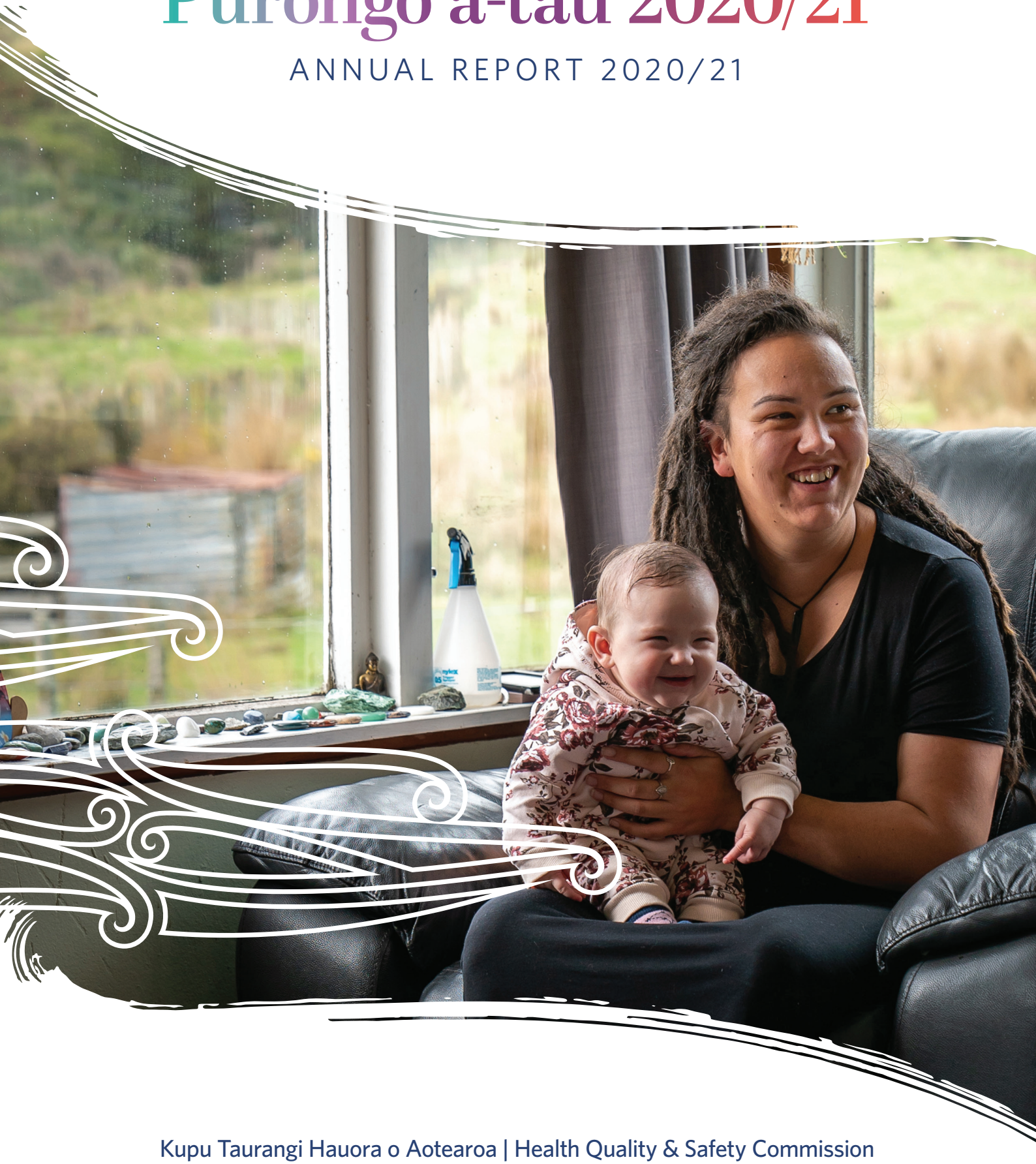
Pūrongo ā-tau 2020/21

ANNUAL REPORT 2020/21



Kupu Taurangi Hauora o Aotearoa | Health Quality & Safety Commission

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

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Cover image: Phoenix Ahomiro and her pēpē Āiorangi, who featured in one of our five videos about giving and receiving culturally responsive care for Te Rā Haumaru Tūroro o Aotearoa | Aotearoa Patient Safety Day 2021.

Tā mātau matakitenga:
Our vision:

Hauora kounga mō te katoa
Quality health for all

Tā mātau uaratanga:
Our mission:

Whakauru. Whakamōhio. Whakaawe. Whakapai ake.
Involve. Inform. Influence. Improve.

Ā mātau kaupapa matua pūmau, i ahu mai i Te Tiriti o Waitangi:
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

Ā mātau kaupapa rautaki matua:
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 high-quality services

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Foreword
Kōrero a mua

The Health Quality & Safety Commission's (the Commission's) annual report for 2020/21 reports against our *Tauākī Koronga | Statement of Intent 2020–24* (SOI)[1] for the first time. As we reflect on our work over the past year, we are mindful of both the present and the future. At the time of writing, Aotearoa New Zealand is managing an outbreak of the Delta variant of COVID-19 against a background of health and disability sector reform. It is a challenging time, but with those challenges come opportunities for improvement.

The Commission is working to embrace and maximise these improvement opportunities while continuing to focus on strengthening and improving the health and disability system, working towards our vision of 'Hauora kounga mō te katoa | Quality health for all'.

As it is the first year of reporting against our current SOI, it is useful to reflect on its development and the core performance challenges we are working to address. In preparing our SOI, we undertook a self-review based on the Performance Improvement Framework[2] to find out how our stakeholders thought we could improve. Those stakeholders set us four performance challenges, which were to:

- embed and enact Te Tiriti o Waitangi within the Commission and all our work, supporting mana motuhake
- set out a clear strategy that places equity at the centre of quality
- develop a new operating model – moving from targeted quality improvement projects to supporting and facilitating system improvement
- build a system more strongly centred on consumers and whānau.

These performance challenges underpin our SOI. One year into our SOI timeline, it is good to report we have progressed against all of them.

In order to embed and enact Te Tiriti o Waitangi within the Commission and all our work and support mana motuhake, we have:

- strengthened and grown our Māori capability, increasing our Māori workforce from 10 percent in 2019 when we did our self-review to 19 percent at the end of 2021
- built a Māori health outcomes team (called Ahuahu Kaunuku) to support and advise us in building effective Te Tiriti o Waitangi partnerships
- built partnerships with Māori in key areas of our work
- continued our staff development in Te Tiriti o Waitangi through courses
- supported staff to establish Te Tira Whakarite (the team that takes forward Te Tiriti in our work). Te Tira Whakarite is working to develop plans and ways of working, sharing and advancing our ability to enact Te Tiriti and support mana motuhake through all our work.

1 Health Quality & Safety Commission. 2020. *Tauākī Koronga | Statement of Intent 2020–24*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/publications-and-resources/publication/4048.

2 Health Quality & Safety Commission. 2019. *Self-review report based on the Performance Improvement Framework | Pūrongorongo arotake whaiaro i whai i te Anga Whakapiki Whakaaturanga*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/publications-and-resources/publication/3916.

This internal work is helping us progress our outward-facing Te Tiriti o Waitangi work and our key strategic priority, 'Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake'. During 2020/21, we also began work in partnership with Māori and the sector to develop a te ao Māori framework for quality improvement in the sector, and indicators to measure progress.

Equity remains central to our work, and central to quality.

- We measure equity and variation across our many indicators, and we have built equity into our new Quality Alerts measures, so equity is at the centre of system thinking about quality and quality risks.
- Equity will be central to the agenda of the Quality Forum (discussed more below), ensuring close national oversight and scrutiny.
- In 2020/21, we completed a report, *Bula Sautu – A window on quality 2021: Pacific health in the year of COVID-19*,[3] which highlighted the challenges faced by Pacific peoples in our health system and their specific needs. It also showed that Pacific peoples bring specific solutions that work for communities, which could help the health system achieve greater health equity for Pacific peoples.

We have carefully considered how we can extend our operating model, so we are working on the system as much as within it.

- In partnership with the Ministry of Health, we have helped to develop the Quality Forum, which brings key agencies together to assess and respond to emerging quality concerns, as a system. We assist and support the Quality Forum with analysis and improvement responses, as needed.
- We have also developed our education and training 'pipeline' so we can help the health workforce build their improvement skills and capability to work in planned quality improvement interventions. A workforce with a good skill base in quality improvement science can undertake local improvement work more independently, enabling us to focus more 'on the system'.

We have also made good progress in our long-standing focus on putting consumers and whānau at the centre of the health and disability system.

- At the time of writing, we are expanding our consumer engagement work in response to the health and disability system reforms. We have developed a draft consumer/whānau engagement code, which will be finalised by July 2022.
- We also began the process of establishing a digital consumer forum to help consumers and providers connect with each other.
- Both initiatives build on our wider programme of work to ensure that consumers and whānau are active partners in health system decision-making and in their care.

While progressing in our four performance challenge areas and advancing our SOI commitments, we have also actively continued to support the sector in managing the COVID-19 response.

- We have continued to build on our COVID-19 resource hub[4] to support health care workers.
- We have developed a quantitative 'rapid effects assessment of COVID-19 on health care' tool that will help the sector understand where the effects of any patient displacement and where extra improvement is needed to help the health system recover.
- We have supported DHBs with infection prevention and control expertise, as well as the Ministry of Health's COVID-19 technical advisory group (TAG) and the TAG's infection prevention and control expert subgroup.
- We highlighted examples of resilient health care in action in response to COVID-19 in a number of online articles[5] and in our *Bula Sautu* report.

Finally, we have enjoyed working in partnership with those shaping the health and disability system reforms to ensure quality, safety and equity are central goals for the reformed system.

We are pleased the Commission's important role in facilitating and overseeing quality in our reformed system has been recognised, and that role looks set to expand as we increase our ability to influence change and improvement effectively in the future.

3 Health Quality & Safety Commission. 2021. *Bula Sautu – A window on quality 2021: Pacific health in the year of COVID-19 | Bula Sautu – He mata kounga 2021: Hauora Pasifika i te tau COVID-19.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/4299.

4 Health Quality & Safety Commission. 2020. *COVID-19 resource hub.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-programmes/other-topics/covid-19-resource-hub/home.

5 Health Quality & Safety Commission. 2020. *Turuki Healthcare and the response to COVID-19 between February and May 2020.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/news-and-events/news/4147. Health Quality & Safety Commission. 2020. *Te Rohe o Te Wairoa, Hawke's Bay, Ngāti Kahungunu and the response to COVID-19 between February and May 2020.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/news-and-events/news/4146.

The 2020/21 year has been enormous. In spite of the tight fiscal environment, the Commission has performed well financially. We started the year expecting an end-of-year deficit of $445,000 and finished the year with a $436,000 surplus, due to savings made from working much more online, travelling less, and from work that was delayed or reprioritised due to COVID-19 activity at the frontline. We will be picking up this work and taking it forward over the next year.

The Commission would like to thank our health workforce for working during an extraordinary time in our history, under intense pressures caused by COVID-19. The Commission will continue to support efforts to improve quality, safety and equity for our workforce as we enter a new chapter in terms of both COVID-19 and health sector reforms.

We look forward to building on our achievements and continuing to make 'Hauora kounga mō te katoa | Quality health for all' part of our future reformed and improved health and disability system.

Dr Dale Bramley
Chair
21 December 2021

Dr Janice Wilson
Chief Executive
21 December 2021

Introduction
Kupu whakataki

This annual report reflects on our work from 1 July 2020 to 30 June 2021 and our progress against the plans that we set in our Statement of Performance Expectations 2020/21 (SPE).[6]

Over 2020/21, the Health Quality & Safety Commission (the Commission) has continued our work to advance our four strategic priorities:

- improving experiences of consumers and whānau
- embedding and enacting Te Tiriti o Waitangi (Te Tiriti), supporting mana motuhake
- achieving health equity
- supporting systems for high-quality services.

