED

2011–12 performance		Measure	2012–13 performance
A plan for implementation of CLAB programmes in ICUs and surgical and neonatal units was completed and key deliverables met	Quantity	National CLAB process for insertion and maintenance is implemented and sustained in all ICUs and HDUs	The CLAB insertion and maintenance process has been implemented in all ICUs and HDUs. Roll-out of the CLAB insertion and maintenance bundles to other clinical areas increased from 30 areas in 17 DHBs in January 2013 to 52 areas in 18 DHBs in May 2013
	Timeliness	30 June 2013	Process was implemented and sustained in all ICUs and HDUs by 30 June 2013
	Quality	Reduction in CLAB rates to <1 per 1000 line days	New Zealand was CLAB-infection free for six non-consecutive months out of 12 in the period April 2013 to March 2013, the post set-up period. During this post set-up period, the CLAB rate was 0.46 per 1000 central line days. This compares with the estimated December 2011 pre-implementation rate of 3.32 per 1000 line days and is well within the target of <1 per 1000 line days. The final *Target CLAB Zero* report from September 2011 to March 2013 is at http://www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/publications-and-resources/publication/1148/.

SURGICAL SITE SURVEILLANCE SYSTEM – ACHIEVED

2011–12 performance		Measure	2012–13 performance
New measure for 2012–13	Quantity	A national surgical site surveillance system is piloted in at least one DHB health care provider	Eight DHBs piloted the programme and training sessions for the next DHBs were held in July 2013
	Timeliness	30 June 2013	System was piloted in eight DHBs by 30 June 2013
	Quality	Data from the pilot are validated and can be used to inform the next phase of the programme	From March to June 2013 the eight development site DHBs submitted data on more than 830 hip and knee procedures. Data validation is ongoing and is supported by the ICNet software process and the national data warehouse. Analysis of initial data by the SSI clinical lead and the Commission has informed the selection of the process measures and targets for the SSI programme. Two learning sessions were held with the demonstration sites, which included discussion of issues around data and how to record data consistently.

SURGICAL HARM (PERIOPERATIVE HARM) REDUCTION – ACHIEVED

2011–12 performance		Measure	2012–13 performance
An assessment of the percentage of procedures where the surgical checklist is used properly was not achieved and became the 2012–13 measure	Quantity	Data collected on the percentage of operations where the surgical safety checklist is used properly[75] and a baseline established to inform the next phase of the programme	There were two data collection processes over the year. The first (which relates to this Statement of Service Performance deliverable) provided the baseline at December 2012 for the reducing perioperative harm programme. The Commission requested information from 20 DHBs about the percentage of operations where the three phases of the surgical safety checklist were used. This showed that the checklist was used properly in 63 percent of operations (based on information provided by 11 DHBs). The second process involved DHBs submitting data for the perioperative harm quality and safety marker. This information was published on 26 June 2013 and showed that the surgical safety checklist was used properly in 71.2 percent of operations. All 20 DHBs provided information.[76] Going forward, all 20 data sets will be used. In addition to data collection, we have gathered information from focus groups exploring attitudes towards the checklist and how it is used. This indicated that most personnel are not seeing the checklist as a team tool to ensure patient safety and facilitate teamwork and communication. Rather they see it as a compliance exercise that individuals and teams are accountable for. The information from both the data collection and focus groups is providing a useful baseline to inform the next phase of the programme.
	Timeliness	30 December 2012	The initial baseline was established by 30 December 2012
	Quality	Data are collected using a proven methodology	The Commission surveyed how the sector currently collects the data as part of its work on developing the quality and safety markers. The results of the survey provided two methodologies to measure the baseline. These methodologies have been approved by the perioperative harm clinical lead and expert advisory group

75 The perioperative harm expert advisory group defined 'properly' as the three phases of the checklist being used.

76 The difference between the December 2012 baseline and the June 2013 information is likely to reflect a mix of a real increase in use of the checklist and greater data accuracy (as the June 2013 information is based on data from all 20 DHBs).

