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STATEMENT OF PERFORMANCE EXPECTATIONS

2019/20

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

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Board statement

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

Prof Alan Merry ONZM FRSNZ
Chair
25 June 2019

Dr Dale Bramley MBChB, MPH, MBA, FAFPHM
Deputy Chair
25 June 2019

Introduction

The Health Quality & Safety Commission (the Commission) is a Crown entity under the New Zealand Public Health and Disability Act 2000 (the Act) and is categorised as a Crown agent for the purposes of the Crown Entities Act 2004.[1] Its purpose, as set out in the Act, is to lead and coordinate work across the health and disability sector to improve the quality and safety of care. Appendix 1 sets out the objectives and functions of the Commission.

This Statement of Performance Expectations (SPE) is provided under section 149C of the Crown Entities Act and describes what the Commission will achieve in 2019/20.

It outlines our reportable output classes, what each output class will achieve (deliverables), how we will assess each one, and associated expected revenue and proposed expenses. It also includes other information the Crown Entities Act or other Acts require an SPE to include.

The forecast financial statements for the financial year and outyears are in line with generally accepted accounting practices. The statements include:

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

We are able to demonstrate tangible improvements in our focus areas, for example, reducing in-hospital falls and surgical infections.[2] Health sector stakeholders expect the Commission to maintain the momentum that has been created with some of our existing work and not lose the value of the investments that the Commission and health sector agencies have made in these programmes. However, it is becoming increasingly difficult for the Commission to maintain activity in these core areas and invest in new and important priority areas.

The Commission sought an increase in baseline funding from Budget 2019 of a minimum of $1.0 million per annum and for inflationary growth to be included in future annual budget bids. This was to return Commission funding levels, in real terms, to the levels at which the Commission was established. This increase was to be applied to enable us to remain in a strong position to continue to improve quality, reduce harm, improve equity of outcomes, add value to the health sector and advance government priorities. The Ministry of Health was not in a position to increase the Commission’s 2019/20 baseline budget at this time.

This SPE has a stronger focus on our support of the Crown’s obligations to Te Tiriti o Waitangi. We are energising greater progress towards advancing Māori health and this requires a different approach and a different way of thinking. Increased activity in this priority area will now be implemented at a slower pace and will be phased across the financial year.

The financial assumptions within this SPE aim to balance existing available Crown funding for the 2019/20 year while transitioning resource to the priority area of Māori health outcomes. At the same time, we have limited planned further development of quality improvement programmes (especially in aged residential care and hospital-based programmes) and used one-off prior year underspend. We have reduced by $0.400 million core expenditure by considering staffing, travel, committee costs, publications, existing quality improvement programme costs, capping or reducing FTEs and a proposed one-off use of Commission balance sheet equity of $0.156 million.

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[1] A Crown agent must give effect to government policy when the responsible Minister directs it.
[2] See Appendix 3 for examples of outcomes and value gained.

The Commission has previously worked within the assumption of keeping reserve levels of around $1.1 million to $1.3 million. The proposed approach for this SPE reduces reserves to $0.994 million.

Assumptions include that an increase in funding will be required in 2020/21 to maintain core work such as our targeted quality improvement programmes and to increase the scale and spread of activity to advance Māori health outcomes. If this bid is not successful, a further reduction of core Commission FTEs and/or programme activities of around $0.600 million per annum will be required from 2020/21, as well as absorbing wage growth of around $0.200 million.

Influences on this SPE

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises that different people with different levels of advantage require different approaches and resources for equitable health outcomes.[3]

New Zealand health system data analysed by the Commission confirms that health inequities are pervasive and persistent, particularly for Māori.[4] The Commission has a vision of 'Mana Taurite Hauora: Health equity for all; where no avoidable, unfair or unjust health inequities exist that are based on differences in ethnicity, socioeconomic circumstances, geography, gender, sexuality, age, specific health conditions or disabilities, or a combination of these'.

The Commission is committed to improving health equity in the first instance for Māori, as tangata whenua and partners with the Crown under Te Tiriti o Waitangi, and this is reflected in our strategic priority for Māori health advancement.

The principles of Te Tiriti o Waitangi underpin this SPE and all the Commission's work. The Commission is committed to meeting Te Tiriti o Waitangi obligations and to upholding Te Tiriti o Waitangi principles of partnership, protection and participation[5] through our work, and through Te Whai Oranga – the Commission's Māori advancement framework.