Due to the continuing impact of COVID-19 and the start of health sector reform, 2020/21 was both a challenging year for the health sector and a year of many opportunities for improvement. The Commission worked to respond positively to challenges and to maximise opportunities. We worked actively to analyse and understand the impacts of COVID-19 on quality to highlight where improvement is needed and to support that improvement. We also worked to showcase positive and resilient responses from the health sector to COVID-19 that we can all learn from. At the same time, we provided advice and support to those making decisions about health system reform so that quality is central to reform. We facilitated ongoing interaction between health sector key leaders and those working towards reform so that collaboration and consultation with the sector on quality, safety and equity was ongoing. At the same time, we also took our planned work forward, had some notable successes and achievements, and we continued our focus on the impacts and outcomes of our work. This introduction briefly covers each of these areas, and then presents the structure of this report.

6 See: https://www.hqsc.govt.nz/assets/General-PR-files-images/Accountability_documents/StatementPerformanceExpectationJun2020.pdf

We took our planned work forward

Table A summarises our progress against the deliverables we set. The deliverables we fully achieved are represented in the darker green. Those we made progress against, but did not fully achieve, are represented in lighter green.Table A shows that we fully achieved 9 of our 13 deliverables and undertook work towards the other four.

Table A: SPE deliverable status

1	2	3	4	5	6	7	8	9	10	11	12	13

Section 1 of this annual report details our report against the expectations that we set. We also discuss the areas where we did not meet our expectations, highlighting the barriers we encountered and the lessons that we have learned.

We had notable successes and achievements

- **Consumer engagement quality and safety marker – a world first**

  The consumer engagement quality and safety marker (QSM) was rolled out to all district health boards (DHBs) to answer the question: 'What does successful consumer engagement look like, and (how) does it improve the quality and safety of services?'

  We now have baseline data to understand where services assess themselves and what actions need to be taken to improve consumer engagement across the system. We believe this to be the first national consumer-focused QSM across the world. At the time of writing this report, the Commission has increased our consumer and whānau partnership work to deliver the consumer voice component required to support health reform. The QSM will be one pillar to inform our understanding as this work is progressed.

- **Work to prevent the deterioration of patients has had positive results**

  Acute deterioration can happen at any point during a patient's admission to hospital. If acute deterioration is recognised early and responded to appropriately, patient outcomes can be improved.

  As a result of the patient deterioration programme:

  — all 20 DHBs have implemented clinical improvements to their adult recognition and response systems across their hospitals.

  — the national adult vital signs chart with the New Zealand early warning score (in paper or electronic equivalent format) is used across the country. This national standardisation means that when clinicians move between hospitals they know how to use this clinical tool and what the different parameters mean.

  The patient deterioration programme has resulted in a 40 percent increase in rapid response team escalations, and a statistically significant decrease in hospital cardiopulmonary arrests, avoiding around 200 to date.

- **Maternity early warning system (MEWS) programme improves care for women**

  The MEWS programme aimed to reduce harm through a nationally consistent, standardised approach to recognising and responding to the acute deterioration of pregnant or recently pregnant inpatient women. All 20 DHBs have now implemented MEWS in their maternity services. Fourteen DHBs have also implemented MEWS across the whole of hospital as of December 2020, with the remaining DHBs to implement hospital wide in 2021.

  Outcome data from Auckland DHB, an original test site for MEWS implementation, has demonstrated a statistically significant reduction in emergency code calls for deteriorating pregnant women and cardiorespiratory arrest calls following implementation of MEWS.

- **COVID-19 health sector improvement and recovery**

  As a part of taking forward our strategic priorities, we undertook analysis and reporting to support the health sector to 'recover' from the impacts of COVID-19. Our work has shown where improvement focus is warranted through a quantitative 'Rapid Effects Assessment of COVID-19 on Healthcare Tool' that we provided to support the sector.

Some other achievements from 2020/21

- We updated more than 200 online quality indicators to help the sector understand where their quality strengths and challenges are, and we have developed 'Quality Alerts' to pinpoint areas of potential concern for the sector to follow up on.
- We delivered at least 24 reports and publications, and 17 newsletters highlighting information and resources to help the health sector improve.
- We trained more than 1,000 people in our seminars, workshops, and education and training courses.

Our work has also highlighted positive, innovative and resilient responses to COVID-19 that we can all learn from. We highlighted kaupapa Māori interventions in a series of online videos,[7] and we highlighted Pacific responses in our *Bula Sautu* report.[8]

- **Our *Bula Sautu* report on Pacific health has attracted considerable public interest**

  Launched in Parliament by Minister Aupito William Sio, *Bula Sautu* met with widespread mainstream and health media coverage that drew upon multiple strands of the life course analysis approach used. The findings of *Bula Sautu* were profiled at conferences and introduced to several government agencies tasked with improving health outcomes for Pacific peoples.

  During the August 2021 outbreak of the Delta variant of COVID-19, findings from the COVID-19 chapters of *Bula Sautu* were referred to in media to help with structuring the correct response for Pacific peoples, and to encourage the widespread successful vaccination campaign that was undertaken.

- **Our te ao Māori quality improvement framework has already been embraced by the sector**

  Our te ao Māori framework development has created a large amount of interest and has been embraced by Māori and non-Māori alike as a key means of promoting quality in ways that draw on mātauranga

7 See: https://www.hqsc.govt.nz/our-programmes/other-topics/covid-19-resource-hub/sharing-experiences-to-learn and https://www.hqsc.govt.nz/news-and-events/news/4146/

8 See: https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/4299/

and te ao Māori worldviews. We found that we needed to slow our plans so that we could take advantage of the opportunities to engage and partner with those who wanted to share their knowledge and perspectives. An interim te ao Māori framework is on our website,[9] and over the next year we are developing an implementation guide to assist the sector.

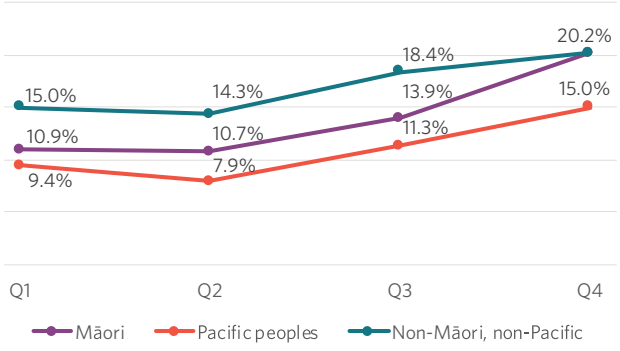
The te ao Māori framework will support the implementation of *Whakamaua: Māori Health Action Plan 2020–2025*[10] and will strengthen the use of te ao and mātauranga Māori across the health sector.

- **Our work to increase response rate equity for primary care patient experience surveys has already shown improvement**

  Our efforts to develop representative patient experience survey response rates have paid off already within primary care (see Figure A). Specifically targeted interventions to encourage Māori and Pacific peoples to respond to patient experience surveys in primary care have already shown increased rates.

  This sets a model that we can use more broadly across our programmes.

Figure A: Adult primary care survey



- **We are building system leadership capability**

  We have delivered an education programme – 'Systems leadership for quality and safety' – to sector leaders committed to improving quality and safety at a group, department or organisation level. The programme learning objectives focused on:

  — the health and disability system as a complex adaptative system

  — the use of evidence and data to drive improvement and innovation

  — working with others across professions, organisations and cultural boundaries to achieve quality and safety goals.

- **Our efforts to implement Te Tiriti o Waitangi are having a positive effect**

  Our efforts to create a more bicultural workplace and our focus on Māori health outcomes, including the establishment of a team with this focus (Ahuahu Kaunuku), is improving our ability to attract and retain Māori staff. Nineteen percent of our staff identify as Māori at the time of writing this annual report, which is close to the levels of the population of New Zealand (16.7%[11]). This mix of staff is helping us ensure that mātauranga Māori is embedded in and strengthening all the work that we do. Not only does the Commission benefit – but also the sector benefits from what we are able to share and how we can support them.

- **An important mortality review recommendation for neonatal health has been implemented**

  The Perinatal and Maternal Mortality Review Committee (PMMRC) 7th report (released in 2013) recommended that **'achieving optimal use of periconceptional folate by young women in New Zealand requires a policy for fortification of bread'.** The recommendation was repeated in the PMMRC 13th report (2019) and again in 2020, this time as an urgent recommendation:

  'URGENT RECOMMENDATION: We strongly recommend to the Government/Ministry for Primary Industries that folic acid fortification of bread be mandatory to reduce both mortality and serious morbidity from neural tube defects.'

  Government is mandating that folic acid will be added to bread, eight years after the PMMRC urgently called for folic acid to be added to bread.[12] The perseverance of the PMMRC has paid off, and we expect to see a reduction in the number and severity of babies born with neural tube defects.

- **Our efforts to influence quality improvement sustainability**

  Improvement programmes effect change, and it is hoped that improvement is sustained in the long term through embedded learning, processes and systems. It is great that we could move two quality safety marker process measures to a sustainability phase this financial year (Falls in March 2021 and Safe Surgery in June 2021). The Commission will continue to monitor quality safety marker outcome measures. Professor Ian Civil, clinical lead of the Commission-led Safe Surgery NZ programme, says: 'The programme's achievements were significant, and the challenge now is for individual organisations and operating facilities to use and maintain initiatives that make surgery safer.'

9 See: https://www.hqsc.govt.nz/publications-and-resources/publication/4355/

10 See: https://www.health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025

11 See: https://www.stats.govt.nz/information-releases/maori-population-estimates-at-30-june-2020

12 See: https://www.stuff.co.nz/national/health/300352263/government-to-mandate-folic-acid-in-most-breadmaking-flour-to-protect-babies

As part of ensuring the sustainability of improvements gained in the patient deterioration programme, we have developed a Patient Deterioration Systems Tracer Audit Guide to support auditors with what to look for in terms of best practice.

We focused on impacts and outcomes

As well as working to move forward with our planned work, we have also had an eye on our impacts and outcomes and how we are progressing against these. We see some promising early signals which suggest that our work is on the right track to achieve our longer-term outcome goals.

All our work, alongside the work of others, contributes towards outcomes, which feed up and contribute to our vision (see the cover page), which also feed up and contribute towards the Government's goals for the health and disability sector and their wellbeing priority 'Physical and mental wellbeing – supporting improved health outcomes for all New Zealanders'.[13]

Table B outlines our strategic priorities and the high-level outcomes we hope our work contributes to, with timeframes over which we might expect to see change, and also reports on what change we can see now. We have reported progress made this year and highlighted key achievements in bold. We have also included relevant achievements from prior years that are relevant for each area, and for the future.