NATIONAL FALLS PREVENTION PROGRAMME – ACHIEVED

2011–12 performance		Measure	2012–13 performance
New measure for 2012–13	Quantity	Accurate baseline information about prevalence of falls and harm from falls	There were two data collection processes over the year. The first (which relates to this Statement of Service Performance deliverable) was completed as part of the feasibility testing done for the quality and safety markers and delivered by 30 December 2012. This showed a baseline of 96 in-hospital fractured neck of femur per annum and 4015 additional occupied bed days. The second phase involved DHBs submitting data for the quality and safety markers. This information was published on 26 June 2013 and provides a more up-to-date baseline, ie,106 in-hospital fractured neck of femur per annum and 3787 additional occupied bed days.
	Timeliness	30 December 2012	Baseline was established by 30 December 2012
	Quality	Accuracy is assured by triangulation of information from internal reporting, serious and sentinel events reports, ACC and the NMDS	Triangulation was carried out as part of the feasibility testing for the quality and safety markers

7.3 Output class 3: Sector and consumer capability

SET OF CORE COMPETENCIES – PARTIALLY ACHIEVED

2011–12 performance		Measure	2012–13 performance
New measure for 2012–13	Quantity	A set of core competencies in quality improvement science is developed which initially relates to the Commission's four priority areas	During the year, we commissioned a report to provide guidance on the core competencies required, the highest priority areas or needs and the resources available locally and globally for developing these skills. The report with a proposed set of core competencies was received on 2 July 2013. Further work is required to finalise the core competencies
	Timeliness	30 June 2013	The report on core competencies was received by the Commission on 2 July 2013
	Quality	The set of competencies is informed by people identified by DHBs and other large providers as experts in improvement science and/or who have expertise in particular areas or methods	A group of experts in improvement science met three times to inform the development of the core competencies. The experts were identified with advice from DHBs and other key stakeholders. The proposed competencies in the report were also informed by a literature review and a survey of key stakeholders about the core competencies required and the support needed to increase capability in improvement science.

PARTNERS IN CARE – ACHIEVED

2011–12 Performance		Measure	2012–13 performance
A register of consumer organisations, groups and individuals undertaking advisory and/or representative roles in the health and disability sector was published	Quantity	Eighty percent of the milestones for 2012–13 in the *Partners in Care* action plan are implemented	The target was exceeded, with 90 percent of the milestones achieved (see Appendix 1 for details). More information relating to health literacy, our consumer register, resources for consumers, consumer narratives, partnership, co-design and other initiatives are at http://www.hqsc.govt.nz/our-programmes/consumer-engagement
	Timeliness	30 June 2013	Ninety percent of the milestones were achieved by 30 June 2013
	Quality	Survey of a cross-section of health and disability sector providers shows at least 60 percent are aware of the Commission's role in supporting consumer/provider partnerships	A survey was completed in June 2013. A total of 373 surveys were completed, a response rate of 18 percent, which is in line with expected line with expected online response rates. Eighty-two percent of respondents are aware of the Commission's work in improving consumer participation. The comments from respondents also provided useful insights.

8.0 Revenue/Expenses for output classes

	Output class 1 Information, analysis and advice		Output class 2 Sector tools, techniques and methodologies		Output class 3 Sector and consumer capability		Total	
	Actual $000	**Budget $000**	**Actual $000**	**Budget $000**	**Actual $000**	**Budget $000**	**Actual $000**	**Budget $000**
Crown and other revenue	6,384	6,384	5,337	4,962	1,630	1,630	13,351	12,976
Interest income	81	39	63	31	20	10	164	80
Total income	**6,465**	**6,423**	**5,400**	**4,993**	**1,650**	**1,640**	**13,515**	**13,056**
Operating expenditure	2,966	3,058	3,099	2,710	848	542	6,913	6,310
Programme expenditure	3,343	3,365	3,251	3,363	1,762	1,198	8,356	7,926
Total expenditure	**6,309**	**6,423**	**6,350**	**6,073**	**2,610**	**1,740**	**15,269**	**14,236**
Surplus/(Deficit)	**156**	**0**	**(950)**	**(1,080)**	**(960)**	**(100)**	**(1,754)**	**(1,180)**

9.0 Financial statements

9.1 Statement of comprehensive income for the year ended 30 June 2013

Actual 2012 $000		Notes	Actual 2013 $000	Budget 2013 $000
	Income			
14,476	Revenue from Crown	2	12,996	12,976
239	Interest income		164	80
412	Other income	3	355	0
15,127	**Total income**		**13,515**	**13,056**
	Expenditure			
3,008	Personnel costs	4	4,036	4,062
105	Depreciation and amortisation	12, 13	131	110
3,065	Other expenses	6	2,746	2,138
6,815	Quality and safety programmes		5,969	5,556
2,200	Mortality programmes		2,387	2,370
15,193	**Total expenditure**		**15,269**	**14,236**
(66)	**Surplus/(Deficit)**		**(1,754)**	**(1,180)**
0	Other comprehensive income		0	0
(66)	**Total comprehensive income**		**(1,754)**	**(1,180)**

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

The accompanying notes form part of these financial statements.

