E 36

Tauākī o Ngā Mahi Ka Whāia |
Statement of Performance Expectations

2020/21

Presented to the House of Representatives pursuant to section 149L of the Crown Entities Act 2004

Published June 2020 by Kupu Taurangi Hauora o Aotearoa |
Health Quality & Safety Commission, PO Box 25496, Wellington 6146

ISBN 978-1-98-859930-4 (print)

ISBN 978-1-98-859931-1 (online)

Available online at www.hqsc.govt.nz

Enquiries to: info@hqsc.govt.nz

Ngā kaupapa | Contents

Kupu whakataki | Foreword

As we were finalising this Statement of Performance Expectations, Aotearoa New Zealand was coming out of lockdown from the COVID-19 pandemic. The COVID-19 pandemic and our response to it have been unprecedented, showing not only how much New Zealanders value their own health, but also how they value the health of their families and whānau and the health of other people in their communities. The health system's response has been remarkable. We have been impressed by the ways in which the health system has quickly adopted and adapted to deliver services in new ways that have helped to prevent the spread of COVID-19. And it seems that the effort of our health system, and the effort of all New Zealand, have worked as intended. We have watched the number of active cases dropping day by day over the last few weeks, to single digits.[1] Our results should be celebrated.

While we celebrate, however, the Health Quality & Safety Commission (the Commission) is also looking to the future. As a quality improvement organisation, the Commission knows and respects the complex, adaptive nature of the health system. We recognise that change in health care has both intended and unintended consequences. It is our specific role and function to focus on the quality of our health and disability services; to consider safety, access, treatment, experience and outcomes across all population groups; and to support improvement. It is our role and function to look for and shine the light on both emerging quality issues and long-term quality challenges, so that we can improve the quality of delivery and better support the health and disability workforce, who have an important role to play in promoting quality and enabling improvement.

Following on from COVID-19, the health system will face significant quality challenges. What are the unintended consequences of the changes made, and what are the new quality and safety challenges that will need to be addressed? What impact do these changes have on the people who use health services? How will an increase in digitally delivered services or the anticipated economic recession affect health equity? How do we manage the treatments and screening that have been postponed? What support, education and training will the health workforce need to recover from COVID-19 and be ready for new quality challenges? How do we work together to shape the changes that have emerged from COVID-19 in the best way for New Zealanders?

These questions are central to the Commission's role and mandate within the health sector. While the health system is remarkable every day in delivering services that improve the health and wellbeing of New Zealanders, the Commission is focused on how we can do this even better. We work broadly across the health and disability sector – including in hospitals, primary care, mental health and addiction services, and aged care – to improve patient safety and reduce harm. COVID-19 has shown Aotearoa New Zealand, the health sector and the Commission how important it is to respond nimbly and quickly to need. The Commission will need to keep this ability as we identify the results of our COVID-19 response and proactively address them over coming months.

[1] www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-current-situation/covid-19-current-cases

We have designed this Statement of Performance Expectations to give the Commission the flexibility it needs to work with the health and disability sector to both identify and support an effective response to the quality issues that will emerge over the coming year.

Tauākī a te poari | Board statement

In signing this statement, we acknowledge we are responsible for the information contained in the Statement of Performance Expectations for the Health Quality & Safety Commission. This information has been prepared in accordance with the requirements of the Public Finance Act 1989 and the Crown Entities Act 2004, and to give effect to the Minister of Health's Letter of Expectations and the Enduring Letter of Expectations from the Ministers of Finance and State Services. It is consistent with our appropriations.

Dr Dale Bramley MBCHB, MPH, MBA, FAFPHM

Chair

29 June 2020

Rae Lamb

Deputy Chair

29 June 2020

Kupu arataki | Introduction

The role of the Health Quality & Safety Commission (the Commission) is to lead and coordinate improvement in the quality and safety of health and disability services.[2] Box 1 (alongside) presents the vision, mission and enduring priorities that our Statement of Intent 2020–24 (SOI) sets out. Box 2 (below) outlines our strategic priorities.

In this Statement of Performance Expectations (SPE), we describe deliverables for advancing our strategic priorities and achieving our vision of 'Quality health for all'. Importantly, we describe how we will assess the impact of each deliverable and we identify the associated revenue and proposed expenses. Our SPE provides detailed performance measures to use in monitoring our progress.[3]

Box 1:

Our vision
Quality health for all

Our mission
Involve Inform Influence Improve

Our enduring priorities, based on Te Tiriti o Waitangi

Kāwanatanga *partnering and shared decision-making*	**Tino rangatiratanga** *recognising Māori authority*
Ōritetanga *equity*	**Wairuatanga** *upholding values, belief systems and worldviews*

Box 2: Our strategic priorities

Improving experience for consumers and whānau	• People and whānau are at the centre of the health and disability system and partner actively in determining their care
Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake	• The health and disability system supports and partners with Māori to achieve the health outcomes that they determine as priorities
Achieving health equity	• Health equity is embedded into all aspects of the health and disabilty system, and into the care relationship
Strengthening systems for quality services	• A stronger health and disability system is proactive and anticipates quality and safety issues. Its leaders authentically focus on trust, partnerships and knowledge sharing

[2] See Appendix 1 for further details of how legislation defines our role.
[3] This SPE also includes other information that the Crown Entities Act 2004 or other Acts require an SPE to cover.

Our vision of ‘Quality health for all’ places people at the heart of our work. Our primary aim is to improve health and disability services so that people receive the care they need and value. We work with whānau, health professionals, health and disability organisations and consumers to improve services.

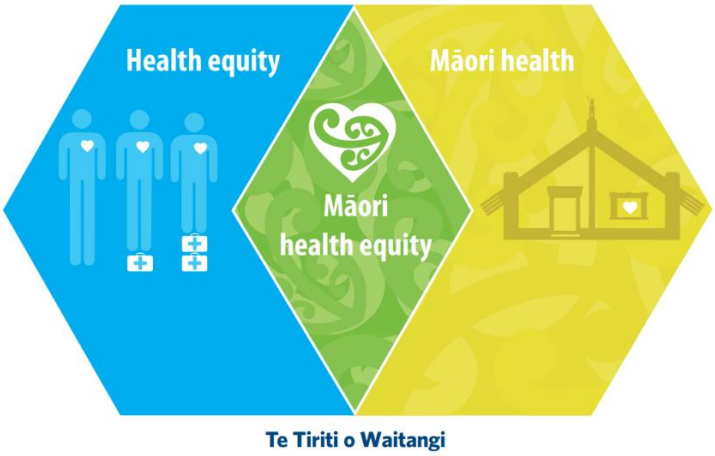
Our work is based on a shared improvement model – the New Zealand Triple Aim. We work alongside our partners and stakeholders to improve health and disability services across three domains:

- **individual:** improved quality, safety and experience of care for people and their whānau
- **population:** improved health and equity for all populations
- **system:** best value for public health system resources.

We also recognise the health and disability workforce as an important enabler of health quality, equity and safety. We work alongside the workforce, building skill and capability across all the work that we do.

We focus on measurement and reporting; sector capability and leadership; providing evidence-based tools and resources; using te ao Māori concepts and worldviews; and using quality improvement methods. We focus broadly on the health and disability sector in our work on improving patient safety and reducing harm. Our existing work programmes focus on quality improvement across hospitals, primary care, and mental health and addiction services. As our resourcing allows, we are expanding our influence within aged care, and considering how we build quality improvement influence across services for people with disabilities as well.

We view health equity and Māori health advancement as separate but interlinked areas, which share achieving Māori health equity as a goal. The diagram below shows how equity, Māori health equity and Māori health overlap, and how Te Tiriti o Waitangi is at the foundation of all of this work.



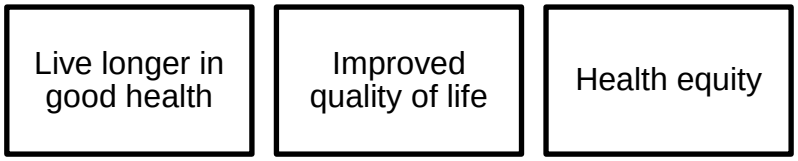
Recognising that Māori have their own health aspirations, priorities, goals and ways of working, we aim to work alongside and with Māori in Te Tiriti-based partnerships, offering tools, resources and support to advance Māori health, so all Māori can live long, healthy lives.

Key influences on this SPE

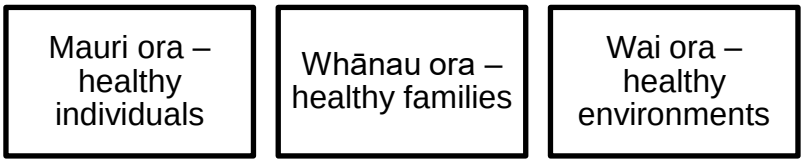
The Commission's vision, mission and priorities are influenced by the broader context we operate in, and in particular by the directions and requirements of Government and of the health and disability sector. At the time of preparing this SPE, the COVID-19 pandemic is another key influence. COVID-19 and the response to it present challenges for our work, and highlight the need for us to be adaptable in the way we collaborate and work across the health and disability sector.

Government directions

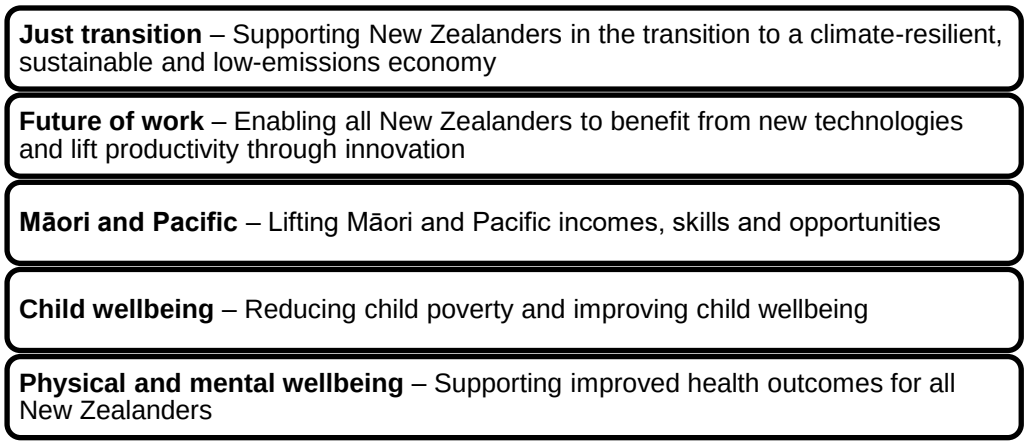
The Commission's work supports the broader health and disability system vision of 'Pae ora, healthy futures', which we share with the Ministry of Health and other health agencies.[4] Our work contributes to the Ministry's three 'Pae ora, healthy futures' goals:



The 'Pae ora, healthy futures' goals and vision are set on a foundation of three interconnected elements:[5]



All of our work aims to improve the quality and safety of the health and disability system, contributing to the wider goals of government.[6]



[4] Ministry of Health. 2020. Our work programme 2019/20. URL: www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20 (accessed 26 April 2020).
[5] As explained by Sir Mason Durie at the launch of He Korowai Oranga – Māori Health Strategy in 2014. www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pae-ora-healthy-futures
[6] www.budget.govt.nz/budget/2020/bps/wellbeing-priorities.htm (accessed 26 June 2020)

In particular, our work across the health and disability system supports physical and mental health for all. This work will span the life course from child wellbeing to our vulnerable older population. We also work to achieve health equity for Māori, Pacific peoples and people with disabilities, alongside all population groups, helping to advance their goals and overall wellbeing.