13 For detail of how outcomes contribute, please see our outcomes framework in Appendix 1.

Table B: Progress towards longer-term outcomes our work contributes to

Strategic priorities	What outcomes we hope to see[14]	What we have achieved this year **Key achievements (bold)** ***What we achieved prior* (italic)**	Future plans[15]
Improving experience for consumers and whānau	Improved patient and whānau experience as a result of improvements made by providers, which they were supported to make by learning from patient experience surveys (3–5 years)	*Between 2014 and 2019, 20% of questions asked in the hospital patient experience survey showed sustained improvements in reported experience.* In 2020, both inpatient and primary care surveys were refreshed. Since August 2020, baselines for a total of 31 new questions in the hospital survey and 49 new questions in the primary care survey were established. **New baseline established.**	Change from these baselines will be measured. It will take a minimum of two years to identify sustained change from a baseline, with expectation that we start to see clear patterns of improvement from 2024 onwards.
	Patient and whānau measures and reporting across our programme areas (qualitative and quantitative) indicating improvement in engagement and experience (3–5 years)	A baseline has been established for the Consumer QSM. **Baselines established.**	Change from these baselines will be measured. It will take a minimum of two years to identify sustained change from a baseline, with expectation that we start to see clear patterns of improvement from 2024 onwards.
Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake	Improved Māori patient experience surveys results (%) from baselines (3–5 years)	Baseline measures established for Māori respondents for the 31 and 49 questions in our two patient experience surveys. **Baselines established.**	Change from these baselines will be measured. It will take a minimum of two years to identify sustained change from a baseline, with expectation that we start to see clear patterns of improvement from 2024 onwards.
	Qualitative and quantitative measures and reporting across programme areas that show improved health equity for Māori (3–5 years)	*Reduction in inequity for surgical site infections following hip and knee replacements from a rate twice as high as for non-Māori, non-Pacific, to statistically identical between 2014 and 2016.*	Reporting by ethnicity on all QSM outcomes will continue. We expect to see maintenance of equity where this exists, and achievement of equity in new programmes.
	Improved Māori health outcome measures (5–10 years)	**Baselines established.**	Progress on all measures in the Māori health equity report will be tracked – and baselines for 2018–20 are available.
Achieving health equity	Maintained or improved patient experience survey representativeness, particularly for groups experiencing health inequity (3–5 years)	A series of technical fixes, including provision of free data and coupling of text and email invitations, led to increased survey response rates. • **The Māori primary care survey response rate increased from 11% to 20% (equal with non-Māori, non-Pacific) between August 2020 and May 2021.** • **The Pacific primary care survey response rate increased from 9% to 15% between August 2020 and May 2021.**	Continued maintenance and improvement of Māori and Pacific survey response rates will be monitored.
	Reductions in unwarranted health care variation measures across population groups (3–5 years)	All Atlas measures are broken down by ethnicity, of which there are well over 100. *There are numerous examples of significant increases in equity, including asthma inhaled corticosteroid dispensing, gout hospital admissions, non-steroidal anti-inflammatory drug use with no urate-lowering therapy, and maternity low birth-rate babies. However, interpretation is complex, because there are many factors contributing to unwarranted variation.*	We will continue to monitor all Atlas measures.
	Greater health equity in our system and programme measures (3–5 years)	*Reduction in inequity for surgical site infections following hip and knee replacements from a rate twice as high as for non-Māori, non-Pacific to statistically identical between 2014 and 2016, and the reduction has been maintained.*	Reporting by ethnicity on all QSM outcomes will monitor maintenance of equity where this exists, and achievement of equity in new programmes.

14 These outcomes were clarified in our 2021/22 SPE.

15 Based on quarterly reporting it takes at least two years to identify sustained and significant improvements from the point at which a baseline is set. To avoid seasonal effects distorting baselines, these need to be collected over the minimum of one year. In addition, the distorting effects of COVID-19 on the operating of the health system (eg, changing case mixes of admitted patients) may further extend the period required to have confidence that improvements are genuine, significant and sustained.

Strengthening systems for high-quality services	Reduced mortality over time in mortality review cohort groups (long term, intergenerational)	*There was a steep reduction in child and youth deaths between 2011 and 2014 – equivalent to around 100 deaths per year.*	Key group mortality rates will continue to be monitored, with a specific focus on deaths likely to be amenable.
	Improved quality and safety measures within our programme areas (2–5 years or longer)	*Since their inception, the following improvements in outcomes and processes associated with the Commission's quality and safety programmes have been identified:* • *Falls – 25% reduction in falls with a fractured neck of femur equating to 175 avoided fractured necks of femur. The patient deterioration programme has resulted in a 40% increase in rapid response team escalations, and a statistically significant decrease in hospital cardiopulmonary arrests, avoiding around 200 to date.* • *Safe surgery – 673 post-operative deep vein thromboses (DVTs)/pulmonary embolisms (PEs) avoided.* • *Infection prevention and control – 17% reduction in post-operative infections for hips and knees equating to 92 avoided infections; 18% reduction in post-operative infections for cardiac surgery equating to 81 avoided infections.* • *The Commission supported 18 improvement projects in primary care, and 14 of 18 showed measurable improvement.*	For all past, continuing and future quality improvement programmes, we will measure key outcomes to quantify avoided harms.
	Reduced number of disability adjusted life years (DALYs) lost due to complications and poor outcomes within our programme areas (2–5 years)	*Based on published estimates of the DALYs loss associated with specific health care related harms, we can estimate the following DALYs avoided to date:* • *Falls – 175 avoided fractured necks of femur = 287 DALYs avoided.* • *Safe surgery – 673 post-operative DVT/PEs avoided = 397 DALYs avoided.* • *Infection prevention and control – 173 avoided post-operative infections = 87 DALYs avoided.*	For all past, continuing and future quality improvement programmes, we will measure key outcomes to quantify avoided harms and seek estimated DALY losses associated with these.
	Reduced bed-days within our programme areas (2–5 years or longer)	*Re-admission (second admission) of older people as a result of an emergency was reduced, resulting in 98,000 fewer bed-days between June 2014 and June 2019.*[16]	Historically, we have focused on bed-days, but we now have measures and indicators that are more useful (such as DALYs and direct measures of harm and/or cost). However, we will continue to measure bed-days when these are relevant.

16 https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/Open4ResultsJune19_final_July2019.pdf

How this report is organised | Te raupapa o te pūrongo nei

In our 2020/21 Statement of Performance Expectations (SPE), the Commission moved from the two output classes that we used to describe 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.

For our single output class, the Commission's part of this annual report is organised into four parts.

- **Part 1 – Our performance statement** covers the standards of delivery performance we achieved compared with the forecast standards in our 2020/21 SPE.
- **Part 2 – Other work that strengthens our performance** covers broader organisation performance information, showing how we strengthen and develop our organisation's performance, as well as the work that we do outside of our SPE.
- **Part 3 – Our financial statements** covers the actual revenue earned, and output expenses incurred, compared with the expected revenues and proposed output expenses included in our SPE.
- **Part 4 – Statement of responsibility | Te whakapuakitanga kawenga** completes our annual report.

The final part of this annual report is made up of Audit New Zealand's audit report on the Commission's work.

Part 1 – Our performance statement

Wāhanga 1 – Tā mātou mahi

This part of our annual report details our performance against the work and deliverables we planned in our SPE. We have reported within each strategic priority area, looking at each deliverable we set.

We report on each of our 13 planned deliverables in tables. The row labelled 'Plan' shows the work that we agreed to deliver in our 2020/21 SPE. The row labelled 'Report', identifies how we have progressed in delivering to our plan. We also use a simple colour coding system to readily identify our performance.

Fully achieved	**Partially achieved**	**Not achieved**	**These indicators were not measured, unless specified, as they are longer-term measures.**
Every requirement of this section of the deliverable was fully achieved.	This requirement of the deliverable was partially achieved.	This deliverable was not achieved.	Table B (page 10) provides available information on what we know of progress towards our longer-term outcome goals.

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

Established evidence shows that engaging consumers and whānau is related to better health and care outcomes.[17] 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.

In 2020/21, we planned and delivered work in two specific areas to help the sector to improve consumer and whānau experience:

- **engaging and co-designing with consumers (SPE 1)**
- **responding to patient experience in hospital and primary care (SPE 2).**

17 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).

Work plan and report table 1: Engaging and co-designing with consumers (SPE 1)

Our work plan for deliverable 1 was ***fully achieved***.

1	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	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.
Report	The primary care co-design programme, with a focus on health inequity, was scoped and delivered.	We completed six learning sessions. We completed eight workshops by 30 June 2021.	Twenty-one of the 24 survey respondents (87.5%) who participated in the co-design workshop agreed or strongly agreed that 'I learned new knowledge or skills from this workshop'. In addition, the mean score of pre- and post-programme self-rating for 'confidence to apply experience based co-design' increased from 3.7 to 7.2 (a 94% increase).[18] Four case studies were collected from teams participating in the sessions and workshops and published on the Commission's website by 30 June.[19]		Four 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.

18 Participant feedback: https://www.hqsc.govt.nz/our-programmes/partners-in-care/publications-and-resources/publication/4322/

19 Case studies: https://www.hqsc.govt.nz/our-programmes/partners-in-care/work-programmes/co-design/#2020/2021

Work plan and report table 2: Responding to patient experience in hospital and primary care (SPE 2)

Our work plan for deliverable 2 was ***fully achieved.***

2	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	Report on patient experience surveys across hospital and primary care.	Four reports will be published. 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.[20] Well-designed reporting provides clear direction and targeting of improvement activities.	Relevant and valid constructs equating to consumer/patient experience show improvement over time.
Report	We reported on patient experience surveys across hospital and primary care.	We published six reports on a secure portal.[21] We shared a report analysing patient experience for people with disabilities with the sector at an integrated advisory group meeting on 17 June 2021.	A range of activities to improve participation rates in Māori and Pacific peoples were tested throughout 2020/21. These included shortening the URL addresses in the survey invitations and pairing of SMS and email notifications for survey participation. A response rate baseline was established for monitoring equity. The baseline was set at Quarter 2 of 2020/21 and is shown in the graph on page 8. Patient experience questions around cultural safety were developed, tested and implemented. The Commission's mahi (work) to identify key concepts and questions to measure patient experience of culturally safe care was guided by a specially convened Māori and Pacific cultural support expert advisory group. The mahi included a literature review and identifying and reviewing existing cultural safety frameworks. The Patient Experience of Care Governance Group and Te Rōpū, the Commission's Māori governance board, both provided feedback. We then devised some draft questions and sought feedback on these from stakeholders from both primary and hospital health care. The questions then went through cognitive pre-testing. Results from patients were collected for the first time in the February 2021 survey round.		

20 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).

21 Six reports were published (three hospital; three primary care), updated on 29 September 2020, 13 October 2020, 18 January 2021, 11 February 2021, 23 April 2021 and 07 May 2021.

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

We want partnerships based on Te Tiriti so that the whole health and disability system and all services support mana motuhake. Our health and disability system and services must have 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 planned and delivered work in two specific areas in 2020/21 to embed and enact Te Tiriti and support mana motuhake:

- **implementing a te ao Māori quality improvement framework (SPE 3)**
- **developing Māori-determined quality improvement measures (SPE 4).**

Work plan and report table 3: Implementing a te ao Māori quality improvement framework (SPE 3)

Our work plan for deliverable 3 was ***partially achieved.***

3	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	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 health care in Aotearoa.
Report	We worked to develop a te ao Māori quality improvement (QI) framework and implementation guide and tested and consulted on it with the wider sector and with Māori health experts.	We held 14 wānanga in total, with Māori providers (8); DHBs (5) and Te Tumu Whakarae (DHB Māori general managers group) (1). We also regularly engaged with te rōpū tohunga, as our expert advisory group and Te Rōpū, the Commission's Māori governance board. The wānanga assisted us to develop, test and consult on the framework. The te ao Māori QI framework was not finalised and published on the Commission's website within the 2020/21 year.	The Commission's advisory groups endorsed the framework in May 2021. The Board endorsed the framework by June 2021. The framework was endorsed in June by the Board rather than March, as further engagement and sessions with advisory boards and the Board itself was required. The draft framework was discussed with Te Rōpū every month during 2021, with drafts of the framework going to three Board meetings during 2021.		

Our work plan for deliverable 3 was ***partially achieved***, as there was a clear need to respond and partner with multiple interested stakeholders in the co-design of the te ao Māori quality improvement framework. Our work plan was delayed so that we could engage more fully, in recognition of the importance of this work. Work will continue in 2021/22.

Understanding quality improvement from a te ao Māori worldview is important to address challenges and barriers that affect Māori health and wellbeing and to improve the quality of health care provided in Aotearoa. In 2020/21, we set out to develop a te ao Māori framework and an implementation guide to advance the uptake and implementation of te ao Māori and mātauranga concepts into general health system design and health practice for all, ultimately aiming to improve the quality of care delivered to and for whānau Māori.