Our *Statement of Intent 2017–21* (SOI) sets the Commission's broader vision and direction, describing the Commission's strategic priorities and values, how we operate and how we manage our organisational health and capability.[6] Our strategic priorities are discussed later in this document. Our SOI sits behind and informs this SPE.

Our SOI also highlights that our work is based on the New Zealand Triple Aim for quality improvement, which we developed in partnership with the sector. It is now broadly followed across the sector. For the triple aim to be effective, its three objectives (equity, improved experience of care and value for system resources) must be addressed simultaneously and in an integrated way.

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[3] Kotahi te Tima – One Team: March 2019 update. Ministry definition of equity signed-off. Ministry of Health formal definition of equity.

[4] www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3364/

[5] Royal Commission on Social Policy. 1988. *The April Report*. Wellington: Royal Commission on Social Policy.

[6] www.hqsc.govt.nz/publications-and-resources/publication/2971

Achieving this purpose depends on doing the right thing and doing things right the first time.

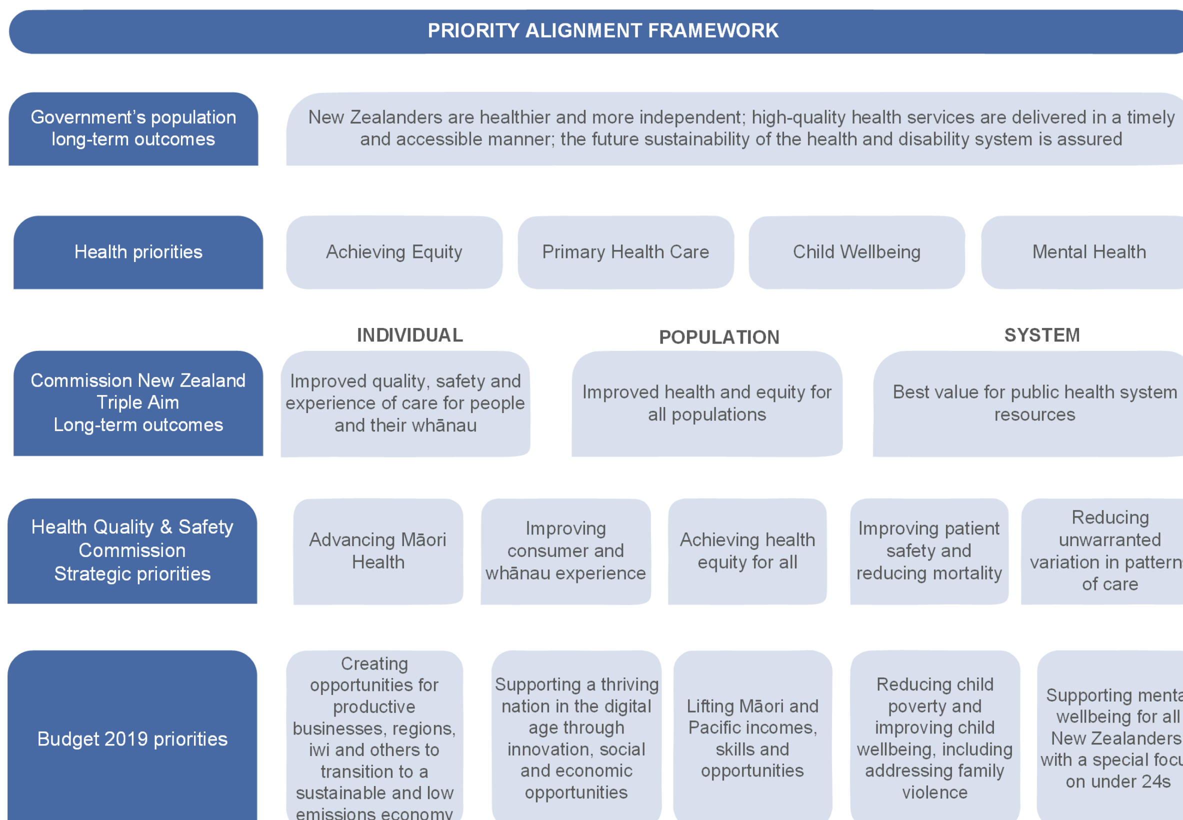
The Commission's SPE has also been influenced by the Minister of Health's expectations, as well as broader government priorities. The Minister of Health provided direction to the Commission in his Letter of Expectations, received on 13 March 2019, which strongly focuses on the importance of equity and Māori health advancement.