Our SPE reflects the Government's Letter of Expectations (LOE), received on 18 March 2020.[7] The Government's priorities for the health sector and its expectations of the Commission's work, as described in the LOE, are central to our SPE. Appendix 3 shows how our SPE deliverables align well with the expectations that the LOE outlines for us.

COVID-19 and the need for flexibility

Our organisation, like others, responded to the challenges that COVID-19 presented to the health and disability sector, as well as to our own workforce, to consumers of health services and to our partners.

In the short term, we refocused our work to help the health and disability sector. We refreshed and expanded resources on infection prevention and control, and developed shared decision-making resources to support conversations between clinicians and consumers and whānau. In addition, we developed a web-based resource hub to provide the health and disability workforce with access to online resources and webinars on keeping themselves well and safe.

In this work, we partnered with other agencies such as the Ministry of Health and Accident Compensation Corporation (ACC) and with key clinical leaders. Consumers were also involved.

Given the uncertainty of all the issues we will face in the post COVID-19 environment, we recognise we will need to be flexible in our SPE plan and deliverables. Some of the work we have focused on during the COVID-19 period may need to continue, and the need for new work is clear.

Changes to develop a stronger and more flexible digital environment throughout the health sector will give us different ways of engaging with the sector. They will also prompt us to examine the quality and safety issues that may arise from these different approaches.

In addition, the impacts of the economic recession will be significant when we consider the analysis of data and information about quality and safety, and in the work of our mortality review committees.

We also need to understand the impacts of delays in diagnosis and treatment of other conditions resulting from our COVID-19 response.

It is clear that analysis of the broader effects of our COVID-19 response on health quality will be required as a way of supporting the health system to manage emerging quality, equity and safety risks proactively. The Commission has responded to these challenges within our SPE.

[7] COVID-19 may change the expectations of the current Associate Minister of Health's Letter of Expectations.

Revenue and financial influences

The Commission's role and mandate have grown since it began in 2011/12, yet core Crown funding has remained unchanged at $12.96 million. The Commission sought funding for cost pressures ($1.1 million) and put forward a first-draft SPE on the assumption that this funding would be provided. This final SPE is put forward on the assumption that there will be no cost-pressure funding. While we will continue to deliver our targeted quality improvement programmes – building quality improvement sector capability, improving sector data capability, and strengthening relationships across the public sector and with Māori and Pacific peoples – our pace will be slower than it would be if we had received funding to address our cost pressures.

The Commission is considered strong in its financial management, enabling it to deliver better services and outcomes for New Zealanders. The forecast financial statements for the 2020/21 year and outyears are in line with generally accepted accounting practices. The statements will include:

- an explanation of all significant assumptions underlying these financial statements
- any other information needed to reflect our forecast financial operations and financial statements fairly.

He pēhea tā mātau mahi | How we work

The Commission works with others, within strong partnerships and relationships (involving), to gather and share intelligence (informing); raise awareness and encourage thought and knowledge sharing (influencing); and support change to improve the health and disability system (improving). We are also committed to enacting Te Tiriti o Waitangi across all areas of our work. Measurement is another important part of how we work, underpinning our understanding of the quality and equity of the health system, where strengths and weaknesses lie, and whether efforts to improve are working.

Involve

Our role is to lead and coordinate improvement efforts. For this reason, involving people in our work is essential.

We are committed to having robust Te Tiriti partnerships with tangata whenua across all our work, and we encourage and expect active Te Tiriti partnering throughout the sector. We are working to involve Māori worldview leaders, experts and whānau Māori to develop solutions based on mana motuhake. As a small organisation, we aim to work with iwi and hapū through the health services and organisations that hold direct relationships with them. We will build stronger partnerships through our work with national Māori organisations and groups.

We work with, and encourage active partnerships with, consumers and whānau and other population groups who experience health inequity, so that their worldviews, needs and experience are central to improvement initiatives.

In working with health sector staff to make improvements, we have a strong focus on clinical leadership. We work with and support quality and safety governance and leadership to help improve the quality of services. We also work with those who can more broadly influence the quality of services, including government agencies and Government. We are committed to extending our networks and building relationships within the disability sector, so that we can strengthen our impact on the quality of services for people with disabilities.

We work with:

- tangata whenua in Te Tiriti partnerships
- consumers and whānau
- those experiencing health inequity
- the health and disability system workforce, leadership and governance
- government agencies
- Government

A useful definition of mana motuhake was provided by a contributor to the Commission's Performance Improvement Framework (PIF) based self-review process:

Mana motuhake

'… in simple terms is the ability of Māori to be Māori, on their terms, and to control things according to their values and what they think is important. And it is about their aspirations for their own development. It is about building their capacity and capability.'

Inform

We work to inform those who can influence the quality of services, as well as to gather information from them.

We make knowledge available and make data and information transparent for people. We share the latest data, information and evidence (local and international). We recognise that those we work with hold valuable intelligence that can help improve quality and safety in the health and disability sector. The worldviews, experiences, ideas, successes and challenges of those we work with provide useful information that helps in making improvements, and we work alongside them to share and spread this intelligence. We are working to look at all our information and intelligence from Te Tiriti and health equity perspectives. We are committed to using information that includes Māori worldview priorities, experiences and solutions.

We publish information on a range of measures of quality, including patient experience surveys; quality and safety markers; measures of variation in practice; and other indicators. Each year we publish *A window on the quality of New Zealand's health care* with an overview of key health quality and safety information.

Influence

As the Commission is a small agency, our ability to influence change is essential to our success.

We influence others by sharing knowledge and understanding in the sector; developing advice, tools and techniques; raising awareness by using our measures and intelligence to identify areas for improvement; and measuring the impact of our change and improvement work. We influence through modelling, demonstration and working alongside people, to show what they can do. We are committed to making mātauranga Māori central in our efforts to influence.

We also work to influence policy that is relevant to improving the health and disability system and health outcomes, by providing evidence-based advice to Government. We recognise the articles of Te Tiriti o Waitangi provide a framework to guide and influence improvement.

One example of the Commission using its influence can be seen in our focus on 'institutional racism' in the health system, in our 2019 publication *A window on the quality of Aoteoroa New Zealand's health care 2019: A view on Māori health inequity.*

We were able to add our voice to the voices of the many researchers and academics who have been showing and calling out instituional racism in health care for a number of years.

As a Crown enitity, we wanted to use our influence within the health sector to move thinking forward, encouraging and advocating for general services and the health system to 'see' and address institutional racism.

Improve

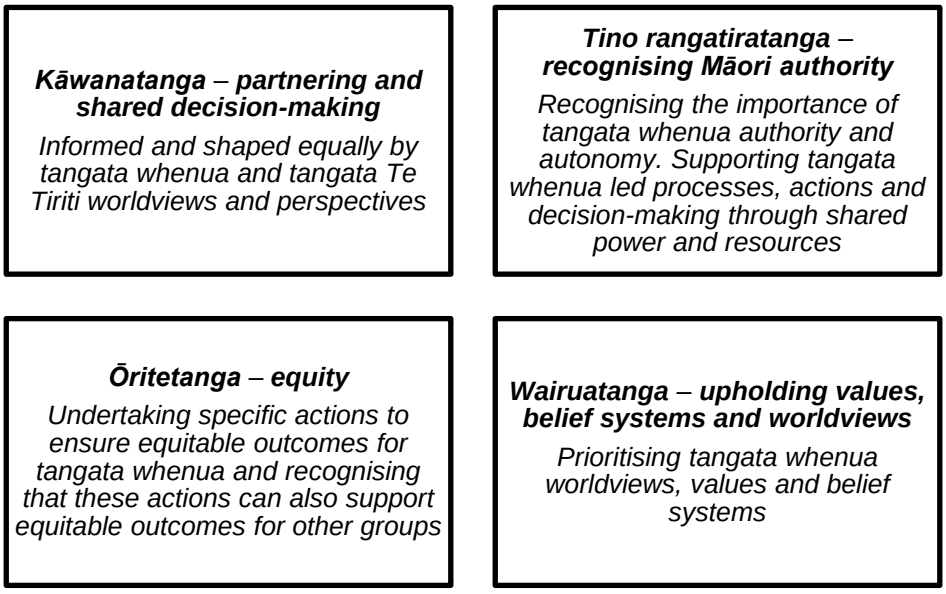
The Commission builds improvement capability and coordinates quality improvement programmes in the sector. We work alongside people and services that are working to improve and we lead improvement in specific areas.

Our work encourages capability development, learning, sharing and working together for change. Through our targeted quality improvement efforts to reduce specific harm in hospitals and our recent work in partnership with aged residential care, primary health and mental health and addiction services, we are supporting the health sector to increase patient safety and reduce harm, while improving quality. We encourage the sector to develop active Te Tiriti partnerships with tangata whenua as part of its improvement efforts, so that improvement benefits Māori and helps to achieve health equity.

Strengthening our commitment to Māori health

We are committed to strongly embedding Te Tiriti o Waitangi in our work, supporting mana motuhake and making te ao Māori perspectives and worldviews central to our work. These challenges have strongly influenced us in developing our SOI and SPE.