9.2 Statement of financial position as at 30 June 2013

Actual 2012 $000		Notes	Actual 2013 $000	Budget 2013 $000
	Assets			
	Current assets			
4,724	Cash and cash equivalents	7	2,303	2,347
314	GST receivable		520	127
8	Debtors and other receivables	8	252	0
31	Prepayments		163	0
5,077	**Total current assets**		**3,238**	**2,474**
	Non-current assets			
306	Property, plant and equipment	12	246	206
76	Intangible assets	13	64	55
382	**Total non-current assets**		**310**	**261**
5,459	**Total assets**		**3,548**	**2,735**
	Liabilities			
	Current liabilities			
1,755	Creditors and other payables	14	1,489	666
173	Employee entitlements	16	282	153
1,928	**Non-current liabilities**		**1,771**	**819**
1,928	**Total liabilities**		**1,771**	**819**
3,531	**Net assets**		**1,777**	**1,916**
	Equity			
3,097	General funds July	17	3,531	3,096
500	Contributed capital		0	0
(66)	Surplus/(Deficit)		(1,754)	(1,180)
3,531	**Total equity**		**1,777**	**1,916**

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

The accompanying notes form part of these financial statements.

9.3 Statement of changes in equity for the year ended 30 June 2013

Actual 2012 $000		Notes	Actual 2013 $000	Budget 2013 $000
3,097	Balance at 1 July		3,531	3,096
	Comprehensive income			
(66)	Surplus/(Deficit)		(1,754)	(1,180)
0	Other comprehensive income		0	0
(66)	**Total comprehensive income**		**(1,754)**	**(1,180)**
	Owner transactions			
500	Capital contribution		0	0
3,531	**Balance at 30 June**	**17**	**1,777**	**1,916**

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

The accompanying notes form part of these financial statements.

9.4 Statement of cash flows for the year ended 30 June 2013

Actual 2012 $000		Note	Actual 2013 $000	Budget 2013 $000
	Cash flows from operating activities			
14,476	Receipts from Crown		12,996	12,976
801	Other revenue		115	0
239	Interest received		160	80
(14,187)	Payments to suppliers		(11,499)	(10,568)
(3,120)	Payments to employees		(3,927)	(4,102)
(105)	Goods and services tax (net)		(206)	115
(1,896)	**Net cash flow from operating activities**	**18**	**(2,361)**	**(1,499)**
	Cash flows from investing activities			
(387)	Purchase of property, plant and equipment		(32)	0
(100)	Purchase of intangible assets		(28)	0
(487)	**Net cash flow from investing activities**		**(60)**	**0**
	Capital flows from financing activities			
500	Capital contribution		0	0
500	**Net cash flows from financing activities**	**17**	**0**	**0**
(1,883)	Net (decrease)/increase in cash and cash equivalents		(2,421)	(1,499)
6,607	Cash and cash equivalents at the beginning of the year		4,724	3,846
4,724	**Cash and cash equivalents at the end of the year**	**7**	**2,303**	**2,347**

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

The accompanying notes form part of these financial statements.

9.5 Notes to the financial statements

Note 1: Statement of accounting policies

REPORTING ENTITY

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

The Commission's primary objective is to provide services to the New Zealand public, 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 2013, and were approved by the Board on 31 October 2013.

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 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 Commission 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 will be required to apply the Public Benefit Entity (Tier 2 reporting entity) of the public sector Public Benefit Entity Accounting Standards. The effective date for the new standards for public sector entities is for reporting periods beginning on or after 1 July 2014. Therefore, the Commission will transition to the new standards in preparing its 30 June 2015 financial statements. The Commission has not assessed 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 2012–13.

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 2012–13.