The Minister expects:

- All health agencies to contribute to a strong, equitable public health system that performs well, focusing on the right things to make all New Zealanders' lives better.
- All health agencies to focus on achieving equity, with a specific focus on achieving equity for Māori across their life course and on meeting Treaty of Waitangi obligations.
- The Commission to continue to perform its core work with clinicians, providers and consumers to improve health and disability support services with a focus on:
  - supporting the implementation of system level measures in the health sector, by raising improvement science capability, in both primary and secondary care settings
  - developing and implementing quality improvement programmes to reduce health inequities
  - supporting a collaborative learning platform to enhance capacity and capability for quality improvement in the health sector, including the integration of primary and secondary care services
  - providing governance, analysis and monitoring of patient experience surveys in primary and secondary care settings
  - actively supporting and contributing to the Ministry of Health's work on better capturing performance information about the quality and safety of New Zealand's health services, including work related to the eventual publication of health data
  - working with the Ministry of Health to respond to the Health and Disability System Review, and implementing the resulting recommendations
  - working collaboratively across the sector to ensure all proposed publications reflect a comprehensive, contextualised and joined-up picture of the New Zealand health system.

The SPE is also informed by the broader direction of government. The following image comes from the Budget 2019 policy statement, showing how the Commission priorities align to the wellbeing focus of budget 2019,[7] Ministry of Health priorities[8,9] and the Commission's SOI.[10]

[7] Source: https://treasury.govt.nz/sites/default/files/2018-12/bps-2019.pdf
[8] Source: www.health.govt.nz/publication/statement-strategic-intentions-2017-2021
[9] Source: www.health.govt.nz/system/files/documents/publications/ala-moui-pathways-to-pacific-health-and-wellbeing-2014-2018-jun14-v2.pdf
[10] Health Quality & Safety Commission. 2017. *Statement of Intent 2017–20*. Wellington: Health Quality & Safety Commission.



Each of the Commission's deliverables are linked to priorities as specified above.

The changing landscape

The need to more actively address health inequity, particularly for Māori, is becoming more widely recognised. Within the health sector, urgency for change has been created by the claim made by Māori to the Waitangi Tribunal (known as the Wai 2575 Health Services and Outcomes Kaupapa Inquiry). The Government inquiry into mental health and addictions, and the broader Aotearoa/New Zealand health and disability sector review Hauora Manaaki ki Aotearoa Whānui (also called informally 'the Simpson Review') focus on improving the health sector and offer the opportunity for learning and change.

Wellbeing is an outcome that is meaningful to the public, and thus the Government is committed to putting people's wellbeing and the environment at the heart of its policies, including reporting against a wider set of wellbeing indicators in future budgets.[11]

In this SPE, we have outlined how our work aligns to the Government's wellbeing approach. This presents a new way of working and thinking about how we develop our priorities as a Commission and measure our success as a change agent for improvement in the quality and safety of care across the health system.

New Zealand's population is changing. Larger groups of people are ageing, and ethnic diversity is increasing. By 2038, Asian and Pacific communities will make up half of New Zealand's total population[12] and alongside Māori, represent a younger and fast-growing population.

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[11] Source: https://treasury.govt.nz/sites/default/files/2018-12/bps-2019.pdf
[12] Meeting the challenge of our future demography: https://ssc.govt.nz/sites/all/files/Diversity%20and%20Inclusion%20approach.pdf

The voice of the consumer representing diverse communities within our society is strong. Consumers demand the right to participate and be involved in policies and interventions designed to improve their wellbeing. The New Zealand public sector recognises consumer experience is important to their organisations, and the value of listening to consumers is real, measurable and immediate.[13]

The difference we make

Our vision is for New Zealand to have a sustainable, world-class, whānau-centred health and disability system, which will attract and retain an excellent workforce through its commitment to continually improve health quality and deliver equitable and sustainable care.

Our role in the sector is to 'shine a light' on quality and safety to identify areas of improvement on which to focus. It is also to 'lend a helping hand' to the sector by supporting the development of improvement programmes and leading the spread of quality and safety improvement skills across the sector and among consumers, their families and whānau.