We apply the three articles of Te Tiriti o Waitangi and the Ritenga Māori Declaration[8] to our work, as the diagram on the right explains. Our approach has synergy with the way the Ministry of Health currently applies Te Tiriti o Waitangi in its wider kaitiakitanga role for the health and disability system.[9]



The Commission is committed to reviewing our internal systems and processes from the perspective of Te Tiriti. We will work with our Te Tiriti partners and stakeholders to develop new measures and measurement approaches that we can use to gauge our progress against the articles of Te Tiriti o Waitangi. We are committed to sharing with the sector what we learn about our own organisation's quality improvement.

We want to support the development of partnerships based on Te Tiriti o Waitangi that recognise, value and integrate mana motuhake solutions across the health and disability system and within daily health practices for all. We are looking critically at how we are doing

[8] Sometimes also called the 'fourth article', the 'forgotten article' or the 'oral article'.
[9] The Ministry of Health has been consulting on aspects of its Māori Health Action Plan, including its approach to Te Tiriti o Waitangi, while we have been developing this SOE. See: www.health.govt.nz/our-work/populations/maori-health/maori-health-action-plan.

this, the tools we are using, the frameworks we are applying, and how we might do this differently to embed and enact Te Tiriti o Waitangi and support mana motuhake solutions. We will need to partner, to listen, to learn and to share through processes such as co-design, working together to develop priorities and learning from concepts and approaches that benefit Māori. Our aim is to support and champion Māori to lead their own improvement in health and disability services and to share successful initiatives that draw on te ao Māori models to improve the quality of services for all. For more information on our work in this area, see 'Priority Two – Whakaarotau Rua: Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake'.

Strengthening our commitment to Pacific health

The Commission has highlighted the inequities among different groups in Aotearoa New Zealand in terms of health service access, treatment, the quality of care delivered and health outcomes, and it is clear that Pacific peoples experience high levels of inequity. Being able to respond appropriately to the needs of those experiencing the greatest health inequities, particularly Māori and Pacific peoples, is essential if we are to improve health outcomes.

The Commission is committed to highlighting and supporting the use of Pacific models of health and wellbeing and Pacific concepts, perspectives, values and knowledge within our quality improvement work.

In 2020/21, the Commission will publish *Window 2021: A Pacific perspective on health in New Zealand* to 'shine the light' on the inequities Pacific peoples are experiencing. As well as using health system data, this publication will draw on the experience of Pacific health experts, Pacific community leaders, Pacific consumers and their families.

Strengthening our commitment to improving services for people with disabilities

We are committed to extending our networks and building stronger relationships within the disability sector, to strengthen our impact on the quality of services for people with disabilities. In 2020/21, we will begin patient experience survey analysis and reporting focused on the experience of people with disabilities; we will strengthen adverse events learning within the disability sector; and we will continue to strengthen partnerships with people with lived experience of disabilities, through our consumer networks and connections across our work programmes.

Since August 2019, the Commission has collected information about disability status from consumers through the New Zealand adult inpatient experience survey and the primary care patient experience survey. We want to better understand how people with disabilities experience primary care, general practice, diagnostic services, and their experience of how

specialists and hospital staff work together to manage their overall care. In 2020/21, we will begin analysing and reporting on the experience of care that people living with disabilities share though the survey processes.

We will also work to strengthen learning from adverse events across the disability sector, with a specific focus on services for people with intellectual disabilities. Learning from adverse events encourages a quality and safety culture of learning and sharing to improve services.

Measurement

Measurement is essential to the way that we work. The Commission publishes over 250 indicators of the quality and safety of Aotearoa New Zealand's health system, most of which give further details for specific ethnic, age and gender groups. Every year in *A window on the quality of Aotearoa New Zealand's health care* we identify how our health system is performing and how it compares internationally.

We measure improvement, and we support and encourage others to measure improvement, as a core quality improvement capability. Finding measurable improvement in an area demonstrates that improvement efforts are working there. On the other hand, an area that shows no measurable improvement can point to the need for different approaches.

We report regularly on preventable harm in *Open4Results*.[10] This publication identifies successes from across the sector, including information on improving health equity, patient wellbeing and health care across whole of system. You can find our most recent *Open4Results* at the Commission's 'Health Quality Intelligence' page: www.hqsc.govt.nz/our-programmes/health-quality-evaluation.

[10] Health Quality & Safety Commission. 2019. *Open4Results*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/Open4ResultsJune19_final_July2019.pdf (accessed 26 April 2020).

Ā mātau mahi SPE i raro i ia kaupapa rautaki mahi | Our SPE work under each of our strategic priorities

Improving experience for consumers and whānau	Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake	*Achieving health equity*	*Strengthening systems for quality services*

Our SOI, published on 30 June 2020, sets out our strategic priorities. Our strategic priorities are strongly integrated and aligned, with many crossovers and areas in common. This section explains each of the specific workstreams and deliverables in our SPE under the strategic priority area that it aligns most closely with.

One output class – supporting and facilitating improvement

The Commission has moved from the two output classes that we have worked with in describing SPE deliverables in the past, 'intelligence' and 'improvement', to a single output class 'supporting and facilitating improvement'. This output class covers our functions of:

- measuring and reporting on the quality and safety of the health and disability system
- leading, coordinating and supporting improvement efforts
- advising the Government on the quality and safety of the health system
- sharing knowledge about and advocating for safety and quality.

This one output class captures the work we will do, as we describe in this SPE, to achieve our strategic priorities and our vision.

Our approach to measuring our work

Our work, and the deliverables we have set within our single output class, aim to improve the health system, so that New Zealanders have better experiences of and outcomes from health care. Our SPE deliverables have both quantity measures (how many of something we do?) and quality measures (did we do it well?) to help us explicitly track our progress toward achieving our expectations.

The outcome measures of our work are ultimately improved experience and improved health outcomes for people. We have referred to the outcomes we are working toward within each strategic priority. However, we anticipate that outcomes will be able to be demonstrated over time, rather than within the SPE period.

- In some cases change is measurable, although the change may take time to be seen.

  For example, patient experience surveys (see SPE 2 below) show how patient experience of care is changing. We can demonstrate that by 2019, half of all survey measures had significantly improved at a national level from a baseline period five years earlier.

- For others, the deliverable provides something essential to support the improvement of quality in our health system, but attributable, specific improvements are unmeasurable, at least in the short term.

For example, the publication of a Window on Pacific health (see SPE 6 below) will not, of itself, improve equity of health care for Pacific populations. However, we know that starkly identifying issues in this way is an effective mechanism for drawing attention to inequities, which can operate as a catalyst for future improvement activity.

See Appendix 2 for a summary of how each of our deliverables contributes to the outcomes that we are aiming for.

Kaupapa matua tuatahi: Te whakapai ake i te wheako mō ngā kiritaki me ngā whānau | Priority 1: Improving experience for consumers and whānau

We want consumers and whānau at the centre of the health and disability system, as active partners in improving the system and in their care.

We will know that we have contributed to improved experience for consumers and whānau when we see improvement in patient experience survey results from baselines, and we see improvements in patient and whānau measures and reporting across our programme areas.

Established evidence shows that engaging consumers and whānau is related to better health and care outcomes.[11] Through our work with the sector on consumer engagement, we have seen that parts of the sector do not fully understand or accept the 'why, what and how' of consumer and whānau engagement. While some services are actively seeking to improve consumer and whānau engagement, others are struggling. The Commission has expertise and an important role in supporting the health and disability system to engage more effectively with consumers and their whānau. We are committed to supporting partnerships between providers and consumers to improve quality and safety of health and disability support services.

As well as having engagement as a priority in all our work, we have focused workstreams for improving people's experience of services. In 2020/21, these workstreams are consumer partnership and co-design, and patient experience surveys.

Engaging and co-designing with consumers

Partnership with consumers is integral to health and disability service delivery. Our focus on co-design supports services to work in partnership with people and their whānau on the solutions to everyday health system and service challenges.

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
1	Scope and deliver a co-design programme in primary care that includes reducing inequity in health care as a key improvement factor.	Hold six learning sessions by 30 June 2021. Hold one to two workshops by 30 June 2021.	80% of participants will report having a greater understanding of co-design in primary care and how it contributes to improving health outcomes and addressing inequity. Case studies will be collected from teams participating in the sessions and workshops, and published on the Commission's website by 30 June.	By teaching co-design, we support the primary care workforce to partner with consumers and whānau effectively, so primary care can better understand what matters to consumers and whānau, better meet their needs and improve their health outcomes.	Case studies show that effective co-design is practised within primary care and that primary care is learning about consumer experience and need and responding to it, as a result of learning sessions and workshops.

[11] See: Doyle C, Lennox L, Bell D. 2013. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open* 3:e001570. URL: https://bmjopen.bmj.com/content/3/1/e001570 (accessed 26 June 2020).

Responding to patient experience in hospitals and primary care

Since 2014, we have been checking back on improvements to care and patient experience by coordinating the New Zealand adult inpatient experience survey. High survey response rates suggest that people want to tell us about their experiences. For the first time in 2018/19, survey responses indicated that about 30,000 hospital inpatients felt they **had** been involved in decisions about their treatment.

The Commission coordinates New Zealand's primary care patient experience survey as well. Through this survey, we aim to find out about patients' experience in primary care and how their general practice, diagnostic services, specialists and hospital staff together manage their overall care.

Data on disability status has been collected in both surveys since August 2019. The impact of disability status, age, ethnicity, gender, socioeconomic status and long-term conditions on experience of care will be analysed and profiled in a quarterly newsletter.

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
2	Report on patient experience surveys across hospital and primary care.	Four reports will be published.[12] A report analysing the impact of factors including disability on patient experience will be analysed and shared with the sector.	Activities to improve participation rates in Māori and Pacific peoples are tested throughout 2020/21. Patient experience questions around cultural safety are developed, tested and implemented. Given these new approaches, a response rate baseline will be established for monitoring equity.	Measurement and reporting interact with a range of incentives to stimulate improvement by health service organisations.[13] Well-designed reporting provides clear direction and targeting of improvement activities.	Relevant and valid constructs equating to consumer/ patient experience show improvement over time.

[12] This number is lower than in 2019/20 because the May and August surveys may not run due to COVID-19.
[13] Fung C, Lim Y, Mattke S, et al. 2008, Systematic Review: The Evidence That Publishing Patient Care Performance Data Improves Quality of Care. *Annals of Internal Medicine* 148: 111–23. URL: https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.691.1541&rep=rep1&type=pdf (accessed 28 June 2020).

Kaupapa matua tuarua: Te whakapūmau me te whakatinana i Te Tiriti o Waitangi, te hāpai i te mana motuhake | Priority 2: Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake

We want partnerships based on Te Tiriti so that the whole health and disability system and all services support mana motuhake.