However, we quickly identified that more wānanga were required than we had initially planned. There was wide interest, and many wanted to participate in this important work aimed at improving the health system for Māori. It became clear that we needed to take the time necessary to ensure wide involvement, to maximise the opportunity to gain knowledge, and to influence health equity, embed and enact Te Tiriti and support mana motuhake.

As a result, in early 2021 we changed our plan and engaged with an extra eight Māori health service providers, the Māori groups in three DHBs and four expert advisory groups. In total, approximately 120 individuals participated in the offered wānanga, across Aotearoa. Extensive consultation also occurred with our governance groups.

An implementation framework and set of measures is under development to support the framework. However, as the framework has required more co-design than had been anticipated, the implementation approach and measures were also delayed and require further testing and adjustment through piloting with organisations over the next year. This process has been written in to the 2021/22 SPE.

Based on best practice, evidence and multiple wānanga, the te ao Māori framework includes four key concepts:

- Wairuatanga – the framework will centre wairuatanga, which makes culture key to the design and delivery of care. Wairuatanga is a constant that also permeates and resonates within the other concepts.
- Pātuitanga – to grow and foster strong partnerships in shared power relationships.
- Rangatiratanga – the right to choose, and decision-making power over our own affairs.
- Whānau – whānau need is at the forefront of service design and delivery.

Work plan and report table 4: Developing Māori-determined quality improvement measures (SPE 4)

Our work plan for deliverable 4 was ***fully achieved.***

4	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	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.
Report	We collected and collated information on te ao Māori models of QI in use across the health sector. We developed a draft set of te ao Māori QI measures with Māori experts, providers and whānau.	We published our collation of te ao Māori models by 30 June 2021, within a literature review on Māori models in use across provider settings. We developed a draft set of te ao Māori QI measures by 30 June 2021.[22]	We engaged eight Māori providers in our te ao Māori QI framework development. We engaged directly with four DHBs in interviews and wānanga, and we engaged with Te Tumu Whakarae (the DHB Māori general managers group which represents all 20 DHBs) as an expert advisory group on te ao Māori QI measures.		

22 The draft set of measures were completed and are visible in the Implementation Plan which was endorsed by the Board at their June 2021 Board meeting. The measures are part of the pilot approach which will occur in the 2021-22 period with a set of specific providers.

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

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

In 2020/21, we set three specific SPE deliverables within our 'achieving health equity' priority. These included:

- analysing the effects of COVID-19 (SPE 5) to better understand impacts on health quality, safety and equity
- continuing the New Zealand Atlas of Healthcare Variation (SPE 6) to highlight areas of inequity where further action is needed for improvement
- sharing *Window 2021: A Pacific perspective on health in New Zealand* (SPE 7), highlighting data analysis and lessons learnt from Pacific health experts and consumers.

Work plan and report table 5: Analysing the effects of COVID-19 (SPE 5)

Our work plan for deliverable 5 was ***fully achieved.***

5	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	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.[23]	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.
Report	We delivered analysis highlighting the broader effects of COVID-19 on the health system, with particular regard to effects on equity of access, quality and outcome.	We made quantitative analysis (in a COVID-19 tool) available in December 2020 to DHB leads (via password) as part of a suite of Quality Alert tools. We offered assistance to ensure information was as useful as possible for the DHB to address inequity and return any areas of delay to pre-COVID-19 levels. We also undertook qualitative analysis work to highlight positive kaupapa Māori responses to COVID-19 in a set of five online videos and a series of articles that highlight resilient health care in action. This series provided accessible and useable analysis for the sector to learn from. These resources were promoted in the Commission's E-Digest and are available on our website.[24]	Development took place with Waitematā DHB and was consulted on and shared with Te Rōpū Whakakaupapa Urutā, the Māori group that was formed to respond to COVID-19. We partnered with providers, including kaupapa Māori providers, to complete these videos and articles.		

23 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).

24 See: https://www.hqsc.govt.nz/our-programmes/other-topics/covid-19-resource-hub/sharing-experiences-to-learn and https://www.hqsc.govt.nz/news-and-events/news/4146/

Work plan and report table 6: Continuing the New Zealand Atlas of Healthcare Variation (SPE 6)

Our work plan for deliverable 6 was ***fully achieved***.

6	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	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.
Report	We continued to report variation in access, treatment options, and outcomes of care and experience.	We updated seven Atlas domains, including analysing population groups, including Māori and Pacific peoples.[26] All DHBs' annual plans are required to meet quality requirements, including addressing equity in at least one of three priority areas (covered in the Atlas) – asthma, gout or diabetes. These are requirements through the Ministry of Health performance processes.	The Contraceptive Atlas was developed in collaboration with experts and was released in December 2020.		

25 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).

26 Contraceptive use by women (7 December 2020): https://public.tableau.com/app/profile/hqi2803/viz/Contraceptionsinglemap2020/AtlasofHealthcareVariationContraception

Diabetes (19 February 2021): https://public.tableau.com/app/profile/hqi2803/viz/DiabetesAtlas2020/AtlasofHealthcareVariationDiabetes

Maternity (9 October 2020): https://public.tableau.com/app/profile/hqi2803/viz/MatenitysinglemapdraftOctober2020/AtlasofHealthcareVariationMaternity

Gout (18 March 2021): https://public.tableau.com/app/profile/hqi2803/viz/Goutsinglemapdraft2021/AtlasofHealthcareVariationGout

Patient deterioration (11 March 2021): https://public.tableau.com/app/profile/hqi2803/viz/AtlasofHealthcareVariationPatientDeterioration/AtlasofHealthcareVariationPatientDeterioration

Polypharmacy (25 June 2021): https://public.tableau.com/app/profile/hqi2803/viz/Polypharmacysinglemap/AtlasofhealthcarevariationPolypharmacy

Surgical procedures (11 September 2020): https://public.tableau.com/app/profile/hqi2803/viz/SurgicalProceduressinglemap/AtlasofHealthcareVariationSurgicalprocedures

Work plan and report table 7: Sharing *Window 2021: A Pacific perspective on health in New Zealand* (SPE 7)

Our work plan for deliverable 7 was effectively ***fully achieved.***

7	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	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.
Report	We developed, completed and published the report, providing it to a limited number of stakeholders under embargo before 30 June 2021. However, we were required to delay public release of the report – titled *Bula Sautu – A window on quality 2021: Pacific health in the year of COVID-19* – until 5 July, at the request of the Associate Minister of Health, to enable a Parliamentary launch.	The report was developed and published by 30 June 2021, and was circulated under embargo to key stakeholders. However, public release of the report was delayed until 5 July, at the request of the Associate Minister of Health, to maximise opportunities for publicity and sector impact.[27] *Bula Sautu* was launched by Minister Aupito William Sio, Minister for Pacific Peoples and Associate Minister of Health,[28] at a Parliamentary launch (155 guests attended). Guests included Pacific health sector leaders and providers and senior system leaders.	Pacific Perspectives were engaged to develop the report in partnership with us. They have been front and centre of the presentation of the report along with Pacific Commission Board member, Dr Colin Tukuitanga. Maven (Pacific PR firm) was engaged by the Ministry of Health to present the report to the Pacific community. Media coverage has been extensive following the launch. A report of metrics is available on request.		

27 See: https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/BulaSautu_WEB.pdf

28 See: https://www.beehive.govt.nz/speech/speech-launch-bula-sautu

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

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

In 2020/21 six workstreams aimed at strengthening systems to support high-quality services were progressed. These were:

- learning from adverse events (SPE 8) – supporting a national approach to reporting, reviewing and learning from adverse events and near misses
- providing 'Quality Alerts' (SPE 9) – bringing together information and indicators in a comprehensive report on each DHB to identify quality issues and make clear comparisons, supporting better understanding of quality strengths and weaknesses and where improvement efforts should be directed
- supporting system-level measures (SPE 10) – scoping a measures library to support the sector in implementing measures across the health system and educational options to support use
- continuing mortality review (SPE 11) – improving systems and practice within services and communities in ways that reduce morbidity and mortality
- building improvement science capability (SPE 12) – supporting the health and disability sector workforce to improve capability and strengthen skills in quality improvement
- strengthening clinical governance in the health and disability sector (SPE 13) – working alongside the Ministry of Health in a strategic review of clinical governance, bringing a focus on health quality and safety.

Work plan and report table 8: Learning from adverse events (SPE 8)

Our work plan for deliverable 8 was ***partially achieved***.

8	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	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.
Report	We strengthened learning from adverse events across the health and disability sector (specifically focusing on intellectual disability services in 2020/21) and improved transparency of reporting through national adverse events dashboards.	We completed five adverse event training workshops that promote the adverse event learning review by 30 June 2021. 162 of the 197 registered health care workers for the workshops completed the full 8-hour workshop and their 8 hours of online learning. National adverse event reporting dashboards were available by December 2020.[29]	The new virtual and online adverse events learning programme curriculum incorporates a culturally appropriate review component, and the Commission is working to ensure that te ao Māori worldviews are integrated into all our learning and training on an ongoing basis. The national adverse event reporting policy 2017 has been reviewed to reflect a te ao Māori worldview. As a result, the virtual and online adverse events learning programme curriculum will be reviewed to reflect these changes in 2021/22. The survey was not completed within the year.		

29 See https://reports.hqsc.govt.nz/AdverseEventsQuarterly/_w_1130dbc9/#!/

Our work plan for deliverable 8 was *partially achieved*. We undertook more workshops and trained more people than we anticipated, and we released the national adverse events reporting dashboards online within the required timeframes.

However, we were unable to complete the required survey on the effectiveness of adverse event reporting dashboards in improving transparency and national learning during the year.

While we progressed with incorporating te ao Māori worldviews throughout our learning and training in 2020/21, this will require ongoing efforts into the future.

We expect to continue with this work after the current COVID-19 outbreak has resolved.

Work plan and report table 9: Providing 'Quality Alerts' (SPE 9)

Our work plan for deliverable 9 was ***fully achieved.***

9	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	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.[30] 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.
Report	We provided quarterly reporting of early identification of potential quality and safety concerns, through a 'Quality Alert'.	Initial design included the quality priorities of the quality dashboard (first released 20 October 2020). Three Quality Alerts, including the addition of the COVID-19 tool in the December version, occurred December, April and June.	Feedback was sought after the initial release and each update, and the Quality Alert has continued to evolve and improve in response to sector feedback.		

30 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).

Work plan and report table 10: Supporting system-level measures (SPE 10)

Our work plan for deliverable 10 was ***fully achieved.***

10	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	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.
Report	We have started the scoping for a library of quality measures for use in the health sector and for working with Māori to support their data capability in priority areas.	There is a project plan in place for the measures library. We have been working closely with the National Hauora Coalition (NHC) to support data analysis and visualisation for Gen 2040.	Our integrated advisory group endorsed progress on the measures library at their meeting in June 2020. We are currently partnering with Māori within the NHC on Gen 2040 and have been actively working in partnership since 2020.		

Work plan and report table 11: Continuing mortality review (SPE 11)

Our work plan for deliverable 11 was ***partially achieved.***

11	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	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.
Report	We used mortality review to improve systems and practice across sectors, within services and communities, to reduce morbidity and mortality.	The mortality review committees published two reports by 30 June 2021.[31] The committees reported quarterly through the SPE scorecard, on committee work, but not specifically recommendations. The Commission/ Secretariat has developed a templated monitoring tool (Excel spreadsheet) for each of the mortality review committees to use. This monitoring tool enables mortality review committees to monitor and track the implementation of the recommendations, the cross-government and sector relationships they hold, and the ongoing engagement. Each committee has tracked implementation of its recommendations through its own monitoring tools and processes. Each committee has documented their approach and is starting to monitor recommendation uptake through ongoing stakeholder and committee relationships.	In developing and finalising their reports, the mortality review committees consulted with key internal and external stakeholders. Two external subject-matter experts reviewed all published reports. At least one of these reviewers has Māori health knowledge and expertise. Each committee has documented their tool and approach and continues to monitor recommendation uptake through ongoing stakeholder and committee relationships.		