We aim to create a useful tension in the system and act both as a catalyst and facilitator, energising and supporting the health sector to use data, information and proven methods to improve services and build capability for continuous quality improvement.

Our future challenge is to look critically at how we are doing this, the tools we are using and the frameworks we are applying, and how we might do this differently to advance Māori health to respond better to our obligations to Te Tiriti. Advancing Māori health will require us to listen, to learn and to share through processes such as co-design, working together to develop priorities and approaches that work for Māori. Our aim is to support and facilitate Māori to lead their own improvement in health and health services.

Within our role, we seek to make the health system more effective and health outcomes more equitable. Inequities in health outcomes exist between Māori, Pacific and all other New Zealanders, including the growing proportion who are of Asian or Indian origin.

Māori and Pacific peoples are 2–3 times more likely to die from conditions that might have been prevented by effective and timely care. The poor health of substantial numbers of our young people reflects the impacts of this growing inequity, and child poverty is a leading problem for New Zealand. These issues influence our prioritisation processes, the planning and implementation of our work programmes, and our wider organisation decision-making.

Preventing avoidable harm and saving valuable system resources also helps system sustainability. We report regularly on harm prevented and money saved through the improvements made by health services in our focus areas. These successes are the result of the work and commitment of the whole sector to improve patient safety and access to information on improving health equity and wellbeing.

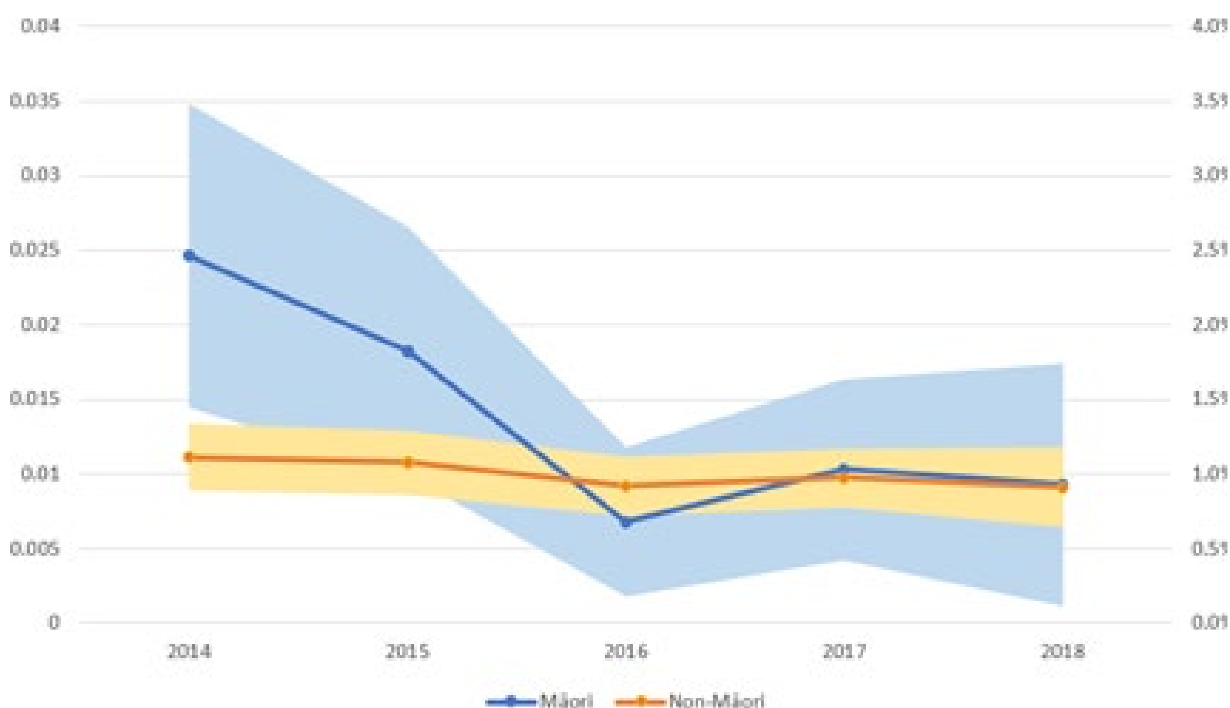
One of the ways we monitor the difference we make is our outcomes matrix, in which a range of programme outcomes are tracked. For example, the impact we have made on surgical site infections is explored in the outcome matrix extract in the table below.