We will know we have contributed to embedding and enacting Te Tiriti and supporting mana motuhake when we can see improvement in Māori patient and whānau experience and, over time, in Māori health outcome measures, both at system level and within our programme areas. However, we recognise that improving wider determinants of health is another key aspect of improving Māori health outcomes.

A central part of our health and disability system and services must be Te Tiriti o Waitangi based relationships that support mātauranga and te ao Māori solutions and uphold mana motuhake. By supporting mana motuhake, we support Māori solutions that work for Māori to advance Māori health, helping to address both institutional racism and inequity. We recognise all health and disability settings can better use te ao Māori values and concepts and integrate them across system design and practice to improve access to care, the quality of services and the health outcomes of all New Zealanders.

Our specific focus for this SPE priority is to develop and implement a te ao Māori quality improvement framework and scope Māori-determined quality improvement measures.

Implementing a te ao Māori quality improvement framework

The Commission will work with Māori to develop a te ao Māori framework for quality improvement. The framework will have accompanying resources designed to guide improvement initiatives from the perspective of te ao Māori.

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
3	Develop a te ao Māori quality improvement (QI) framework and implementation guide, and test and consult on it with the wider sector and with Māori health experts.	Hold at least 10 wānanga to develop, test and consult on the framework. Produce the te ao Māori QI framework and implementation guide for publication on the Commission website by 30 June 2021.	The Commission's advisory groups endorse the framework. The Board will endorse the framework by March 2021.	A te ao Māori QI framework and implementation guide will encourage and enable the health workforce to draw on Māori worldviews and models directly in their improvement work and enable the application of the Articles of Te Tiriti o Waitangi in practice	Drawing on te ao Māori, and strengthening Te Tiriti partnerships, will strengthen and broaden quality improvement practice to better meet the needs of Māori and improve the experience and outcomes for all who access healthcare in Aoteroa .

Developing Māori-determined quality improvement measures

To help embed Te Tiriti and support mana motuhake in our work, the Commission will partner with Māori to scope the development of Māori-determined quality improvement measures.

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
4	Collect and collate information on te ao Māori models of QI in use across the health sector. Develop a draft set of te ao Māori QI measures with Māori experts, providers and whānau.	Publish our collation of te ao Māori models by 30 June 2021. Develop a draft set of te ao Māori QI measures by 30 June 2021.	Engage at least five Māori providers in our te ao Māori QI framework development. Engage at least five district health boards (DHBs) in work on te ao Māori QI measures.	Developing a collation of Māori QI models of practice will demonstrate the success of Māori QI practice to the sector and encourage general services to learn from te ao Māori. Developing a set of Māori QI measures is fundamental to being able to measure the success of change work, according to te ao Māori standards and worldviews.	Te ao Māori approaches will be better understood and valued within general services. Quality will be able to be measured using te ao Māori measures that emphasise elements valued by Māori.

Kaupapa matua tuatoru: Te whai kia ōrite te hauora | Priority 3: Achieving health equity

We want systems, services and the workforce to prioritise equity and work to achieve equitable access, treatment and outcomes.

We will know our work has contributed to health equity when we highlight health care variation and inequities across population groups, and we see greater health equity in our system and programme measures.

The Commission's work, along with the work of many others, has demonstrated inequities in the determinants of health, in access to health services, in treatment and quality of care, and in outcomes for different groups in the Aotearoa New Zealand health system, and notably for Māori[14] and Pacific peoples.[15] In our work, we describe health inequities as avoidable and unfair differences in health outcomes. Health equity means people receive the care they need – which is different from health equality, where everyone receives the same care.[16] In short, a health equity approach is about recognising different needs and responding appropriately.

If health systems and services and the health workforce can respond appropriately to the needs of those experiencing the greatest health inequities, particularly Māori and Pacific peoples, they will help achieve health equity. High-quality health services use health equity and culturally safe approaches to enable people with greater need to access services and get treatment that meets their needs. In matching response to need, high-quality health care supports greater equity of health outcomes across all population groups.

The Commission will contribute to our strategic priority of achieving health equity in 2020/21 through our work on analysing the effects of the health system's response to COVID-19 on different population groups, as well as our work on the *New Zealand Atlas of Healthcare Variation* and *Window 2021: A Pacific perspective on health in New Zealand*.

Analysis of effects of COVID-19

Massive changes due to the COVID-19 pandemic and health system responses to it have created a range of uncertainties and unknowns. Rapid change in service delivery approaches, consumer and whānau responses to change, delayed screening and treatment and anticipated economic recession are expected to impact population groups and health quality, safety and equity differently. Understanding the broader effects of change on quality will be required to support the health and disability system to proactively manage quality risks and ensure improvement.

[14] Health Quality & Safety Commission. 2019. *A window on the quality of Aotearoa New Zealand's health care 2019: A view on Māori health equity.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3721 (accessed 30 April 2020).
[15] Health Quality & Safety Commission. 2018. *A window on the quality of Aotearoa New Zealand's health care 2018.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/assets/Health-Quality-Evaluation/Windows_Document/Window-Jun-2018.pdf (accessed 5 May 2020)
[16] Poynter M, Hamblin R, Shuker C, et al. 2017. *Quality improvement: no quality without equity?* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/assets/Other-Topics/Equity/Quality_improvement_-_no_quality_without_equity.pdf (accessed 26 April 2020).

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
5	Deliver analysis highlighting the broader effects of COVID-19 on the health system, with particular regard to effects on equity of access, quality and outcome.	Analysis will be made available in forms that support the health and disability system to 'recover' in ways that best address pre-existing inequities (by December 2020).	Partner with DHBs, primary health organisations and Māori organisations in producing the analysis.	Measurement and reporting interact with a range of incentives to stimulate improvement by health service organisations.[17]	Responses to the monitoring of access, quality and outcomes of care with an equity lens contribute to demonstrable improvement in these measures over time. Where access, quality or outcomes issues are identified, health services and the system will be able to respond early to improve quality.

New Zealand Atlas of Healthcare Variation

The New Zealand Atlas of Healthcare Variation highlights how geographic areas differ in the way they provide and use health services and in their health outcomes. It covers over 20 domains, with each one dealing with a specific clinical area. Each domain also includes more detailed analyses based on age, ethnicity and gender, allowing users to see the impact of demographic variables on, for instance, the regular dispensing of medication or hospitalisation rates. These analyses highlight areas of inequity where further action is needed for improvement.

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
6	Report variation in access, treatment options, and outcomes of care and experience.	Update at least four Atlas domains. Atlas domains will include analysis across population groups, including Māori and Pacific peoples. All DHBs have actions in their annual plans to improve in the priority areas of asthma, gout or diabetes.	Develop Atlas domains with experts.	Measurement and reporting interact with a range of incentives to stimulate improvement by health service organisations.[18] Well-designed reporting provides clear direction and targeting of improvement activities.	Where indicators have a clear positive direction, improvement at a national level is seen. Where there is no clear positive direction, variation reduces. In both cases, inequity between different groups reduces.

[17] Fung et al 2008, *op.cit.*
[18] *Ibid.*

A Pacific perspective on health in New Zealand

The Commission has committed to publish *Windows 2021: A Pacific perspective on health in New Zealand* in 2020/21 (the 'Pacific Window'). The Pacific Window insights will include lessons learnt from Pacific health experts and consumers. This workstream will provide information needed to develop high-quality health policies and improvement programmes that are effective, relevant and meaningful for Pacific New Zealanders.

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
7	Publish *Window 2021: A Pacific perspective on health in New Zealand*.	Publish a report by 30 June 2021. Evidence shows we are sharing the report with health sector leaders and providers.	Pacific experts are appropriately engaged in the design and shaping of the report. We will review metrics such as media coverage, downloads of the report, requests for further information and useful work coming out of the report.	This opportunity makes the most of the knowledge and ideas of recognised Pacific leaders, helping to establish and maintain systems that facilitate cultural safety, information sharing, learning, early identification of quality and safety concerns, and appropriate solutions at all levels.	Over time the inequities identified in the report are reduced, and the good practice identified spreads. Understanding, within the health and disability sector, of the different and changing needs and intersectionality of diverse Pacific populations improves.

Kaupapa matua tuawhā: Te whakakaha i ngā pūnaha mō ngā ratonga tino kounga | Priority 4: Strengthening systems for quality services

We want systems that facilitate cultural safety, information sharing, learning, early identification of quality and safety concerns, and appropriate solutions at all levels.

We know that our work is contributing to a stronger system for high-quality services when we see:

- ***more whānau involvement in adverse event reviews, learning and communication***
- ***DHBs addressing issues raised in 'Quality Alerts' that are relevant to them***
- ***reduced mortality over time, in mortality review cohort groups***
- ***improved capability in data and measurement, quality improvement science and clinical governance within the health system and the health workforce***
- ***improved quality and safety measures across the system and in our programme areas.***

Around the world, health quality and safety work has made great progress through using quality improvement approaches in focused interventions and through reactive approaches, based on data and learning from past events. However, the process of anticipating, monitoring and responding to early changes in quality and safety is slow. Proactive approaches and more complex systemic quality improvement challenges, such as institutional racism and health inequity, require a greater focus on partnerships, and on open and transparent communication between consumers and those delivering care. A high-quality health and disability system needs the relevant tools, intelligence and capability to identify emerging issues at all levels, so that it can avoid harm as much as possible. The health and disability system needs a capable and skilled workforce that is well positioned to manage the quality challenges that we face.

A high-quality health and disability system also needs to look beyond its own structural and systemic biases so that it can address ongoing patterns of harm, including inequitable access, effectiveness and outcomes for particular population groups. Using data and partnerships to build intelligence, alongside appropriate responses to complex challenges, is important to develop a more resilient and stronger Aotearoa New Zealand health and disability system.

Six workstreams are aimed directly at strengthening systems to support high-quality services. These are: learning from adverse events; providing 'Quality Alerts' to support the sector; supporting system level measures; continuing mortality review; building improvement science capability, and strengthening clinical governance within the health and disability sector.

Learning from adverse events

The purpose of the *National Adverse Events Reporting Policy 2017* (the policy) is to help improve the quality and safety of health and disability services as well as people's experience of them. The policy supports a national approach to reporting, reviewing and learning from adverse events and near misses. The policy is based on six principles (open communication, consumer participation, culturally appropriate review practice, system changes, accountability and safe reporting) that health and disability service providers must base their internal policies and processes on.