While a tool was developed to assist in the tracking of committee recommendations, more work is required to build our understanding of progress, so we can support the committees to make more effective recommendations in the future.

31 The PMMRC 14th report was released on 16 February 2021: https://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/4210/
The Perioperative Mortality Review Committee (POMRC) published its 9th report, Equity in outcomes following major trauma among hospitalised patients, on 21 April 2021. https://www.hqsc.govt.nz/our-programmes/mrc/pomrc/publications-and-resources/publication/4274/

Work plan and report table 12: Building improvement science capability (SPE 12)

Our work plan for deliverable 12 was ***partially achieved***.

12	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	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.
Report	We strengthened 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.	15 of the 20 Commission-sponsored health care workers completed the improvement advisor education and training programme by 30 June 2021. 156 senior health leaders participated in the system leadership programme for quality and safety by 30 June 2021, attending workshops and online Zoom sessions. We worked with the Ministry of Health and then with Silverstripe to complete specific requirements for the collaborative quality improvement sharing platform by 30 June 2021.	The Commission was able to establish a baseline for measuring the improvement of participation for Māori and Pacific peoples, but was unable to measure change in 2020/21. The Ko Awatea Improvement Advisor evaluation report demonstrates a 94.8% increase in understanding and application of improvement science. Twenty two of 107 system leadership workshop participants responded to a Survey Monkey follow-up survey. Of these, 64% reported an increased understanding and application of improvement science. We did not proceed to broader consultation and testing with stakeholder networks within the year.		

This deliverable was partially achieved. While we continued our important improvement science capability building work and met the quantity measures we set, we had more variable results in achieving our quality measures.

Work plan and report table 13: Strengthening clinical governance in the health and disability sector (SPE 13)

Our work plan for deliverable 13 was effectively ***fully achieved.***

13	Deliverable	Performance measures		How this will make a difference	Outcome affected
		Quantity	Quality		
Plan	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.
Report	We worked to strengthen clinical governance in the health and disability sector by providing strategic leadership in the Ministry-led review of clinical governance in the sector.	In 2020/21 we participated in a Ministry-led programme of work that aims to improve clinical governance systems.	We supported this work, providing data, system intelligence and direction in key priority areas. We established and facilitated a Quality Forum as a key component of clinical governance during system change – as the functions of the health and disability leadership council changed. We purposefully and regularly sought the views of participants from the agencies involved in a collaborative co-design process within the Quality Forum itself. The Quality Forum has been designed and shaped in response to participant feedback to enhance the value of participation from those involved.		

Part 2 – Other work that strengthens our performance

Wāhanga 2 – He mahi anō hei whakakaha i tā mātou mahi

This section details the Commission's governance structure (our Board) and how the Board is supported by advisory groups that help inform decision-making. It also details our monitoring and reporting processes that ensure that our Minister and government know about our work and the quality, safety and equity of our health system.

We also detail other work we are doing to strengthen and build our performance. This work includes embedding and enacting Te Tiriti across all that we do – strengthening our partnerships and engagement abilities, working sustainably, increasing the accessibility of the information we publish, and supporting and developing our people and increasing our diversity.

Finally, we briefly report on our third party funded work that we undertake with the support of partners.

Governance – our Board

The Commission is governed by a Board of 10 members who are appointed by the Minister of Health and led by Dr Dale Bramley. The most up-to-date information about our Board can be found on our website.[32]

The Board is supported in its governance decision-making by key advisory groups.

Te Rōpū Māori advisory group

Te Rōpū Māori advises our Board and chief executive on strategic issues, priorities and frameworks and provides guidance and support for working in active Te Tiriti partnerships with Māori. Te Rōpū Māori also advises on our work programme and campaigns. Membership consists of up to six Māori health sector experts whose peers across the health and disability sector recognise them for their skills and knowledge. The most up-to-date membership information is available on our website.[33]

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

Consumer advisory group

The Commission's Board established the consumer advisory group to advise from a consumer perspective and provide a consumer view on health quality and safety. The consumer advisory group has four members, and two of these identify as Māori. The Commission's website has the most recent information on membership.[34]

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

32 See: https://www.hqsc.govt.nz/about-us/our-people/board-members/

33 See: https://www.hqsc.govt.nz/about-us/te-ropu-maori/members/

34 See: https://www.hqsc.govt.nz/our-programmes/partners-in-care/consumer-advisory-group/

Audit committee

The audit committee provides assurance and help to the Board on our financial statements and internal control systems. The audit committee is made up of Andrew Boyd (an independent member), Shenagh Gleisner, Dr Dale Bramley and the Commission management.

Monitoring and reporting

In 2020/21, we continued providing regular briefings on our work and on quality issues, and quarterly update reports on performance against our SPE, to the Minister with delegated responsibility for the Commission. We met regularly with the Minister of Health and kept the Minister and Ministry of Health informed of any potentially contentious events or issues in a timely manner.

Over the year to 30 June 2021, the Commission has provided the Ministry of Health and Minister of Health with information to allow monitoring of our performance, including:

- quarterly statements of financial performance, financial position and contingent liabilities
- quarterly reporting on progress against our performance measures
- quarterly reporting on emerging quality and safety risks as part of the no surprises expectation
- an annual report in accordance with the Crown Entities Act 2004 and Public Finance Act 1989.[35]

Strengthening and developing our organisation

In 2020/21, we have continued our important work to strengthen our organisation so that we can more effectively facilitate and contribute to 'Hauora kounga mō te katoa | Quality health for all'.

Embedding Te Tiriti o Waitangi in all that we do

We continue our work to embed Te Tiriti o Waitangi in all that we do, further building on our SOI[36] commitment.

Over this period, we have strengthened and grown our Māori health outcomes team (now called Ahuahu Kaunuku). This team supports the Commission to develop partnerships with iwi, hapū, Māori communities and organisations to support improvement initiatives that address the needs and issues of populations experiencing the worst health outcomes. Ahuahu Kaunuku also coordinates ongoing staff capability building in te reo and tikanga Māori for all Commission staff.

We have also continued our staff development in Te Tiriti o Waitangi through Te Tira Whakarite (the team that takes forward Te Tiriti). Our internal work to ensure our work is Te Tiriti based also helps us to take forward our outward-facing Te Tiriti o Waitangi work and strategic priority.

Partnering and engaging

As a partnership-focused organisation, we collaborate with and support others to work towards quality health for all. This means working across the system with our partners and stakeholders, including iwi, hapū, whānau Māori, Pacific peoples, clinicians, government agencies, academics, non-governmental organisations, the health sector workforce and professional health bodies. In 2020/21, we have continued to build partnerships and work with others where we can influence improvement.

Environmental sustainability

In December 2020, the Government announced a climate change emergency and the establishment of the Carbon Neutral Government Programme to accelerate emissions reductions in the public sector and be carbon neutral by 2025. The Commission is committed to fully reduce our carbon footprint and become carbon neutral by 2025 and is well on the way to this, as all our travel carbon is offset annually. The current focus is to measure the Commission's emissions using the tools provided by the Ministry of Business, Innovation and Employment and the Ministry for the Environment to provide a baseline to measure future reductions.

Our travel carbon is fully offset each year. For 2020/21, we reduced our travel carbon over 50 percent from the previous year. Our carbon offset was 152 tonnes down from 324 tonnes in 2019/20 and down from 483 tonnes in 2018/19.

35 Section 50D(3b) of the New Zealand Public Health and Disability Act 2000 requires the Commission to, at least yearly, report to the Minister of Health on the progress of mortality review committees. It must also include each report in the next year's annual report, which provides the Commission's report against its SPE.

- The Perinatal and Maternal (PMMRC) 14th Annual report was released on 16 February 2021: https://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/4210/ And
- The Perioperative Mortality Review Committee (POMRC) published its report, equity in outcomes following major trauma among hospitalised patients: Ninth report of the Perioperative Mortality Review Committee (the report) on 21 April 2021. https://www.hqsc.govt.nz/our-programmes/mrc/pomrc/publications-and-resources/publication/4274/

36 Statement of Intent 2020–24. See: https://www.hqsc.govt.nz/assets/General-PR-files-images/Accountability_documents/StatementOfIntent2020-24.pdf

In addition, operating through all-of-government contracts, we estimate indicative savings over the life of contracts to be close to 10 percent savings, from air travel, information technology hardware, mobile voice and data services and office consumables, totalling close to $0.200 million.

Accessibility

The Commission is a signatory of the Government Accessibility Charter, which is a commitment to providing accessible information and online tools to all disabled people. Signing the charter indicates the Commission is committed to working progressively over a five-year period to making information intended for the public accessible to everyone so that everyone can interact with us in a way that meets their individual needs and promotes their independence and dignity. The charter is a commitment to making accessibility 'business as usual', and the Commission has initiated the development of a five-year plan with the major action for 2021/22 being a full refresh of the Commission's website.

Developing and strengthening our organisation through our people

Our people are our greatest asset. We provide equal employment opportunities and ensure our policies, practices and processes are fair and equitable for all job applicants and employees. We recognise the Crown's obligations under Te Tiriti and the aspirations of Māori, other ethnic or minority groups, and people with disabilities. We recognise the importance of human resources, infrastructure and leadership to improve working conditions and provide better health services for whānau Māori, Pacific peoples and all New Zealanders. The Commission values its people and emphasises the value of working together through the kaupapa of 'kotahitanga'.

The Commission staff are supported with annual professional development, and during 2020/21 over 15 percent of staff took up offers of a secondment, additional duties or internal promotions.

As of 30 June 2021:

- The Commission had 85 staff members (78 full-time equivalents (FTEs)). One of these FTEs was on secondment for the full year.
- Seventy-one were full-time (70 in 2020) and 24 were part-time (20 in 2020).
- Sixty percent had more than two years of service with the Commission (53 percent in 2020).
- Seventeen percent of staff were fixed-term, up from 14 percent in 2020.
- Around 6 percent of our staff identify that they live with a disability. Wherever possible, we ensure the workplace environment is suitable for our people with disabilities.
- We have a relatively consistent distribution of age groups within our staff, which are outlined in Figure C below.
- We have increased our Māori workforce over the past four years from 6 percent to 19 percent.