[13] Included in the list of considered consumers are Māori/hapū/iwi, consumer advisory groups, health clinicians, other health agencies, the Ministry of Health, district health boards, other health services providers, the rainbow community, mortality advisory groups, clinical review teams, health networks and diverse population networks.

Outcome matrix

Aim	To reduce the national surgical site infection (SSI) rate for orthopaedic and cardiac surgery by 25% – achieved
Outcomes (including avoided costs of harm)	SSI rates significantly reduced (June 2015 to June 2018) from 1.2 to 0.9% resulting in 94 fewer post-operative infections – $3.8 million avoided costs SSI rates for Māori declined from 2.5 times higher than non-Māori to identical between 2014 and 2016 (see graph below)
Value	47 additional years of healthy life from avoided SSIs – $8.5 million value gained for healthy years of life

SSI rate per 100 procedures



Further examples of how we show the effects of our work are shown in Appendix 3.

From traditional quality improvement approaches to partnership for equity

Our strategic direction incorporates our commitment to advancing Māori health, both within the Commission and in how we work with key stakeholders across the health system.

Understanding what quality improvement is for Māori is an important factor in determining the right approach to tackle complex issues affecting Māori. Quality of care and its effects on broader definitions of wellness for Māori should be self-determined. Meaningful Māori health gains are gains in areas that are priorities for Māori.

As we address the complex challenges that our system currently faces, we need to be focused on broad system-level change and systems thinking. We will pursue broader systems thinking, grounded in Te Tiriti o Waitangi principles, and develop quality improvement approaches for Māori.

Working with stakeholders

To meet our deliverables, we partner with district health boards (DHBs); the Ministry of Health; the Health and Disability Commissioner; the Accident Compensation Corporation (ACC); PHARMAC; clinical/health leaders; Māori leaders and advisors; consumers, families and whānau; an interagency equity hub; consumer advisory consultative panels; public and private hospitals; primary care providers; the aged care, mental health and disability sectors; non-governmental organisations (NGOs); international experts; and contracted providers. We work across agencies to share the work we do and what we know to improve health equity for New Zealand's vulnerable populations.

Strategic priorities

Our *Statement of Intent 2017–21*, published in June 2017, sets out our strategic priorities. We have recently reviewed those priorities and acknowledge the need to strengthen our commitment to Te Tiriti o Waitangi. In response, we have added a fifth strategic priority: 'Advancing Māori health'. The five strategic priorities and key areas of work in 2019/20 are set out below. In this SPE, we have amended 'Reducing harm and mortality' to 'Improving patient safety and reducing mortality'. This reflects a broader focus on safety. The Commission's Statement of Intent will be revised during 2019/20 and will reflect these changes.

Priority 1: Advancing Māori health

- Strengthening partnerships with national Māori health organisations and networks.
- Partnering with local Māori communities on improvement projects, using a co-design methodology to support self-determination of priorities and approaches.
- Partnering with Māori to develop kaupapa Māori improvement methods that will improve the quality and safety of health and disability services for Māori.
- Including Te Tiriti o Waitangi partnership into the clinical governance framework.
- Strengthening our Te Tiriti work and more actively promoting Te Tiriti o Waitangi as a tool and approach to improvement.
- Scoping and developing partnership approaches to extend or enhance primary care improvements for Māori.

Priority 2: Improving consumer and whānau experience

- Rolling out a quality and safety marker for consumer engagement across the DHBs.
- Partnering with providers to target and improve the lowest-scoring areas in their patient experience surveys.

- Promoting providers' use of co-design methodology and supporting projects that focus on equity.

Priority 3: Achieving health equity for all

- Designing and measuring all quality improvement programmes to reduce health inequities, for example the mental health and addiction improvement programme and its first focus of eliminating the use of seclusion.
- Implementing our Whakakotahi primary care improvement initiatives, contributing to reducing inequity and barriers to access.

Priority 4: Improving patient safety and reducing mortality

- Partnering with the sector and consumers to design and implement patient safety and improvement programmes to achieve measurable and sustainable improvement.
- Working in and across government and the health sector to promote learning from adverse events, including promoting the national adverse events policy.
- Supporting the mortality review committees to make evidence-based recommendations for systemic change to reduce deaths and preventable harm.