To support providers to embed these principles in their own policies and processes, we offer education, resources, advice and national-level adverse event reporting. Through this work, we can identify quality themes and issues that may not be apparent at a local level, and share them nationally.

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
8	Strengthen learning from adverse events across the health and disability sector (specifically focusing on intellectual disability services in 2020/21) and improve transparency of reporting through national adverse events dashboards.	Complete three adverse event training workshops that promote the adverse event learning review by 30 June 2021. Up to 150 health care workers complete the two-day adverse event training workshops. National adverse event reporting dashboards are available for the hospital sector by 31 December 2020.	Apply and integrate te ao Māori worldviews across all training and learning. Conduct a survey on the effectiveness of adverse event reporting dashboards in improving transparency of and national learning from adverse events.	Partnering with Māori and including te ao Māori worldviews will provide understanding of Māori experience and understanding of adverse events and of solutions. Training the workforce in adverse event review supports useful reviews that can identify issues and improvements locally. Supporting national reporting can improve transparency and help to share learnings nationally.	Adverse event review will lead to solutions that work better for Māori. Adverse event review will more effectively identify improvements to reduce future events. National sharing and learning from adverse events will improve.

Quality Alerts to provide information on each DHB

In 2020/21, we will develop and produce a quarterly ‘Quality Alert’ aimed at supporting DHB Boards and executive to govern, and the health sector workforce to improve, quality and safety, using information relevant to their own DHB. The Quality Alert will bring together information and indicators in a comprehensive report on each DHB, from which it is possible to identify quality issues within a DHB and make clear comparisons with other DHBs.

This work will support DHBs to better understand their own quality strengths and weaknesses, and direct their attention to where they should focus their improvement efforts. We will also encourage DHBs to share successful approaches and to learn from other DHBs that have different strengths.

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
9	Provide quarterly reporting of early identification of potential quality and safety concerns, through a 'Quality Alert'.	The initial design of the Quality Alert approach will be in place and operating from December 2020. At least three Quality Alerts are made available to DHBs from December 2020 onwards.	Feedback will be sought after each version of the Quality Alert, from DHBs. Necessary changes to the Quality Alert will be made within two report cycles.	Measurement and reporting interact with a range of incentives to stimulate improvement by health service organisations.[19] In particular, early warning of deteriorating performance allows organisations and systems to identify problems quickly and respond to them before outcomes deteriorate further. As part of this response, it is possible to expose and deal with underlying systemic issues.	Alerts are addressed and specific examples of concern show improved performance over time.

Supporting system-level measures

By supporting the health and disability sector workforce to improve capability in measurement, we can strengthen skills in understanding quality strengths and weaknesses. The Commission will scope a measures library that we can use to support the sector in implementing measures across the health system. We will also scope educational options to support the sector in using the library.

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
10	Support the implementation of system-level measures in the health sector by building a library of quality measures, for use in the health sector, and for working with Māori to support their data capability in priority areas.	Partially scope and build a measures library. Scope and test a range of options to build capability in using data for quality improvement and achieving equity of outcomes. There will be early engagement with Māori providers to support them in building data capability in priority areas, for example, child health.	The Commission's external expert advisors will endorse progress on the measures library. It will be completed by 30 June 2022. Some partnering with Māori providers will be evident by 30 June 2021.	Responding to measurement and reporting requires development of skills and capabilities in data and analytics. The measures library, by sharing robust and tested measures across the sector, is an essential support to building this capability.	Measures from the library are used within the sector to inform and support improvement, which is reflected in better patient outcomes over time.

Mortality review

We use mortality review to improve systems and practice within services and communities in ways that reduce morbidity and mortality. The Commission hosts five statutory mortality review committees: Child & Youth Mortality Review Committee; Family Violence Death

[19]Fung C, Lim Y; Mattke, S, Damberg C, and Shekelle P. 2008, Systematic Review: The Evidence That Publishing Patient Care Performance Data Improves Quality of Care. *Annals of Internal Medicine 148:111-123* URL: https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.691.1541&rep=rep1&type=pdf (accessed 28 June 2020)

Review Committee; Perinatal & Maternal Mortality Review Committee; Perioperative Mortality Review Committee; and Suicide Mortality Review Committee.

Mortality review meets its responsibilities to Te Tiriti of Waitangi by continually improving the quality of mortality review equity reporting through the use of Te Pou, the Māori responsiveness rubric and its guidelines.[20] Developed by the Māori caucus of the mortality review committees, Ngā Pou Arawhenua, Te Pou is a tool that the committees can use to follow a Māori-centred approach in gathering, interpreting and reporting data on Māori mortality.

The mortality review committees report and publish regularly. They make recommendations on particular sectors or topics to the health sector, and to wider government agencies, with the aim of influencing system changes and reducing mortality and morbidity. The mortality review committees also monitor the progress agencies make in implementing the recommendations that apply to them.

In 2020/21 the mortality review committees will produce at least two evidence-based reports containing recommendations for improvement that align with the strategic priorities of the Commission. They will also develop a cross-committee tool to monitor the response to recommendations in a coordinated way. The five mortality review committees will be able to use the tool to track all their recommendations for improvement to identify whether and how DHBs, health providers and health professionals, along with wider government agencies and key stakeholders that influence the determinants of health, have implemented or progressed with them.

The mortality review committees also support a local child and youth mortality review system that operates in DHBs. This system encourages a multidisciplinary and multi-agency approach to review child and youth mortality, in order to apply the learnings locally and nationally.

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
11	Use mortality review to improve systems and practice across sectors, within services and communities, to reduce morbidity and mortality.	The mortality review committees will publish at least two reports by 30 June 2021. The committees will report on the implementation and progress of recommendations every six months. Develop a monitoring tool to track and follow up on recommendations from the reports of the five committees over the previous five years.	In developing and finalising their reports, the mortality review committees consult with key internal and external stakeholders. Two external subject-matter experts will review all published reports. The monitoring tool will provide evidence of clear pathways that have led to recommendation uptake, such as report distribution, ongoing cross-agency relationships and committee membership.	Mortality review committee reports and recommendations lead to measurable improvement and reduced mortality over time. The monitoring tool will help the committees to make their recommendations as influential as possible, maximising their impact.	Systems and practice across sectors, within services and communities, will be improved, to reduce morbidity and mortality within the groups that the mortality review committees focus on.

[20] www.hqsc.govt.nz/publications-and-resources/publication/3903

Improvement science capability

The Commission is continually focused on building leadership capability in quality improvement and patient safety. This work aligns with Government's expectation for the Commission to support a collaborative learning approach to increase capacity and capability for quality improvement and patient safety in the health sector. The Commission will continue to provide the health and disability workforce with quality improvement and safety knowledge and skills appropriate to their roles, and to provide opportunities for professional development and shared learning.

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
12	Strengthen capability in improvement science across the health and disability sector by: sponsoring participation in improvement advisor education and training; implementing a sector-wide system leadership programme for quality and safety; and working with the Ministry of Health to identify requirements for a quality improvement sharing and learning platform.	Up to 20 health care workers complete the improvement advisor education and training programme by 30 June 2021. Up to 60 senior health leaders participate in the system leadership programme for quality and safety by 30 June 2021. Complete specific requirements for the collaborative quality improvement sharing platform by 30 June 2021.	Increased participation from Māori and Pacific providers will be evident by 30 June 2021. Conduct participant evaluations for each course and analyse them for content relevance, best practice and learning outcomes. 80% of participants will report an increased understanding and application of improvement science. Test the requirements with the health and disability sector, and stakeholder networks feed into the quality improvement sharing platform development.	Evidence shows that strengthening capability in improvement science across the health and disability sector improves the quality and safety of health care. Evidence supports networks as a means of improved outcomes. A national collaboration platform with easy access to QI resources and information allows for improved experiences of care and outcomes.	Sharing with and learning from others and strengthened workforce capability will increase patient safety and quality improvement activities and lead to improved quality and safety of care.

Strengthening clinical governance in the health and disability sector

Strong clinical governance is essential to the quality of health and disability services. The Commission will work alongside the Ministry of Health (the Ministry) to undertake a strategic review of clinical governance in the health and disability sector. Our involvement in this process will strengthen the focus on health quality and safety in the review.

SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
13	Strengthen clinical governance in the health and disability sector, by providing strategic leadership in the Ministry-led review of clinical governance in the sector.	Participate in a Ministry-led programme of work that aims to improve clinical governance systems by 30 June 2021.	Provide data, system intelligence and direction in key priority areas of clinical governance as identified by the health and disability system leadership council. The Commission will seek views on ways to enhance the value of its participation in the process, from other agencies involved.	A collaborative approach to system governance of quality, with a diversity of agencies and expertise, will improve experiences and outcomes of health care in Aotearoa New Zealand.	Improved clinical governance of quality will improve the quality of services and the system.

Ngā hononga ki ētahi hunga kē | Third-party partnerships

In addition to carrying out our work that Government funds directly, the Commission partners with third parties when improvement goals fit with our priorities and mandate. DHBs, ACC and the Ministry of Health have contributed funding to our third-party revenue projects. These programmes have helped the Commission expand the scope and scale of improvement work in specific areas.

In contributing to these projects, the Commission brings a focus on improving outcomes for Māori, equity of health outcomes for all and partnerships with consumers. The level of expansion through third-party partnerships within specific areas indicates how highly sector agencies value our role and work. The following are the current projects supported with third-party revenue.

Mental health and addiction improvement

The Commission's DHB-funded national mental health and addiction quality improvement programme started in July 2017. In 2020/21 we will continue to work closely with DHB project teams to implement three improvement projects:

- Zero seclusion: towards eliminating seclusion
- Connecting care: Improving service transitions
- Learning from adverse events and consumer, family and whānau experience.

This programme will have an external independent evaluation in 2020 and the findings will inform its priorities and delivery.

We are working with DHBs to keep mental health quality improvement central to the work programme in the changing environment associated with COVID-19.

Major trauma quality improvement programme

From March 2019 to June 2023, ACC is funding the Commission to provide intelligence and improvement support to the National Trauma Network. This support will build on the work to date and support the network to move towards a sustainable business platform. Areas of focus include traumatic brain injury, major haemorrhage, rehabilitation services and implementing national destination protocols. We will apply an equity lens to all improvement work.

Advance care planning

DHBs are funding the Commission to promote advance care planning within the health sector and to the public. Advance care planning is the process of thinking about, talking about and planning for future health care and end-of-life care. Areas of focus for the programme are promotion, resources, education and training, and monitoring and evaluation. Priority audiences include Māori and diverse communities.