Figure B: Gender

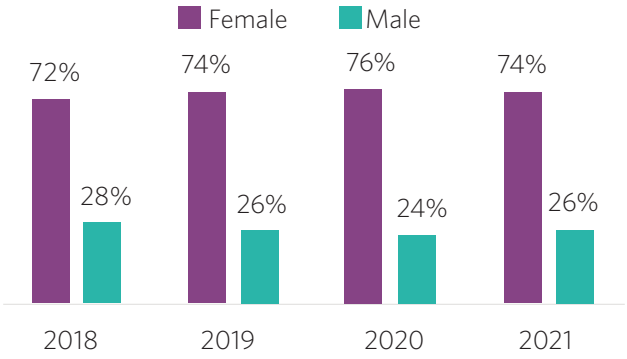


Figure C: Age demographics

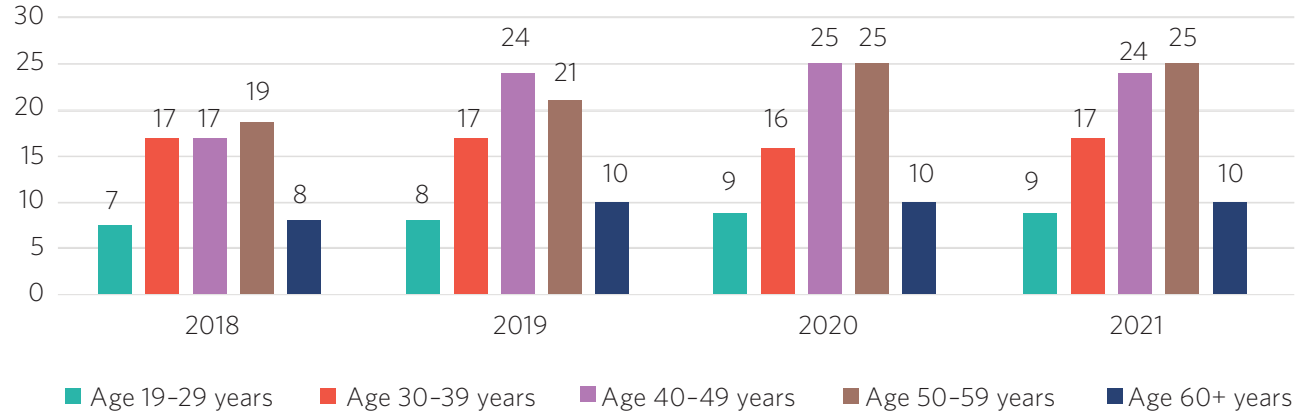
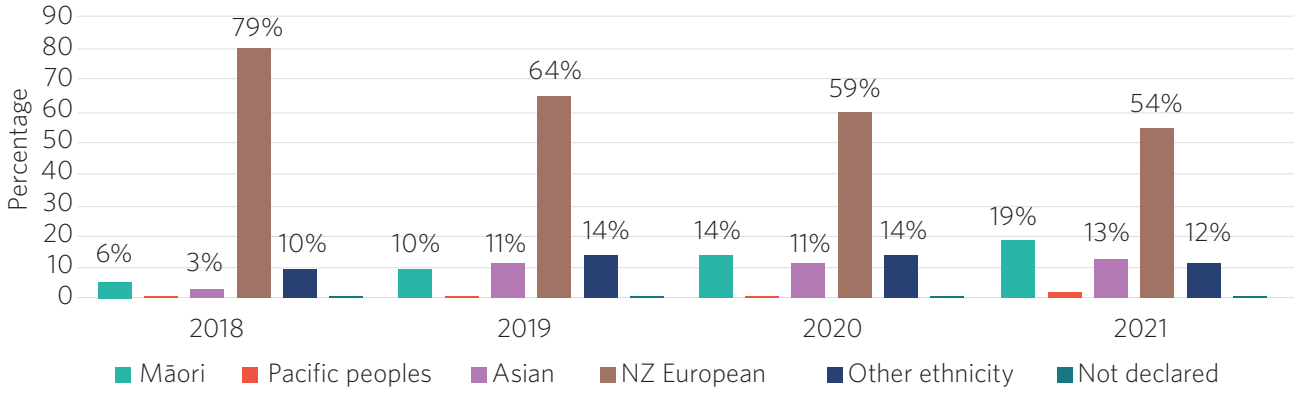


Figure D: Ethnicity



Equal employment opportunities and the Rainbow Tick

The Commission has an equality and diversity policy in place and is committed to equal employment for all groups of people. We were proud to have received the Rainbow Tick in June 2019 and are now going through a re-certification process in 2021/22. To get the original certification, we completed a diversity and inclusion process that assessed that our workplace understands, values and welcomes sexual and gender diversity.

We have already made advances in promoting equal employment opportunities and increasing the diversity of our staff through our recruitment plans, with a particular focus on Māori.

Remuneration

We worked closely with the Ministry of Health, our monitoring agency, to reach agreement on annual remuneration levels. Staff who were employed in their current role before 31 December 2019, are permanent or on a fixed-term employment agreement of more than 12 months and are in a band lower than 17 were eligible for consideration for an increase as a result of this year's remuneration review process. The increase in salary for those eligible was around 1–2 percent, and the total cost implications were less than $0.045 million.

Gender pay equity

Our gender pay gap has increased in the past 12 months. Compared to median salaries in 2019/20, the gap is calculated at 7 percent, up from 2 percent in 2020 (10% in 2019). The increase during the period relates to taking on additional senior male leaders in 2021 and the departure of three senior female executive staff. Although the gap has increased, it remains lower than the last reported public service average pay gap, which was 9.6 percent in 2020. We are unable to calculate a 'motherhood penalty' total because we do not collect this level of personal detail from staff.

Flexibility and work design

The Commission supports flexible work arrangements for employees who have carer responsibilities[37] and for other reasons, such as study and career development. Flexible arrangements may include:

- changes to hours of work
- part-time work
- working from home.

The Commission's information technology and modern communication technologies also let staff work flexibly, and during the COVID-19 lockdowns staff have been able to work remotely.

Staff wellness and wellbeing

Our staff are our greatest asset and resource. Staff are passionate about their work and invest a lot of energy and time working for the Commission. Their wellbeing is important to us and helps them to do the best job they can. We see immense value in supporting staff so they can carry out their work and still have time for their families, whānau and outside-of-work interests, as well as being supported in dealing with work-related stress. We want to be an employer of choice, and operating with this recognition helps us to attract and retain the best people for our work.

Over the year, we built on our existing wellness and wellbeing work by adding in more support for our staff, particularly around COVID-19 and its impacts. In particular, we:

- undertook four wellbeing check-in surveys during Alert Levels 3 and 4 so that we could understand the support our staff needed
- supported staff to work more flexibly, better enabling staff to meet business requirements in ways that worked for them

37 Meeting the provision of Part 6AA of the Employment Relations Act 2000.

- provided an additional payment of $15 per week during Alert Levels 3 and 4 for all permanent and fixed-term staff
- organised an external mental wellness check-in survey for staff, which was run by our health, safety and wellness committee
- offered resilience workshops to all staff
- offered all managers training on 'Understanding Mental Health in the Workplace for People Leaders'.

Health and safety

The Commission has a primary duty of care to ensure the health and safety of its staff, contractors and visitors. To do this, the Commission ensures collective responsibility for proactively promoting and encouraging safe and healthy work practices. Managers, staff, contractors, facilities contractors and the health, safety and wellness committee all have a role in supporting health, safety and wellbeing in the Commission.

The Commission's Board, through the chief executive, is updated regularly on all matters relating to the Commission's health and safety. Managers maintain a watching brief and are proactive in addressing and minimising any potential situations where stress or fatigue could develop. The managers and staff have the opportunity to take part in risk and hazard identification and regularly review work and systems to minimise any risks.

Staff who might suffer from a workplace injury or illness receive appropriate rehabilitative care. Staff also have the opportunity to take part in any external health and safety audits that are conducted. In all cases, staff are encouraged to take part in wellness activities while receiving ongoing education about health and safety. All health, safety and wellness committee representatives are required to receive training to carry out their health and safety duties.

Third party funded work

The Commission also partners with other organisations with common interests to undertake work that contributes to 'quality health for all'. We are working across a range of programmes that are funded through partnerships with third parties.

Mental health and addiction improvement

The mental health and addiction quality improvement programme has focused on delivering outputs required from the five projects agreed with the sector, and sector quality improvement capability building. While COVID-19 issues have complicated activity, the programme has seen excellent engagement across the sector on all projects, including the 'Zero seclusion: Safety and dignity for all | Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha' project, and the newly initiated 'Maximising physical health | Te whakanui ake i te hauora ā-tinana' project. A strong focus on Māori health equity supports all projects. The programme has completed the fourth of the five funded years and has recently had a funding extension for a further two, to a total seven years.

Major trauma quality improvement programme

The Commission continues to provide intelligence and improvement support to the National Trauma Network via our contract with the Accident Compensation Corporation (ACC). The contract is progressing well on all areas of focus:

- major haemorrhage (now complete)
- quality improvement facilitator course (complete)
- rehabilitation services (project scoped) and Māori experiences of trauma project (interviews underway)
- national trauma patient long-term outcome survey (six-month interviews underway)
- traumatic brain injury (scoping stage).

Advance care planning

This programme has extended its reach into different communities to share the process of thinking about, talking about and planning for future health care and end-of-life care.

Health care associated infections

The Commission is working with DHBs to ensure that infection prevention and control remains central to the work programme in the changing environment associated with COVID-19. This work is funded and supported directly by DHBs.

- New Zealand's first national health care associated infection point prevalence survey (PPS) was completed in 2021 across all 20 DHBs. The Commission used the European Centre for Disease Control methodology adapted for New Zealand. The PPS has provided an estimated burden of health care associated infection in DHB hospitals. It provides evidence to support further infection prevention and control quality improvement initiatives.
- Working with infection prevention and control nurse specialists, the Commission implemented the use of a 'deep dive tool' to identify and make improvements to practice within orthopaedic surgery.
- The Commission also facilitated a second cohort of hospitals using collaborative methodology to implement a number of strategies aimed at reducing preoperative anti-staphylococcal infection.

Paediatric focus in deteriorating patient work

The Commission continues to work 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. Tools and resources are in development.

Australia and New Zealand Intensive Care Society – clinical register

The Commission maintains the Australia and New Zealand Intensive Care Society's clinical register for New Zealand intensive care units.

Patient experience surveys

The primary and secondary care patient experience surveys are run on behalf of the Ministry of Health. This year, the Commission's other work relevant to ensuring the use of experience surveys for sector improvement is reported in more detail under SPE 2.

Part 3 – Our financial statements

Wāhanga 3 – Pūrongo pūtea

Managing our finances

The Commission works carefully within its funding levels and annually delivers on the Government's expectations.

By using modern communication systems, such as videoconferencing, we have been able to work differently and reduce face-to-face meetings. Our accommodation and associated costs are considerably lower than most similar agencies. In addition, we keep costs low by outsourcing corporate support services such as legal, human resources and information technology services.

We maintain sound management of public funding by complying with relevant requirements of the Public Service Act 2020, the Public Finance Act 1989 and applicable Crown entity legislation. The annual audit review from Audit New Zealand provides useful recommendations on areas for improvement. We implement these recommendations, with the oversight by our audit committee.

Compliance

We meet our good employer requirements and obligations under the Public Finance Act 1989, the Public Records Act 2005, the Public Service Act 2020, the Health and Safety at Work Act 2015, the Crown Entities Act 2004 and other applicable Crown entity legislation through our governance, operational and business rules. We continue to use the ComplyWith legislative compliance information, monitoring and reporting programme, which shows we have a consistently high level of overall compliance. We will continue to comply with all legislative requirements and proactively implement processes to address any issues that arise wherever possible.

Risk management

All Commission staff are aware of the process for risk identification and management. The Board, chief executive, senior management team and programme managers identify strategic and operational risks in consultation with their teams, as appropriate. Programme managers are accountable for risks in their programmes.

Risk management is a standing agenda item at each Board meeting. Our audit committee provides independent assurance and help to the Board on our financial statements and the adequacy of systems of internal controls.

Financial statements

Revenue/expenses for output classes for the year ended 30 June 2021

	Output class 1		Total	
	$000s		$000s	
	Actual	Budget	Actual	Budget
Revenue				
Crown revenue	14,283	14,253	14,283	14,253
Interest revenue	3	20	3	20
Other revenue	4,597	4,436	4,597	4,436
Total revenue	**18,883**	**18,709**	**18,883**	**18,709**
Expenditure				
Operational and internal programme costs	13,441	13,191	13,441	13,191
External programme cost	5,006	5,963	5,006	5,963
Total expenditure	**18,447**	**19,154**	**18,447**	**19,154**
Surplus/(deficit)	436	(445)	436	(445)

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.

Statement of comprehensive revenue and expenses for the year ended 30 June 2021

Actual 2020		Notes	Actual 2021	Budget 2021
$000			$000	$000
	Revenue			
14,253	Revenue from Crown	2	14,283	14,253
24	Interest revenue		3	20
4,662	Other revenue	3	4,597	4,436
18,939	**Total revenue**		**18,883**	**18,709**
	Expenditure			
10,595	Personnel costs	4	10,476	10,570
180	Depreciation and amortisation	12, 13	154	175
2,995	Other expenses	6	2,811	2,446
3,532	External quality and safety programmes		3,440	4,073
1,752	External mortality programmes		1,566	1,890
19,054	**Total expenditure**		**18,447**	**19,154**
(115)	**Surplus/(deficit)**		**436**	**(445)**
0	Other comprehensive revenue		**0**	**0**
(115)	**Total comprehensive revenue**		**436**	**(445)**

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

The accompanying notes form part of these financial statements.