Priority 5: Reducing unwarranted variation in patterns of care

- Using the Atlas of Healthcare Variation to drive quality improvement, stimulate debate and reduce variation.
- Promoting increased transparency of outcomes and processes of care in line with the Ombudsman's expectations to focus attention and debate around areas of unwarranted variation in performance.
- Implementing improvement programmes to reduce variation in practice – for example, through greater consistency in using early warning scores to respond to patient deterioration.

Output classes

The Commission groups its activities into two output classes:

- Output class 1: Intelligence
- Output class 2: Improvement.

This approach reflects the core work of the Commission, which we define as our intelligence and improvement ‘hubs’: centres of expertise to help the sector to better understand and drive improvement. They are the foundation of the way we work.

The intelligence hub measures and reports on health quality and safety so we can identify the scale of the challenges faced by the system and measure the success of programmes designed to address those challenges.

This involves strengthening partnerships with iwi, hāpū, Māori communities and organisations to share analytical approaches, and intelligence and data. This supports and informs evidence-based decision-making and greater self-determinism for Māori populations experiencing the worst health outcomes in New Zealand.

Fostering a greater understanding of issues like variation in service provision or outcomes helps to promote improvement because it assists health decision makers to understand the unintended consequences of policies and processes.

The work of the mortality review committees comes under output class 1.

The improvement hub leads and coordinates improvement activity in partnership with consumers, families and whānau. The hub has a focus on building the sector’s capability and expertise for change, leading improvement programmes based on recognised methodologies, developing and sharing nationally consistent tools and guidance, and fostering networks so those leading improvement work can share ideas and support each other.

Output class 1: Intelligence

Background

One of our statutory roles is to measure and provide public reports on the quality and safety of the sector.[14] This includes making national and international comparisons to identify where improvement is needed. Effective and transparent reporting and analysis of quality and safety data, incidents and trends stimulate improvement, encourage discussion and help us to prioritise areas for improvement.

Our intelligence work

Good intelligence is essential to drive improvement and does so in three ways:

- Understanding the quality of health services and how well they meet the needs of the population they serve. This is a prerequisite for improvement.
- Publication of information about the quality of services. When done well, this is shown to stimulate improvement.
- Evaluating the effects of improvement activities on services. Without this, there is no way of knowing whether or not improvement activities have worked.

The Commission's intelligence work covers each of these areas. In some areas of our work, the interventions are directly attributable to the Commission, benefiting from its positioning as an independent and authoritative commentator.[15] In other cases, the Commission partners with the Ministry of Health and other agencies and individuals, who know more than us, amplifying its power to influence the system. In doing this we make use of national health collections, the Integrated Data Infrastructure and specially collected data.

Measuring quality and safety in New Zealand health care

The Commission publishes over 250 indicators on the quality and safety of New Zealand's health system. The vast majority of the measures of outcome and process the Commission publishes are broken down by sub-populations; notably by ethnicity but also by age and gender. Shining a light on inequity is a crucial first step to eliminating it.

These measures are aggregated in different ways. Our annual publication *A window on the quality of New Zealand's health care* helps show the public how our health system is performing and how it compares internationally. In 2017/18 this report considered measures of equity, safety, patient experience and effectiveness. It was published online in May 2018.

We also publish a series of integrated quality dashboards to display progress on quality performance in DHBs. The dashboards were first issued publicly in 2018. This allows the patterns of DHBs' quality achievements and challenges to be understood, and provides a more detailed picture at a local level.

Improved consumer engagement and experience

Our primary care patient experience survey was developed in partnership with the Ministry of Health and launched in 2016. The results are released publicly on a quarterly basis. The primary care survey joined our quarterly experience survey for adult inpatients, which we have been conducting in all DHBs since August 2014. The survey gathers feedback about the care people receive in public hospitals.

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[14] Refer to Appendix 1 for details on the Commission's role, under which Act and the relevant section.
[15] See Appendix 3 for measures and outcomes.

Information from these surveys is used by DHBs to improve services for patients and identifies the differences in experience of different groups. With the addition of the primary care survey, this opportunity has been extended to general practice teams and primary health organisations (PHOs). The aim is to identify areas for improvement and drive change.

Quality and safety markers

Quality and safety markers (QSMs) are a mix of structure, process and outcome measures designed to track the sector's progress against targets in key Commission improvement work programmes. The markers measure how much the sector is taking up good practice, how much harm is reduced and where money can be saved.