Healthcare associated infections

The Commission has led a national programme in partnership with DHBs and more recently ACC since 2011. Initially the programme focused on a central line associated infection (CLAB) quality collaborative and improving the compliance of health care workers with the World Health Organization's 'five moments for hand hygiene'. The New Zealand surgical site infection improvement programme was added in 2012. In 2019 DHBs agreed to partner with the Commission to support a sustainable extension of the programme's scale and spread.

We are also working with DHBs to ensure that infection prevention and control remains central to the work programme in the changing environment associated with COVID-19.

Paediatric focus in deteriorating patient work

The Commission is working with the Paediatric Society of New Zealand and sector, supporting a working group to reach consensus on national paediatric vital signs charts and early warning scores. The tools and guidance for the national Paediatric Early Warning System will include four vital signs charts to cover ages 0–12+ years, using the same human factors principles as those used for the New Zealand Early Warning System and the Maternity Early Warning System.

Australia and New Zealand Intensive Care Society – clinical register

The Australia and New Zealand Intensive Care Society (ANZICS) is the leading advocate on all matters related to intensive care. ANZICS leads the world in intensive care research through its Clinical Trials Group and patient databases, including the Adult Patient Database, the Paediatric Intensive Care Registry and Critical Care Resources. The Commission holds the contract for the ANZICS clinical register. ANZICS is devoted to all aspects of intensive care medical practice through ongoing professional education.

The Ministry of Health provides funding that goes directly and in total to ANZICS for it to provide the register to New Zealand intensive care units.

Patient experience surveys

We hold the contract for the primary and secondary care patient experience surveys on behalf of the Ministry of Health and DHBs, respectively.

Te hauora me te kaha o te whakahaere | Organisational health and capability

As an improvement organisation, the Commission prioritises our own capability and capacity, so that we are best positioned to help the health sector improve. This section outlines our areas of focus for organisational health and capability in 2020/21.

Fulfilling our responsibilities under Te Tiriti o Waitangi

The Commission is clearly focused on our ability to enact Te Tiriti o Waitangi across all aspects of our work.

Supporting mātauranga and te ao Māori solutions and upholding mana motuhake is central to health system and service improvement in Aotearoa. We recognise te ao Māori values and concepts can be better integrated across health system design and practice in all health settings, as a way of improving access, the quality of health services and health outcomes for all New Zealanders. We embed and reflect Māori worldviews and values, including rangatiratanga, mātauranga, wairuatanga and tikanga, in the Commission's programmes of work.

Continuing to build our internal capability in specific areas

We are increasing the capability of staff to identify inequity and design programmes to improve health equity. Examples of initiatives for this purpose are Health Equity Assessment Tool training, Te Tiriti o Waitangi workshops, the Kapasa policy framework, Yavu – Foundations of Pacific Engagement, and the Rainbow Tick.

The Commission has been successful in achieving the Rainbow Tick (www.rainbowtick.co.nz) and assessed as meeting the Aotearoa New Zealand standard for gender and sexual diversity in employment. We join several public sector agencies that have achieved the Rainbow Tick.

We are committed to strengthening our capability in te ao Māori so that we can embed it more strongly across all of our work.

Like other government agencies, we are looking at ways to make our public-facing documents more accessible.

We will continue to work together to define and develop a culture that enables the Commission to build the skills necessary to provide better support for improving health practice across the health sector.

Governance and strategic advice

The Board of the Commission consists of at least seven members, who are appointed under section 28 of the Crown Entities Act 2004. They provide advice and direction on the Commission's strategic intentions and future direction.

In addition to our Board governance, the Commission gains support for our governance and strategic advice from:

- Te Rōpū Māori, our Māori advisory group
- our consumer advisory group.

Environmental Sustainability Strategy

The Commission recognised early on the possible emissions reductions that could be made through careful purchasing of supplies and services and by off-setting carbon emissions from flight travel. The Commission began off-setting flight carbon emissions through the Fly Neutral programme (run by Air New Zealand) from July 2018 and has also looked to reduce travel itself by using technology such as Zoom to hold meetings rather than having them face to face.

The Commission uses the All of Government procurement templates and Government Electronic Tender Service (GETS) templates, which require suppliers bidding to demonstrate their sustainability strategy.

The Commission staff formed a subgroup to consider other ways to improve sustainability. The subgroup addressed areas such as printing, stationery purchasing and cleaning contracts, all of which promote the use of sustainable and renewable products and low waste. Next steps will be to continue to promote alternatives to travel, use of Zoom for conferences and workshops, and reductions in printing and energy savings in the office.

An Environmental Sustainability Strategy will be developed to document the work already under way as well as that planned. It is expected that the strategy will be complete by 30 September 2020.

Ngā matapae o ngā pūrongo pūtea mō te whā tau ka mutu hei te 30 o Pipiri 2023 | Prospective financial statements for the four years ending 30 June 2023

For the 2020/21 financial year, the Commission has combined the previous two output classes ‘improvement’ and ‘intelligence’ into one output class called ‘supporting and facilitating improvement’. The change is due to the size of the organisation and because the majority of activities planned related to both output classes. Therefore, separate output classes are no longer provided within the SPE.

Prospective statement of comprehensive revenue and expense

	Planned	Forecast	Planned	Planned	Planned
	12 months to 30 June 2020	12 months to 30 June 2020	2020/21	2021/22	2022/23
	$'000	$'000	$'000	$'000	$'000
Revenue					
Revenue from Crown	14,254	14,253	14,253	14,253	14,253
Interest revenue	40	26	20	20	20
Other revenue	4,417	4,623	4,436	4,436	4,436
Total operating revenue	**18,711**	**18,902**	**18,709**	**18,709**	**18,709**
Expenditure					
Salaries	10,885	10,478	10,570	10,615	10,620
Travel	369	301	287	265	265
Consultants and contractors	214	601	214	214	214
Board	219	200	218	218	218
Committees	359	301	309	309	309
Printing/communication	224	195	214	214	214
Lease costs	430	587	525	525	525
Overhead and IT expenses	631	728	671	671	671
Other expenses	8	8	8	8	8
Total internal programme and operating expenditure	**13,329**	**13,399**	**13,016**	**13,039**	**13,044**
Quality and safety programmes	4,051	3,681	4,073	3,778	3,778

Mortality review programmes	1,784	1,722	1,890	1,740	1,740
Total external programme expenses	**5,835**	**5,403**	**5,963**	**5,518**	**5,518**
Depreciation and amortisation	166	180	175	152	147
Total expenditure	**19,330**	**18,982**	**19,154**	**18,709**	**18,709**
Operating surplus/deficit	**(619)**	**(80)**	**(445)**	**0**	**0**

Note: Numbers are rounded. See 'Key assumptions for proposed budget in 2020/21 and outyears' later in this section for explanations.

The 2020/21 planned deficit of $0.445 million relates to revenue received and recognised in prior years for suicide mortality review ($0.170m), mental health quality improvement ($0.100m), expansion of the surgical site infection improvement programme ($0.100m) and the residual of the maternal morbidity improvement programme ($0.075m) where activity is to be delivered in 2020/21 rather than 2019/20.

For 2020/21, revenue assumptions include:

- $12.976 million core Crown revenue
- $0.312 million from the Ministry of Health per year for the Primary Care Patient Experience survey
- $0.750 million from the Ministry of Health for suicide mortality review
- $0.215 million from the Ministry of Health for the Australia and New Zealand Intensive Care Society Centre for Outcome and Resource Evaluation (ANZICS CORE) registry
- $1.500 million per year from DHBs as revenue associated with mental health quality improvement
- $1.229 million for DHB funding of the national data warehouse and expansion of the surgical site infection improvement programme
- $0.791 million from ACC for provision of support for the National Trauma Network
- $0.791 million from DHBs as revenue associated with advance care planning
- $0.125 million from adverse event and leadership workshops
- $0.020 million interest.

Prospective statement of changes in equity

	Planned	Forecast	Planned	Planned	Planned
	12 months to 30 June 2020	**12 months to 30 June 2020**	**2020/21**	**2021/22**	**2022/23**
	$'000	**$'000**	**$'000**	**$'000**	**$'000**
Opening balance	**1,113**	**1,288**	**1,208**	**763**	**763**
Capital contributions	500	500	500	500	500
Total comprehensive income:					
Net surplus / (deficit)	(619)	(80)	(445)	0	0
Balance at 30 June	**994**	**1,708**	**1,263**	**1,263**	**1,263**

Note: Numbers are rounded.

Prospective statement of financial position

	Planned	Forecast	Planned	Planned	Planned
	12 months to 30 June 2020	**12 months to 30 June 2020**	**2020/21**	**2021/22**	**2022/23**
	$'000	**$'000**	**$'000**	**$'000**	**$'000**
Accumulated funds	**944**	**1,708**	**1,263**	**1,263**	**1,263**
Represented by current assets					
Cash and cash equivalents	1,858	2,904	2,196	2,180	2,327
GST receivable	317	106	107	101	101
Debtors and other receivables	261	230	370	370	370
Prepayments	56	105	60	60	60
Total current assets	**2,492**	**3,345**	**2,733**	**2,711**	**2,858**
Non-current assets					
Property, plant and equipment	192	198	313	261	114
Intangible assets	0	0	0	0	0
Total non-current assets	**192**	**198**	**313**	**261**	**114**
Total assets	**2,684**	**3,543**	**3,046**	**2,972**	**2,972**
Current liabilities					
Creditors	1,136	1,124	1,173	1,097	1,097
Employee benefit liabilities	554	711	610	612	612
Total current liabilities	**1,690**	**1,835**	**1,783**	**1,709**	**1,709**
Total liabilities	**1,690**	**1,835**	**1,783**	**1,709**	**1,709**
Net assets					
	994	**1,708**	**1,263**	**1,263**	**1,263**

Note: Numbers are rounded.