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Creditors and other payables

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

Employee entitlements

Short-term employee entitlements

Employee benefits 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

An additional $0.35m was received from Hutt Valley DHB associated with the joint eMedicines Management programme.

Note 4: Personnel costs

	Actual 2012 $000	Actual 2013 $000
Salaries and wages	2,583	3,725
Recruitment	175	35
Temporary personnel	44	0
Membership, professional fees and staff	84	115
Training and development		
Defined contribution plan employer contributions	71	*87
Increase/(Decrease) in employee entitlements	51	74
Total personnel costs	**3,008**	**4,036**

**includes a $0.005m credit that relates to 2012*

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 2012 $000	Actual 2013 $000
Audit fees to Audit NZ for financial audit	29	29
Staff travel and accommodation	295	314
Printing/Communications	306	258
Consultants and contractors	1,208	1,038
Board costs/mortality committees	560	493
Outsourced corporate services and overhead	654	591
Other expenses	13	23
Total other expenses	**3,065**	**2,746**

Note 7: Cash and equivalents

	Actual 2012 $000	Actual 2013 $000
Cash at bank and on hand	4,724	2,303
Term deposits with maturities less than three months	0	0
Total cash and cash equivalents	**4,724**	**2,303**

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 2012 $000	Actual 2013 $000
Debtors and other receivables	8	252
Less: provision for impairment	0	0
Total debtors and other receivables	**8**	**252**

Fair value

The carrying value of receivables approximates their fair value.

Impairment

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

Note 9: Investments

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

Note 10: Inventories

The Commission has no inventories for sale in 2012–13.

Note 11: Non-current assets held for sale

The Commission has no current or non-current assets held for sale in 2012–13.

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 2011	0	0	0	0
Additions	143	129	115	387
Balance at 30 June 2012/1 July 2012	143	129	115	387
Additions	9	15	8	32
Balance at 30 June 2013	152	144	123	419
Accumulated depreciation and impairment losses				
Balance at 1 July 2011	0	0	0	0
Depreciation expense	46	24	11	81
Balance at 30 June 2012	46	24	11	81
Balance at 1 July 2012	46	24	11	81
Depreciation expense	49	36	7	92
Balance at 30 June 2013	95	60	18	173
Carrying amounts				
At 1 July 2011	0	0	0	0
At 30 June and 1 July 2012	97	105	104	306
At 30 June 2013	57	84	105	246

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 2011	0
Additions	100
Balance at 30 June 2012/1 July 2012	100
Additions	28
Balance at 30 June 2013	128
Accumulated amortisation and impairment losses	
Balance at 1 July 2011	0
Amortisation expenses	24
Balance at 30 June 2012/1 July 2012	24
Amortisation expenses	40
Balance at 30 June 2013	64
Carrying amounts	
At 1 July 2011	0
At 30 June and 1 July 2012	76
At 30 June 2013	64

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 2012 $000	Actual 2013 $000
Creditors	749	705
Accrued expenses	1,006	784
Other payables	0	0
Total creditors and other payables	**1,755**	**1,489**

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 2012 $000	Actual 2013 $000
Current portion		
Accrued salaries and wages	101	136
Annual leave	72	146
Total current portion	**173**	**282**
Non-current portion	**0**	**0**
Total employee entitlements	**173**	**282**

No provisions for sick leave, retirement or long service have been made in 2012–13.

Note 17: Equity

	Actual 2012 $000	Actual 2013 $000
General funds		
Balance at 1 July	3,097	3,531
Surplus/(Deficit) for the year	(66)	(1,754)
Capital contributions	500	0
Balance at 30 June	**3,531**	**1,777**

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 2012 $000	Actual 2013 $000
Net surplus/(deficit)	**(66)**	**(1,754)**
Add/(Less) non-cash items		
Depreciation	105	131
Total non-cash items	**105**	**131**
Add/(Less) movements in statement of financial position items		
(Inc)/Dec in Debtors and other receivables	389	(450)
(Inc)/Dec in Creditors and other payables	(2,454)	(265)
(Inc)/Dec in Prepayments	18	(132)
(Inc)/Dec in Employee entitlements	112	109
Net movements in working capital	**(1,935)**	**(738)**
Net cash flow from operating activities	**(1,896)**	**(2,361)**

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 2012 $000	Actual 2013 $000
Not later than one year	120	161
Later than one year and not later than five years	249	192
Later than five years	0	0
Total non-cancellable operating leases	**369**	**353**

The Commission leases a property (from 1 August 2011) at Level 6, Classic House, 15–17 Murphy Street, 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.