Statement of financial position as of 30 June 2021

Actual 2020			Actual 2021	Budget 2021
$000		Notes	$000	$000
	Assets			
	Current assets			
2,582	Cash and cash equivalents	7	3,047	2,196
121	Goods and services tax receivable		199	107
264	Debtors and other receivables	8	431	370
107	Prepayments		121	60
3,074	**Total current assets**		**3,798**	**2,733**
	Non-current assets			
220	Property, plant and equipment	12	159	313
0	Intangible assets	13	0	0
220	**Total non-current assets**		**159**	**313**
3,294	**Total assets**		**3,957**	**3,046**
	Liabilities			
	Current liabilities			
768	Creditors and other payables	14	873	1,173
692	Employee entitlements	16	708	510
52	Revenue in advance		168	0
1,512	**Total current liabilities**		**1,749**	**1,683**
	Non-current liabilities			
110	Employee entitlements	16	99	100
110	**Total non-current liabilities**		**99**	**100**
1,622	**Total liabilities**		**1,848**	**1,783**
1,673	**Net assets**		**2,109**	**1,263**
	Equity	17		
1,288	General funds July		1,173	1,208
500	Contributed capital		500	500
(115)	Surplus/(deficit)		436	(445)
1,673	**Total equity**		**2,109**	**1,263**

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

The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2021

Actual 2020		Notes	Actual 2021	Budget 2021
$000			$000	$000
1,788	Balance at 1 July		1,673	1,708
	Total comprehensive revenue and expenses for the year			
(115)	Surplus/(deficit)		436	(445)
	Owner transactions			
0	Capital contribution		0	0
1,673	**Balance at 30 June**	17	**2,109**	**1,263**

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

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2021

Actual 2020 $000		Notes	Actual 2021 $000	Budget 2021 $000
	Cash flows from operating activities			
14,253	Receipts from Crown		14,403	14,253
5,251	Other revenue		4,427	4,296
24	Interest received		3	20
(10,308)	Payments to suppliers		(8,413)	(8,315)
(8,856)	Payments to employees		(9,784)	(10,671)
36	Goods and services tax (net)		(78)	(1)
400	Net cash flow from operating activities	18	558	(418)
	Cash flows from investing activities			
(33)	Purchase of property, plant and equipment		(93)	(290)
0	Purchase of intangible assets		0	0
(33)	Net cash flow from investing activities		(93)	(290)
	Capital flows from financing activities			
0	Capital contribution		0	0
0	Net cash flows from financing activities		0	0
367	**Net (decrease)/increase in cash and cash equivalents**		**465**	**(708)**
2,215	Cash and cash equivalents at the beginning of the year		2,582	2,904
2,582	**Cash and cash equivalents at the end of the year**	7	**3,047**	**2,196**

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

The accompanying notes form part of these financial statements.

Notes to the financial statements

Note 1: Statement of accounting policies

Reporting entity

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

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

The financial statements for the Commission are for the year ended 30 June 2021 and were approved by the Board on 21 December 2021.

Basis of preparation

The financial statements of the Commission have been prepared on a going concern basis. The accounting policies have been applied consistently throughout the period.

Standards issued and not yet effective and not early adopted

Standards and amendments issued but not yet effective that have not been early adopted and that are relevant to the Commission are as follows.

Amendment to PBE IPSAS 2 Cash Flow Statements

An amendment to Public Benefit Entity International Public Sector Accounting Standard (PBE IPSAS) 2 requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for the year ending 30 June 2022, with early application permitted. This amendment will result in additional disclosures. The Commission does not intend to early adopt the amendment.

PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces Public Benefit Entity International Financial Reporting Standard (PBE IFRS) 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. The Commission has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The Commission does not intend to early adopt the standard.

PBE FRS 48 Service Performance Reporting

Public Benefit Entity Financial Reporting Standard (PBE FRS) 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. The Commission has not yet determined how application of PBE FRS 48 will affect its statement of performance. It does not plan to early adopt the standard.

Statement of compliance

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

These financial statements have been prepared in accordance with and comply with Tier 2 public benefit entities accounting standards. These financial statements comply with the PBE Standards Reduced Disclosure Regime.

Measurement base

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

Budget figures

The budget figures are derived from the statement of performance expectations as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Functional and presentation currency

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

Changes in accounting policies

There have been no changes in accounting policies.

Critical accounting estimates and assumptions

In preparing these financial statements, the Board has made estimates and assumptions concerning the future. These estimates and assumptions might differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

There are no estimates and assumptions for 2020/21 that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant accounting policies

Revenue

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

Revenue from the Crown

The Commission is primarily funded through revenue received from the Crown, which is restricted in its use for the purpose of meeting the Commission's objectives as specified in the Statement of Intent. The Commission considers no conditions are attached to the funding, and it is recognised as revenue at the point of entitlement. The fair value of revenue from the Crown revenue has been determined to be equivalent to the amounts due in the funding arrangements.

Grants received

Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Interest

Interest income is recognised using the effective interest method.

Foreign currency transactions

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

Operating leases

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

Cash and cash equivalents

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

Debtors and other receivables

Debtors and other receivables are measured at face value less any provision for impairment. No provisions for impairment are in place in 2020/21.

Short-term receivables are recorded at the amount due, less an allowance for credit losses. The Commission applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables. In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the days past due. Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation or a failure to make contractual payments for a period of greater than 90 days past due.

Bank deposits

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

Inventories

Inventories held for sale are measured at the lower of cost (calculated using the first-in, first-out basis) and net realisable value. No inventories are held for sale in 2020/21.

Property, plant and equipment

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

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

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

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

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

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

Impairment of property, plant, and equipment

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

Value in use is determined using an approach based on either a depreciated replacement cost approach, a restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written-down to its recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive revenue and expense and decreases the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in surplus or deficit. The reversal of an impairment loss on a revalued asset is recognised in other comprehensive revenue and expense and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in surplus or deficit, a reversal of an impairment loss is also recognised in surplus or deficit.

For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in surplus or deficit.

Depreciation

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

Building fit-out (over the term of building lease)
10 years 10% SL

Leasehold improvements
10 years 10% SL

Computers
3 years 33% SL

Office equipment
5 years 20% SL

Furniture and fittings
5 years 20% SL

Intangibles

Software acquisition

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

Amortisation

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

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

Acquired computer software
3 years 33% SL

Impairment of property, plant and equipment, and intangible assets

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

Non-cash-generating assets

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

Goods and services tax

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Creditors and other payables

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

Employee entitlements

Salary and wages are recognised as employees provide services.

Short-term employee entitlements

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

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Note 2: Revenue from the Crown

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

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

The Commission received an additional $0.150 million revenue towards the COVID-19 monitoring tool, and $0.120 million of the budgeted $0.750 million suicide mortality review has been treated as revenue in advance.

Note 3: Other revenue

Total other revenue received was $4.597 million (2020: $4.662 million), consisting of:

- $1.500 million (2020: $1.500 million) from DHBs for the mental health and addiction quality improvement programme
- $0.830 million (2020: $0.892 million) from DHBs for the advance care planning programme
- $1.228 million (2020: $1.225 million) from DHBs for infection prevention and control
- $0.106 million (2020: $0.056 million) from additional workshop and event revenue
- $0.795 million (2020: $0.802 million) from ACC for the National Trauma Network
- $0.014 million (2020: $0.050 million) from adverse events training workshops
- $0.008 million (2020: $0.044 million) from ACC and PHARMAC for Patient Safety Week
- $0.101 million (2020: $0.000 million) from Council of Medical Colleges for Choosing Wisely
- $0.000 million (2020: $0.067 million) from DHBs for patient experience surveys question set
- $0.000 million (2020: $0.019 million) from ACC and PHARMAC towards behavioural insights measurement
- $0.015 million (2020: $0.007 million) other revenue.

Note 4: Personnel costs

	Actual 2020 $000	Actual 2021 $000
Salaries and wages	9,546	9,789
Recruitment	54	140
Temporary personnel	380	216
Membership, professional fees and staff training and development	199	150
Defined contribution plan employer contributions	217	215
Increase/(decrease) in employee entitlements	199	(34)
Total personnel costs	**10,595**	**10,476**

Employer contributions to defined contribution plans include Kiwi Saver, the Government superannuation fund, and the National Provident Fund.

Note 5: Capital charge

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

Note 6: Other expenses

	Actual 2020 $000	Actual 2021 $000
Audit fees to Audit New Zealand for financial audit	36	37
Staff travel and accommodation	295	209
Printing and communications	219	182
Consultants and contractors	619	524
Board costs	208	189
Mortality review committees	283	215
Lease rental	526	526
Outsourced corporate services and overheads	803	925
Other expenses	6	4
Total other expenses	**2,995**	**2,811**

Note 7: Cash and cash equivalents

	Actual 2020 $000	Actual 2021 $000
Cash at bank and on hand	2,582	3,047
Total cash and cash equivalents	**2,582**	**3,047**

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

While cash and cash equivalents at 30 June 2021 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

Note 8: Debtors and other receivables

	Actual 2020 $000	Actual 2021 $000
Debtors and other receivables	264	431
Less: provision for impairment	0	0
Total debtors and other receivables	**264**	**431**

Fair value

The carrying value of receivables approximates their fair value.

Impairment

The impairment of short-term receivables is now determined by applying an expected credit loss model.

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

Note 9: Investments

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

Note 10: Inventories

The Commission has no inventories for sale in 2020/21.

Note 11: Non-current assets held for sale

The Commission has no current or non-current assets held for sale in 2020/21.

Note 12: Property, plant and equipment

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

	Computer	Furniture and office equipment	Leasehold improvements	Total
		$000	$000	$000
Cost or valuation				
Balance at 1 July 2019	397	381	85	863
Additions	4	30	0	34
Disposals	(31)	(6)	0	(37)
Balance at 30 June 2020/1 July 2020	371	405	85	861
Additions	89	4	0	93
Disposals	0	0	0	0
Balance at 30 June 2021	460	409	85	954
Accumulated depreciation and impairment losses				
Balance at 1 July 2019	161	295	40	496
Depreciation expense	128	35	17	180
Elimination on disposal	(29)	(6)	0	(35)
Balance at 30 June 2020/1 July 2020	260	324	57	641
Depreciation expense	107	33	14	154
Elimination on disposal	0	0	0	0
Balance at 30 June 2021	367	357	71	795
Carrying amounts				
At 1 July 2019	236	86	45	367
At 30 June and 1 July 2020	111	81	28	220
At 30 June 2021	93	52	14	159

The Commission does not own any buildings or motor vehicles. There are no restrictions over the title of the Commission's assets, nor any assets pledged as security for liabilities.

Note 13: Intangible assets

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

	Acquired software
	$000
Cost	
Balance at 1 July 2019	1
Additions	0
Disposals	0
Balance at 30 June 2020/1 July 2020	**1**
Additions	0
Disposals	0
Balance at 30 June 2021	**1**
Accumulated amortisation and impairment losses	
Balance at 1 July 2019	**1**
Amortisation expenses	0
Elimination on disposal	0
Balance at 30 June 2020/1 July 2020	1
Amortisation expenses	0
Elimination on disposal	0
Balance at 30 June 2021	**1**
Carrying amounts	
At 1 July 2019	0
At 30 June and 1 July 2020	0
At 30 June 2021	0

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

Note 14: Creditors and other payables

	Actual 2020	Actual 2021
	$000	$000
Creditors	**373**	**604**
Accrued expenses	392	261
Other payables	3	8
Total creditors and other payables	**768**	**873**

Creditors are non-interest bearing and are normally settled on 30-day terms. Therefore, the carrying value of creditors and other payables approximates their fair value.

Note 15: Borrowings

The Commission does not have any borrowings.