Prospective statement of cash flows

	Planned	Forecast	Planned	Planned	Planned
	12 months to 30 June 2020	**12 months to 30 June 2020**	**2020/21**	**2021/22**	**2022/23**
	$'000	**$'000**	**$'000**	**$'000**	**$'000**
Cash flows used in operating activities					
Cash provided from:					
Crown Revenue	14,254	14,253	14,253	14,253	14,253
Interest received	40	26	20	20	20
Other income	4,386	5,195	4,296	4,436	4,436
Cash disbursed to:					
Payments to suppliers	(8,323)	(8,681)	(8,315)	(8,019)	(7,942)
Payments to employees	(10,885)	(10,143)	(10,671)	(10,612)	(10,620)
Net goods and services tax	11	51	(1)	6	0
Net cash flows from (used in) operating activities	**(517)**	**701**	**(418)**	**84**	**147**
Cash flows used in investing activities					
Cash disbursed to:					
Purchase of property, plant, equipment and intangibles	(40)	(12)	(290)	(100)	0
Net cash flows (used in) investing activities	**(40)**	**(12)**	**(290)**	**(100)**	**0**
Cash flows used in financing activity					
Equity injection	0	0	0	0	0
Net cash flows (used in) finance activities	**0**	**0**	**0**	**0**	**0**
Net increase / (decrease) in cash and cash equivalents	(557)	689	(708)	(16)	147
Plus, projected opening cash and cash equivalents	2,415	2,215	2,904	2,196	2,180
Closing cash and cash equivalents	**1,858**	**2,904**	**2,196**	**2,180**	**2,327**

Note: Numbers are rounded.

Declaration by the Board

The Board acknowledges its responsibility for the information contained in the Commission's forecast financial statements. The financial statements should also be read in conjunction with the statement of accounting policies on page 43.

Key assumptions for proposed budget in 2020/21 and outyears

In preparing these financial statements, we have made estimates and assumptions about the future, which may differ from actual results.

Estimates and assumptions are continually evaluated and based on historical experience and other factors, including expectations of future events believed to be reasonable under the circumstances.

As we face the pandemic of COVID-19 in Aotearoa New Zealand, we will see both direct impacts on the health sector itself and effects on our economy and businesses across the nation. In this time of uncertainty, as with others in the sector, our engagement with partners and consumers has been impacted. As such, the financials of this SPE may need to change to accommodate the viability and achievability of our deliverables as the Aotearoa New Zealand health sector recovers from the impacts of COVID-19.

The Commission's role and mandate have gradually grown, as expected, since it began in 2011/12, yet core Crown funding has remained unchanged at $12.96 million.

The Commission sought funding for cost pressures (1.1 million) and put forward a first-draft SPE on the assumption that this funding would be provided. This second, final SPE is put forward on the assumption that there will be no cost-pressure funding. While we continue our targeted quality improvement programmes, building quality improvement sector capability, improving sector data capability and strengthening relationships across the public sector and with Māori and Pacific peoples, our pace will necessarily be slower than if our cost pressures had been addressed through funding.

Each year when developing the SPE, the Board and management continue to look for savings, reprioritisation and compromises to match programme activity to Crown funding levels and absorb any cost pressures. We have a consistent record of delivering our outputs while remaining within budget.

Mechanisms to address cost pressures include working within available funding, keeping indirect organisational costs low, internal prioritisation processes, and working with ACC, the DHB sector, private providers and other stakeholders to identify opportunities that are mutually beneficial to accelerate the delivery timeframes or expand the scope of our work.

Key assumptions are listed below.

- While personnel costs have been assessed on the basis of expected staff mix and seniority, these may vary. Total expenditure will be maintained within forecast estimates, even if individual line items vary. There may be movements between salary, contractor and programme costs.
- Outyear costs in the operating budget are based on a mix of no general inflationary adjustment and limited general inflationary adjustment.
- The timing of the receipt of Crown revenue is based on quarterly payments made at the beginning of the quarter on the fourth of the month.
- Salaries include no increases for staff earning above band 16 for 2020/21.

- The 2020/21 planned deficit of $0.445 million relates to revenue received and recognised in prior years for suicide mortality review ($0.170m), mental health ($0.100m), expansion of the surgical site infection improvement programme ($0.100m) and the residual of the maternal morbidity improvement programme ($0.075m) where activity is to be delivered in 2020/21 rather than 2019/20.
- The Commission continues to work within the assumption of keeping reserve levels of around $1.1 million to $1.3 million.
- Information technology hardware and furniture replacement is planned for 2020/21 and 2021/22.

Pūrongo o ngā kaupapahere kaute | Statement of accounting policies

Reporting entity

The Health Quality & Safety Commission is a Crown entity as defined by the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000 and is domiciled in New Zealand. As such, the Commission is ultimately accountable to the New Zealand Crown.

The Commission's primary objective is to provide public services to New Zealanders, rather than to make a financial return. Accordingly, the Commission has designated itself as a public benefit entity for the purposes of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

Basis of preparation

Statement of compliance

These prospective financial statements have been prepared in accordance with the Crown Entities Act 2004. This includes meeting the Act's requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

The prospective financial statements have been prepared in accordance with Tier 2 public benefit entity accounting standards.

The prospective financial statements have been prepared for the special purpose of this SPE to the Minister of Health and Parliament. They are not prepared for any other purpose and should not be relied on for any other purpose.

These statements will be used in the annual report as the budgeted figures.

The preceding SPE narrative informs the prospective financial statements and the document should be read as a whole.

The preparation of prospective financial statements requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. Actual financial results achieved for the period covered are likely to vary from the information presented and the variations may be material.

Measurement system

The financial statements have been prepared on a historical cost basis.

Functional and presentation currency

The financial statements are presented in New Zealand dollars. The functional currency of the Commission is New Zealand dollars.

Significant accounting policies

The accounting policies outlined will be applied for the next year when reporting in terms of section 154 of the Crown Entities Act 2004 and will be in a format consistent with generally accepted accounting practice.

The following accounting policies, which significantly affect the measurement of financial performance and of financial position, have been consistently applied.

Budget figures

The Commission has authorised these prospective financial statements for issue in June 2020.

The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies the Commission adopted to prepare the financial statements. The Commission is responsible for the prospective financial statements presented, including the appropriateness of the assumptions underlying the prospective financial statements and all other required disclosure. It is not the Commission's intention to update the prospective financial statements after they are published.

Revenue

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

Revenue from the Crown

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

Interest

Interest income is recognised using the effective interest method.

Operating leases

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

Cash and cash equivalents

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

Debtors and other receivables

Debtors and other receivables are measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment.

Bank deposits

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

Inventories

Inventories held for sale are measured at the lower of cost (calculated using the first-in first-out basis) and net realisable value.

Property, plant and equipment

- Property, plant and equipment asset classes consist of building fit-out, computers, furniture and fittings, and office equipment.
- Property, plant and equipment are shown at cost, less any accumulated depreciation and impairment losses.
- The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the Commission and the cost of the item can be measured reliably.
- Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are included in the prospective statement of financial performance.
- Costs incurred after 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 financial performance 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:

- Computers 3 years 33% SL
- Office equipment 5 years 20% SL
- Furniture and fittings 5 years 20% SL

Intangibles

Software acquisition:

- Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.
- Costs associated with maintaining computer software are recognised as an expense when incurred.

- Costs associated with developing and maintaining the Commission's website are recognised as an expense when incurred.

Amortisation:

- Amortisation begins when the asset is available for use and ceases at the date the asset is derecognised.
- The amortisation charge for each period is recognised in the prospective statement of financial performance.
- The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Acquired computer software	3 years	33% SL

Impairment of non-financial assets

Property, plant and equipment, and intangible assets that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate 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.

Āpitihanga 1: Ngā whāinga me ngā mahi a te Kōmihana | Appendix 1: Commission objectives and functions

Objectives of the Health Quality & Safety Commission (the Commission)[21]

The objectives of the Commission are to lead and coordinate work across the health and disability sector for the purposes of:

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

Functions of the commission

The functions of the Commission are:

1. to advise the Minister on how quality and safety in health and disability support services may be improved; and
2. to advise the Minister on any matter relating to —
   - health epidemiology and quality assurance; or
   - mortality; and
3. to 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; and
4. to provide public reports on the quality and safety of health and disability support services as measured against —
   - the quality and safety indicators; and
   - any other information that the Commission considers relevant for the purpose of the report; and
5. to promote and support better quality and safety in health and disability support services; and
6. to disseminate information about the quality and safety of health and disability support services; and
7. to perform any other function that —
   - relates to the quality and safety of health and disability support services; and
   - the Commission is for the time being authorised to perform by the Minister by written notice to the Commission after consultation with it.

In performing its functions, the Commission must, to the extent it considers appropriate, work collaboratively with —

1. the Ministry of Health; and
2. the Health and Disability Commissioner; and
3. providers; and
4. any groups representing the interests of consumers of health or disability support services; and

[21] Section 59B–C, New Zealand Public Health and Disability Act 2000.

5. any other organisations, groups, or individuals that the Commission considers have an interest in, or will be affected by, its work.

Āpitihanga 2 | Appendix 2: SPE deliverables

Strategic priority	SPE	Deliverable	Performance measures		How this will make a difference	Outcome affected
			Quantity	Quality		
Improving experience for consumers and whānau	1	Scope and deliver a co-design programme in primary care that includes reducing inequity in health care as a key improvement factor.	Hold six learning sessions by 30 June 2021. Hold one to two workshops by 30 June 2021.	80% of participants will report having a greater understanding of co-design in primary care and how it contributes to improving health outcomes and addressing inequity. Case studies will be collected from teams participating in the sessions and workshops, and published on the Commission's website by 30 June.	By teaching co-design, we support the primary care workforce to partner with consumers and whānau effectively, so primary care can better understand what matters to consumers and whānau, better meet their needs and improve their health outcomes.	Case studies show that effective co-design is practised within primary care and that primary care is learning about consumer experience and need and responding to it, as a result of learning sessions and workshops.
Improving experience for consumers and whānau	2	Report on patient experience surveys across hospital and primary care.	Four reports will be published.[22] A report analysing the impact of factors including disability on patient experience will be analysed and shared with the sector.	Activities to improve participation rates in Māori and Pacific peoples are tested throughout 2020/21. Patient experience questions around cultural safety are developed, tested and implemented. Given these new approaches, a response rate baseline will be established for monitoring equity.	Measurement and reporting interact with a range of incentives to stimulate improvement by health service organisations.[23] Well-designed reporting provides clear direction and targeting of improvement activities.	Relevant and valid constructs equating to consumer/ patient experience show improvement over time.