The Commission subleases an office space at 650 Great South Road, Penrose, Auckland, off the Ministry of Health for up to six staff. The sublease expires in December 2015.

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

Note 20: Contingencies

Contingent liabilities

The Commission has no contingent liabilities

Contingent assets

The Commission has no contingent assets.

Note 21: Related party transactions

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

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

Significant transactions with government-related entities

The Commission has been provided with funding from the Crown of $13.0m ($14.5m 2012) 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 $0.84m ($0.76m 2012),Canterbury DHB $0.46m ($0.2m 2012), Counties Manukau DHB $1.1m ($0.98m 2012), Southern DHB $0.31m ($0.6m 2012), the University of Otago $0.57m ($0.64m 2012), Air New Zealand $0.41m ($0.26m 2012) and Waitemata DHB $0.56m ($0.43m 2012).

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 2013 totalled $5.8m ($1.9m 2012) 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[77] totalled $1.01m ($0.84m 2012).

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 $1.1m ($0.98m 2012). The Commission also contracted for $0.12m ($0.18m 2012) with General Practice New Zealand, where a Board member is the chair. The Commission contracted with Waitemata DHB $0.56m ($0.43m 2012) where a new Board member (June 2013) holds a senior position. The Commission contracted with Canterbury DHB $0.46m ($0.2m 2012) where a Board member is a member of the DHB clinical board.

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 2012–13 year was:

	Actual 2012 $000	Actual 2013 $000
Professor Alan Merry* (Chair)	29	29
Dr Peter Foley	18	14
Mrs Shelley Frost*	16	15
Dr David Galler*	15	15
Dr Peter Jansen*	15	8
Mr Geraint Martin*	15	15
Mrs Anthea Penny	15	15
Alison Paterson		1
Total Board member remuneration	**123**	**112**

Fees were in accordance with the Cabinet Fees Framework.

77 Key management personnel for 2012–13 include the Chief Executive, General Manager, Director of Measurement and Evaluation and Chief Financial Officer. Board members have been reported separately.

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.

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 2012	Employees 2013
$100,000–109,999		2
$120,000–129,999	2	1
$130,000–139,999	3	3
$150,000–159,999		2
$180,000–189,999	1	2
$200,000–209,999	1	
$210,000–219,999		1
$230,000–239,999		1
$360,000–369,999	1	
$370,000–379,999		1
Total employees	**8**	**13**

During the year ended 30 June 2013 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.

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

Note 27: Explanation of major variances against budget

Explanations for major variances from the Commission's budgeted figures in the 2012–13 Statement of Intent are as follows:

Statement of comprehensive income

The year-end result for the year to 30 June 2013 is $1.754m deficit against a planned Statement of Intent deficit of $1.180m. As outlined in the 2011–12 annual report, a further carry forward of programme activity meant that the planned deficit for 2012–13 had been forecast to increase by around $0.5m to $1.6m. The year-end results are in line with this position and are in line with forecasts included in the 2013–16 Statement of Intent.

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

- Crown revenue exceeds budget expectations by $0.020m. Interest revenue is higher than budget by $0.1m due to interest being earned on the retained earnings and programmes underspend during the first three quarters of 2012–13.
- Budgets are as per the Statement of Intent prospective financial statements which do not include $0.35m of revenue from the National Health IT Board associated with the joint eMedicines Management (eMM) programme. Additional income associated with the eMM programme is offset by the use of additional staffing, travel and contractor costs associated with the programme.

The variance relating to contractors is due to:

- the initial use of contractors delivering the eMM programme
- contracting for communication roles and a consumer adviser role within the Commission
- temporary cover for staff vacancies in the first half of the year.

Quality, safety and mortality review programme expenditure was $8.4m. The main drivers of the programme variation within 2012–13 relate to:

- completion of Quality and Safety Challenge activity, which was carried forward from 2011–12
- an expanded *Partners in Care* work programme, including an in-house consumer advisor role
- the *Open for better care* campaign
- additional investment in sector improvement advisor and patient safety capability training places.