Note 16: Employee entitlements

	Actual 2020 $000	Actual 2021 $000
Current portion		
Accrued salaries and wages	156	195
Annual leave and long-service leave	536	513
Total current portion	692	708
Non-current portion long-service leave	110	99
Total employee entitlements	**802**	**807**

No provision for sick leave or retirement leave has been made in 2020/21 as these have been assessed as immaterial. Provision for long-service leave has been made in 2020/21.

Note 17: Equity

	Actual 2020 $000	Actual 2021 $000
Contributed Capital		
Balance at 1 July	500	500
Capital contribution	0	0
Repayment of capital	0	0
Balance at 30 June	500	500
Accumulate surplus/(deficit)		
Balance at 1 July	1,288	1,173
Surplus/(deficit) for the year	(115)	436
Balance at 30 June	1,173	1,609
Total Equity	**1,673**	**2,109**

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

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

	Actual 2020 $000	Actual 2021 $000
Net surplus/(deficit)	**(115)**	**436**
Add/(less) movements in statement of financial position items		
Debtors and other receivables	574	(245)
Creditors and other payables	(546)	222
Depreciation	180	154
Prepayments	21	(14)
Employee entitlements	286	5
Net movements in working capital		
Net cash flow from operating activities	**400**	**558**

Note 19: Capital commitments and operating leases

Capital commitments

There were no capital commitments at balance date (2020: nil).

Operating leases as lessee

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

	Actual 2020 $000	Actual 2021 $000
Not later than one year	354	465
Later than one year and not later than five years	0	321
Later than five years	0	0
Total non-cancellable operating leases	**354**	**786**

At balance date, the Commission leases a property (from 1 March 2014) at Levels 8 and 9, 17 Whitmore Street, Wellington. The lease expires in March 2023. The value of the lease to March 2023 is $0.749 million.

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

The Commission sub-leases an office space at 650 Great South Road, Penrose, Auckland, from the Ministry of Health for up to 10 staff. The sub-lease expiry date is December 2021.

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

Note 20: Contingencies

Contingent liabilities

The Commission has no contingent liabilities (2020: $nil).

Contingent assets

The Commission has no contingent assets (2020: $nil).

Note 21: Related party transactions

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

The Commission is a wholly owned entity of the Crown.

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

Key management personnel

Salaries and other short-term employee benefits to key management personnel[38] totalled $1.34 million, 4 FTE (2020: $1.50 million, 5 FTE).

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

The total value of remuneration paid or payable to each Board member (or their employing organisation*) during the full 2020/21 year was as follows.

	Actual 2020 $000	Actual 2021 $000
Prof Alan Merry* (outgoing Chair) – term expired	7	0
Dr Bev O'Keefe – term expired	4	0
Dame Alison Paterson – term expired	6	0
Dr Dale Bramley* (new Chair)	26	29
Robert Henderson* – term expired	4	0
Mr Andrew Connolly	15	11
Gwendoline Tepania-Palmer – term expired	6	0
Dr Gloria Johnson* – resigned	6	0
Dr Jennifer Parr	13	15
Philomena Antonio	7	15
Dr Collin Tukuitonga	3	15
Professor Peter Crampton	4	15
Raewyn Lamb (Deputy Chair)	14	0
Shenagh Gleisner	11	14
Dr Tristram Ingham	3	15
Dr Wil Harrison	3	15
Total Board member remuneration	**132**	**144**

* means member paid by their employing organisation

Due to the impact of COVID-19, some Board members chose not to claim Board fees (or had reduced fees).

Fees were in accordance with the Cabinet Fees Framework.

The Commission has provided a deed of indemnity to Board members for certain activities undertaken in the performance of the Commission's functions.

The Commission has taken directors' and officers' liability and professional indemnity insurance cover during the financial year regarding the liability or costs of Board members and employees.

No Board members received compensation or other benefits in relation to cessation.

38 Key management personnel for 2020/21 include the chief executive; director, health quality improvement and deputy chief executive (disestablished part year); director, health quality intelligence; medical directors (two part-year FTE in 2020/21 – role was new to key management in 2020); and chief financial officer. Board members are reported separately. Combined all these roles equated to the equivalent of 3.95 actual FTE for the financial year.

Members of other committees and advisory groups established by the Commission are paid according to the Cabinet Fee's Framework, where they are eligible for payment. Generally, daily rates are $463 per day for chairs and $330 per day for committee members.

Note 23: Employee remuneration

Total remuneration paid or payable was as follows.

	Employees 2020	Employees 2021
$100,000–$109,999	8	2
$110,000–$119,999	4	5
$120,000–$129,999	9	8
$130,000–$139,999	6	7
$140,000–$149,999	0	2
$150,000–$159,999	4	2
$160,000–$169,999	1	3
$170,000–$179,999	2	0
$180,000–$189,999	2	3
$200,000–$209,999	1	0
$230,000–$239,999	1	3
$240,000–$249,999	1	1
$250,000–$259,999	1	0
$260,000–$269,999	0	0
$270,000–$279,999	1	1
$330,000–$339,999	1	0
$390,000–$399,999	0	1
$400,000–$409,999	1	0
Total employees	**43**	**38**

During the year ended 30 June 2021 no employees received compensation or other benefits in relation to cessation.

Note 24: Events after the balance date

There were no material events after the balance date.

Note 25: Financial instruments

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

Note 26: Capital management

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

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

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

Note 27: Explanation of major variances against budget

Explanations for major variances from the Commission's budgeted figures in the 2020/21 SPE follow.

Statement of comprehensive revenue and expenses

The year-end result for the year to 30 June 2021 is a $0.436 million surplus against a planned SPE deficit of $0.445 million. The main drivers of this surplus variance were that there have been a mix of cost savings, especially around travel savings, use of Zoom and savings in the mortality review programme spend area.

The results do include some delayed activity relating to third party spending and some planned programme related expenditure that did not go ahead either due to COVID-19 impacting on the ability to deliver the activity with frontline services or due to the planned internal activity now no longer being a priority. Vacancies and several fixed-term roles ending also added to this surplus position in the last few months of the financial year.

The delayed activity (non-SPE related) that will need to be spent in 2021/22 is around ($0.375 million) consisting of:

- $0.200 million mental health programme – delays in the mental health quality improvement programme that will be required to be spent in 2021/22
- $0.075 million trauma programme – year-to-date timing delays with the severe traumatic brain injury quality improvement programme that will be required to be spent in 2021/22
- $0.100 million progressing the development of a measures library now required to be spent in 2021/22.

Statement of financial position

Cash and cash equivalents were higher than budgeted due to expenditure on both staffing and programmes being less that budget. Property, plant and equipment is underspent. The Commission had planned to replace its laptop fleet in 2020/21, but because of manufacturing delays due to COVID-19 this will now show in the 2021/22 financial statements.

Employee entitlements are $0.198 million higher than budgeted mainly due to a higher level of accrued annual leave while staff deferred taking holidays due to the COVID-19 lockdowns.

Equity levels at the end of June 2021 are $2.109 million.

Statement of changes in cashflow

Because the Commission had an underspend in 2020/21, 'Payment to suppliers' and 'Payments to employees' were both lower than budgeted figures.

The Commission had planned to replace its laptop fleet in 2020/21, but because of manufacturing delays due to COVID-19 this will now show in the 2021/22 financial statements and is why 'Cashflows from investing activity' are $0.197 million lower than budget for 2021.

Note 28: Acquisition of shares

Before the Commission subscribes for purchase or otherwise acquires shares in any company or other organisation, it will first obtain the written consent of the Minister of Health. The Commission did not acquire any such shares and currently does not plan to do so.

Note 29: Responsibilities under the Public Finance Act

To comply with our responsibilities under the Public Finance Act 1989, we report here the activities funded through the Crown Vote Health and how performance is measured against the forecast information contained in the Estimates of Appropriations 2020/21 and of those as amended by the Supplementary Estimates.

Monitoring and Protecting Health and Disability Consumer Interests (M36)

This appropriation is intended to achieve the following: Provision of services to monitor and protect health consumer interests by the Health and Disability Commissioner, district mental health inspectors and review tribunals, and the Mental Health Commission.

Output class financials	Actual 2020/21 $000	Budget 2020/21 $000	Location of end-of-year performance information
Crown Funding (Vote Health – Monitoring and Protecting Health and Disability Consumer Interests (M36))	12,976	12,976	The end-of-year performance information for this appropriation is reported in the 'Our performance statement' section (page 13).

The Commission also received Crown funding of:

- $0.750 million from Vote Health – Mental Health (with $0.120 million treated as revenue in advance)
- $0.215 million from Vote Health – National Personal Health Services
- $0.312 million from Vote Health – Primary Health Care Strategy
- $0.150 million from Vote Health – COVID-19 Public Health Response funding.

As a consequence of the COVID-19 global pandemic, we have assessed the impact of the pandemic on the Commission. We have also reviewed our financial statements on a line-by-line basis and made any adjustments necessary in accordance with NZ GAAP. Overall, we concluded that the impact of the COVID-19 pandemic was not material to the entity's operations or current year financial statements. The main factors contributing to this conclusion are as follows.

- *Revenue* – This is mainly Crown and DHB revenue, which was not impacted by COVID-19.
- *Cash* – There was no impact to the carrying value of cash on hand.
- *Receivables* – There was no impact to the expected credit loss model when calculating impairment losses. The Commission deals with customers with little or no credit risk.
- *Property, plant and equipment* – The Commission purchases plant and equipment mainly from the all-of-government panel of suppliers.
- *Payables* – No accrued costs related to the expected impact of COVID-19 have been made.
- *Employee liabilities* – No changes have been assessed as being required for calculations of employee liabilities associated with COVID-19.

Part 4 – Statement of responsibility

Wāhanga 4 – He kupu haepapa

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

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

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

In the Board's opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Commission for the year ended 30 June 2021.

Signed on behalf of the Board:

Dr Dale Bramley

Chair, Board

21 December 2021

Shenagh Gleisner

Chair, Audit Committee

21 December 2021

Auditor's report | Te pūrongo a te kaiarotake

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of the Health Quality & Safety Commission's financial statements and performance information for the year ended 30 June 2021

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

Opinion

We have audited:

- the financial statements of the Commission on pages 36 to 52, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements including a summary of significant accounting policies and other explanatory information; and
- the performance information of the Commission on pages 9 to 11, 13 to 27, 35 and 52 to 53.

In our opinion:

- the financial statements of the Commission on pages 36 to 52:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2021; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with the Public Benefit Accounting Standards Reduced Disclosure Regime; and
- the performance information on pages 9 to 11, 13 to 27, 35 and 52 to 53:
  - presents fairly, in all material respects, the Commission's performance for the year ended 30 June 2021, including:
    - for each class of reportable outputs:
      - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
      - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriations; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 21 December 2021. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the Commission for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The Board is responsible for such internal control as they determine is necessary to enable them to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Commission for assessing the Commission's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to merge or to terminate the activities of the Commission, or there is no realistic alternative but to do so.

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

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 8, 12, 28 to 34 and 58, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Commission accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1: International Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Other than in our capacity as auditor, we have no relationship with, or interests, in the Commission.

Stephen Usher
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Appendix 1: Our outcomes framework, clarified in our 2021/22 Statement of Performance Expectations

Our contribution to the Government's 'wellbeing priorities'

Physical and mental wellbeing
Supporting improved health outcomes for all New Zealanders

Our contribution to the Government's goals for the health system

- Improve child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention
- Better population outcomes supported by a strong, equitable public health and disability system
- Better population health and outcomes supported by primary care

Our vision

Quality health for all

Our strategic priorities (and the outcomes we seek)

- 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

Our work

Supporting and facilitating improvement
Improving the quality of health and disability services for consumers and whānau by leading and facilitating efforts in the health and disability system, including a focus on the transformational direction of our approach to mental health and addiction through the agreed actions from the Government Inquiry into Mental Health and Addiction

Te Kāwanatanga o Aotearoa

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