[22] This number is lower than in 2019/20 because the May and August surveys may not run due to COVID-19.
[23] Fung et al 2008, *op.cit.*

Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake	3	Develop a te ao Māori quality improvement (QI) framework and implementation guide, and test and consult on it with the wider sector and with Māori health experts.	Hold at least 10 wānanga to develop, test and consult on the framework. Produce the te ao Māori QI framework and implementation guide for publication on the Commission website by 30 June 2021.	The Commission's advisory groups endorse the framework. The Board will endorse the framework by March 2021.	A te ao Māori QI framework and implementation guide will encourage and enable the health workforce to draw on Māori worldviews and models directly in their improvement work, as well as encourage Te Tiriti o Waitangi partnerships.	Drawing on te ao Māori, and strengthening Te Tiriti partnerships, will strengthen and broaden quality improvement practice to better meet the needs of Māori and other groups.
Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake	4	Collect and collate information on te ao Māori models of QI in use across the health sector. Develop a draft set of te ao Māori QI measures with Māori experts, providers and whānau.	Publish our collation of te ao Māori models by 30 June 2021. Develop a draft set of te ao Māori QI measures by 30 June 2021.	Engage at least five Māori providers in our te ao Māori QI framework development. Engage at least five district health boards (DHBs) in work on te ao Māori QI measures.	Developing a collation of Māori QI models of practice will demonstrate the success of Māori QI practice to the sector and encourage general services to learn from te ao Māori. Developing a set of Māori QI measures is fundamental to being able to measure the success of change work, according to te ao Māori standards and worldviews.	Te ao Māori approaches will be better understood and valued within general services. Quality will be able to be measured using te ao Māori measures that emphasise elements valued by Māori.

Achieving health equity	5	Deliver analysis highlighting the broader effects of COVID-19 on the health system, with particular regard to effects on equity of access, quality and outcome.	Analysis will be made available in forms that support the health and disability system to 'recover' in ways that best address pre-existing inequities (by December 2020).	Partner with DHBs, primary health organisations and Māori organisations in producing the analysis.	Measurement and reporting interact with a range of incentives to stimulate improvement by health service organisations.[24]	Responses to the monitoring of access, quality and outcomes of care with an equity lens contribute to demonstrable improvement in these measures over time. Where access, quality or outcomes issues are identified, health services and the system will be able to respond early to improve quality.
Achieving health equity	6	Report variation in access, treatment options, and outcomes of care and experience.	Update at least four Atlas domains. Atlas domains will include analysis across population groups, including Māori and Pacific peoples. All DHBs have actions in their annual plans to improve in the priority areas of asthma, gout or diabetes.	Develop Atlas domains with experts.	Measurement and reporting interact with a range of incentives to stimulate improvement by health service organisations.[25] Well-designed reporting provides clear direction and targeting of improvement activities.	Where indicators have a clear positive direction, improvement at a national level is seen. Where there is no clear positive direction, variation reduces. In both cases, inequity between different groups reduces.
Achieving health equity	7	Publish *Window 2021: A Pacific perspective on health in New Zealand*.	Publish a report by 30 June 2021. Evidence shows we are sharing the report with health sector leaders and providers.	Pacific experts are appropriately engaged in the design and shaping of the report. We will review metrics such as media coverage, downloads of the report, requests for further information and useful work coming out of the report.	This opportunity makes the most of the knowledge and ideas of recognised Pacific leaders, helping to establish and maintain systems that facilitate cultural safety, information sharing, learning, early identification of quality and safety concerns, and appropriate solutions at all levels.	Over time the inequities identified in the report are reduced, and the good practice identified spreads. Understanding, within the health and disability sector, of the different and changing needs and intersectionality of diverse Pacific populations improves.

[24] *Ibid.*
[25] *Ibid.*

Strengthening systems for quality services	8	Strengthen learning from adverse events across the health and disability sector (specifically focusing on intellectual disability services in 2020/21) and improve transparency of reporting through national adverse events dashboards.	Complete three adverse event training workshops that promote the adverse event learning review by 30 June 2021. Up to 150 health care workers complete the two-day adverse event training workshops. National adverse event reporting dashboards are available for the hospital sector by 31 December 2020.	Apply and integrate te ao Māori worldviews across all training and learning. Conduct a survey on the effectiveness of adverse event reporting dashboards in improving transparency of and national learning from adverse events.	Partnering with Māori and including te ao Māori worldviews will provide understanding of Māori experience and understanding of adverse events and of solutions. Training the workforce in adverse event review supports useful reviews that can identify issues and improvements locally. Supporting national reporting can improve transparency and help to share learnings nationally.	Adverse event review will lead to solutions that work better for Māori. Adverse event review will more effectively identify improvements to reduce future events. National sharing and learning from adverse events will improve.
Strengthening systems for quality services	9	Provide quarterly reporting of early identification of potential quality and safety concerns, through a 'Quality Alert'.	The initial design of the Quality Alert approach will be in place and operating from December 2020. At least three Quality Alerts are made available to DHBs from December 2020 onwards.	Feedback will be sought after each version of the Quality Alert, from DHBs. Necessary changes to the Quality Alert will be made within two report cycles.	Measurement and reporting interact with a range of incentives to stimulate improvement by health service organisations.[26] In particular, early warning of deteriorating performance allows organisations and systems to identify problems quickly and respond to them before outcomes deteriorate further. As part of this response, it is possible to expose and deal with underlying systemic issues.	Alerts are addressed and specific examples of concern show improved performance over time.

[26] *Ibid.*

Strengthening systems for quality services	10	Support the implementation of system-level measures in the health sector by building a library of quality measures, for use in the health sector, and for working with Māori to support their data capability in priority areas.	Partially scope and build a measures library. Scope and test a range of options to build capability in using data for quality improvement and achieving equity of outcomes. There will be early engagement with Māori providers to support them in building data capability in priority areas, for example, child health.	The Commission's external expert advisors will endorse progress on the measures library. It will be completed by 30 June 2022. Some partnering with Māori providers will be evident by 30 June 2021.	Responding to measurement and reporting requires development of skills and capabilities in data and analytics. The measures library, by sharing robust and tested measures across the sector, is an essential support to building this capability.	Measures from the library are used within the sector to inform and support improvement, which is reflected in better patient outcomes over time.
Strengthening systems for quality services	11	Use mortality review to improve systems and practice across sectors, within services and communities, to reduce morbidity and mortality.	The mortality review committees will publish at least two reports by 30 June 2021. The committees will report on the implementation and progress of recommendations every six months. Develop a monitoring tool to track and follow up on recommendations from the reports of the five committees over the previous five years.	In developing and finalising their reports, the mortality review committees consult with key internal and external stakeholders. Two external subject matter experts will review all published reports. The monitoring tool will provide evidence of clear pathways that have led to recommendation uptake, such as report distribution, ongoing cross-agency relationships and committee membership.	Mortality review committee reports and recommendations lead to measurable improvement and reduced mortality over time. The monitoring tool will help mortality review committees to make their recommendations as influential as possible, maximising their impact.	Systems and practice across sectors, within services and communities, will be improved, to reduce morbidity and mortality within the groups that the mortality review committees focus on.

Strengthening systems for quality services	12	Strengthen capability in improvement science across the health and disability sector by: sponsoring participation in improvement advisor education and training; implementing a sector-wide system leadership programme for quality and safety; and working with the Ministry of Health to identify requirements for a quality improvement sharing and learning platform.	Up to 20 health care workers complete the improvement advisor education and training programme by 30 June 2021. Up to 60 senior health leaders participate in the system leadership programme for quality and safety by 30 June 2021. Complete specific requirements for the collaborative quality improvement sharing platform by 30 June 2021.	Increased participation from Māori and Pacific providers will be evident by 30 June 2021. Conduct participant evaluations for each course and analyse them for content relevance, best practice and learning outcomes. 80% of participants will report an increased understanding and application of improvement science. Test the requirements with the health and disability sector, and stakeholder networks feed into the quality improvement sharing platform development.	Evidence shows that strengthening capability in improvement science across the health and disability sector improves the quality and safety of health care. Evidence supports networks as a means of improved outcomes. A national collaboration platform with easy access to QI resources and information allows for improved experiences of care and outcomes.	Sharing with and learning from others and strengthened workforce capability will increase patient safety and quality improvement activities and lead to improved quality and safety of care.
Strengthening systems for quality services	13	Strengthen clinical governance in the health and disability sector, by providing strategic leadership in the Ministry-led review of clinical governance in the sector.	Participate in a Ministry-led programme of work that aims to improve clinical governance systems by 30 June 2021.	Provide data, system intelligence and direction in key priority areas of clinical governance as identified by the health and disability system leadership council. The Commission will seek views on ways to enhance the value of its participation in the process, from other agencies involved.	A collaborative approach to system governance of quality, with a diversity of agencies and expertise will improve experiences and outcomes of health care in Aotearoa New Zealand.	Improved clinical governance of quality will improve the quality of services and the system.

Āpitihanga 3 | Appendix 3: How SPE deliverables align with Government expectations

SPE number	1	2	3	4	5	6	7	8	9	10	11	12	13
Enduring priorities, based on Te Tiriti o Waitangi													
Kāwanatanga – partnering and shared decision-making	✓		✓	✓			✓	✓		✓	✓		
Tino rangatiratanga – recognising Māori authority			✓	✓						✓	✓		
Ōritetanga – equity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Wairuatanga – upholding values, belief systems and worldviews		✓	✓	✓			✓	✓		✓	✓		
Strategic priorities													
Improving experience for consumers and whānau	✓	✓	✓	✓	✓		✓	✓					
Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake		✓	✓	✓				✓		✓	✓	✓	
Achieving health equity	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Strengthening systems for high-quality services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Government's expectations: key priorities for the health system													
Improving child wellbeing						✓					✓		
Improving mental wellbeing	✓						✓	✓				✓	
Improving wellbeing through prevention	✓					✓	✓					✓	
Better population outcomes supported by a strong and equitable public health and disability system	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Better population health and outcomes supported by primary health	✓	✓				✓	✓			✓	✓		
Government's expectations: the Commission's contribution													
Achieving equity	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	
Embedding Te Tiriti o Waitangi and achieving pae ora for Māori		✓	✓	✓				✓			✓	✓	
System-wide working					✓	✓			✓	✓	✓		✓
Supporting system-level measures		✓				✓			✓	✓			
QI programmes for safety, quality, health outcomes and health equity	✓		✓	✓		✓		✓	✓	✓		✓	
Collaborative learning platform										✓		✓	
Patient experience surveys		✓											
Supporting the Ministry of Health on performance information and data					✓	✓		✓	✓	✓	✓		✓
Working collaboratively on all publications						✓					✓		
Improved clinical governance	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓

New Zealand Government