Statement of financial position

GST receivable is high in quarter four due to the significant programme activity in the final quarter of 2012–13. Debtors of $0.25m were outstanding at the end of June 2013 but have since been received (July 2013).

Creditors are materially higher that original budget levels due to a number of contract payment terms having been negotiated quarterly in arrears yet original budget assumptions were that invoices would be paid monthly in arrears.

Statement of changes in cashflow

The overall decrease in cash and cash equivalents relates to significant quarter four programme activity. The Commission is paid at the beginning of each quarter and contract terms with providers are generally negotiated as 20th of the month following delivery.

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 has not acquired any such shares, nor are there any current plans to do so.

10.0 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 non-financial performance information for the year ended 30 June 2013

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

We have audited:

- the financial statements of the Commission on pages 65 to 83, that comprise the statement of financial position as at 30 June 2013, 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 non-financial performance information of the Commission that comprises the report about outcomes on pages 12 to 16 and the statement of service performance on pages 51 to 64.

Opinion

In our opinion:

- the financial statements of the Commission on pages 65 to 83:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Commission's:
    - financial position as at 30 June 2013;
    - financial performance and cash flows for the year ended on that date;
- the non-financial performance information of the Commission on pages 12 to 16 and 51 to 64:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects the Commission's service performance and outcomes for the year ended 30 June 2013, including for each class of outputs:
    - its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - its 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 31 October 2013. 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 non-financial performance information are free from material misstatement.

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

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

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

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 non-financial performance information 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 and outcomes.

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

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 non-financial performance information 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 External Reporting Board.

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

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

Appendix 1: Board and committee membership

Board members

Professor Alan Merry (Chair)
Dr Peter Foley (Deputy Chair until April 2013)
Mrs Shelley Frost (Deputy Chair from June 2013)
Dr David Galler
Dr Peter Jansen (until 25 January 2013)
Mr Geraint Martin
Mrs Anthea Penny
Alison Paterson (from 29 May 2013)
Dr Dale Bramley (from 12 June 2013)

Board committees

Finance and Audit Committee:

- Geraint Martin (Chair)
- Alison Paterson
- Anthea Penny
- Andrew Boyd

Capability Committee:

- Shelley Frost (Chair)
- David Galler
- Anthea Penny
- Kathy Kane

Communication and Engagement Committee:

- Alan Merry (Acting Chair)
- Shelley Frost
- David Galler

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 until 12 June 2013)	Dr Leona Wilson (Chair)	Dr Nicholas Baker (Chair)	Associate Professor Julia Tolmie (Chair)
Dr Sue Belgrave (Chair from 12 June 2013)	Dr Jonathan Koea	Professor Edwin Mitchell	Ms Ngaroma Grant
Dr Beverley Lawton	Ms Teena Robinson	Dr Sharon Wong	Professor Dawn Elder
Ms Sue Bree	Dr Philip Hider	Ms Susan Matthews	Ms Miranda Ritchie
Dr Margaret Meeks	Dr Catherine (Cathy) Ferguson	Ms Anthea Simcock	Professor Barry Taylor
Dr Graham Sharpe	Dr Digby Ngan Kee	Mr Tamati Cairns	Ms Fia Turner
Dr Sue Crengle	Dr Anthony Williams	Mr Paul Nixon	Judge Paul von Dadelszen
Ms Gail McIver	Ms Rosaleen Robertson	Dr Pat Tuohy	Associate Professor Denise Wilson
Ms Linda Penlington	Dr Michal Kluger	Dr Terryann Clark	
Ms Alison Eddy	Professor Jean-Claude Theis	Dr. Stuart Dalziel	

Roopu Māori members

Tuwhakairiora (Tu) Williams (Chair)
Dr Rees Tapsell
Riripeta Haretuku
Leanne Te Karu
Dr Lance O'Sullivan
Denise Wilson

Postal address

Health Quality & Safety Commission
PO Box 25496
Wellington 6146

Telephone: 04 901 6040
Fax: 04 901 6079
Email: info@hqsc.govt.nz
Web: www.hqsc.govt.nz

Auditor

Audit New Zealand on behalf of the Auditor-General

www.hqsc.govt.nz

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

open FOR BETTER CARE
Hāpai ake te taiora

New Zealand Government