The QSMs will continue to be published quarterly. The suite of QSMs has been expanded to include additional measures to assist our improvement work, in the areas of medication safety, pressure injuries and patient deterioration. We have developed and tested a consumer engagement QSM which has been beneficial to improving safety outcomes for patients.

Serious adverse events reporting

Our national reporting on the adverse events reported to us has shifted from placing an emphasis on reporting raw numbers and types of events to learning from those events. The latest adverse events report shows health providers in New Zealand are continuing to develop and improve their systems for reporting, reviewing and learning from adverse events. We produce this report annually.

Mortality review

Mortality review is used to improve systems and practice within services and communities to prevent deaths. Five statutory mortality review committees are hosted by the Commission and work across agencies, encouraging them to consider improvement in their practices and implement recommendations. The committees also monitor the progress those agencies have made with recommendations from previous years.

Mortality review committees report or publish regularly, based on review and analysis of mortality, and make sector- or topic-specific recommendations to influence system changes to reduce mortality and morbidity. In 2019/20 the committees will produce at least two reports and hold two national events to share the contents of their reports.

The Commission supports the Government's priority of child health through the work of the Child and Youth Mortality Review Committee (CYMRC). The CYMRC produces two main types of reports: an annual data report and special topic reports. In recent years special topic reports have included pool fencing and sudden unexpected death in infancy (SUDI) with rangatahi suicide in development.

The CYMRC has reported and monitored child mortality rates for 14 years. The most recent data clearly shows that mortality is not evenly distributed in the population. Mortality rates are highest in areas of high deprivation, with those in decile 10 (the most deprived) being two and a half times more likely to die than those in decile one. The large burden of mortality for Māori and Pacific communities is due to the combination of their overall mortality rates being higher, and their overrepresentation in high deprivation areas.

The CYMRC continues to work closely with other government agencies, namely the Ministry of Education, Oranga Tamariki and the Ministry of Health to support the prevention of child mortality. The CYMRC also supports a local mortality review system that is embedded in

DHBs and encourages multidisciplinary and multi-agency review of the majority of child deaths. The learnings from these reviews are applied locally and nationally.

The Commission also supports government priorities through the work of the Family Violence Death Review Committee and the Perinatal and Maternal Mortality Review Committee.

Ngā Pou Arawhenua is a caucus of Māori members that supports the mortality review programme to provide appropriate Māori engagement and advice. Ngā Pou Arawhenua has led the design and implementation of a framework (Te Pou) to ensure committees follow a Māori-centred approach in their data gathering, analysis and reporting where appropriate.

Transparency of information

In 2017/18 we collaborated with the Australia New Zealand Acute Coronary Syndrome programme to build a performance dashboard for them, using a co-design methodology. This approach is proving a model for others to follow, and we will work with other clinical groups to encourage increased transparency of outcomes in line with the requirements of the Ombudsman's ruling in 2016.[16]

We will continue to publish evidence-based reports and discussion papers on health quality and safety in peer-reviewed journals. This is part of our role as leaders in spreading quality improvement methodology and expertise more widely.

New Zealand Atlas of Healthcare Variation

The Atlas of Healthcare Variation highlights variations by geographic area in the provision and use of health services and health outcomes. This prompts debate and raises questions about health service use and provision among users and providers of health services, which helps to stimulate improvement and reduce unwarranted variation.

Each Atlas domain illustrates a specific clinical area, and there are over 20 domains. Atlas domains present sub-analyses by age, ethnicity and sex. These allow users to see the impact of demographic variables on, for instance, the regular dispensing of medication or hospitalisation rates. These analyses highlight areas of inequity where further action may be needed for improvement.

[16] Office of the Ombudsman. Request for surgical complications data. June 2016. www.ombudsman.parliament.nz/system/paperclip/document_files/document_files/1635/original/402136_etc_-_request_for_surgical_complications_data.pdf?1467187036

Output class 1: Intelligence

SPE #no	Deliverable/activity/output	Performance measure	Alignment to Commission's strategic and Statement of Intent priorities
1	Implement the new consumer engagement quality and safety marker	• The number of DHBs submitting data to the Supporting, Understanding, Responding and Evaluating (SURE) framework by June 2020	• Improving consumer and whānau experience
2	Publish four reports on patient experience of hospital services and four reports on patient experience in primary care	• The % of DHBs who have explicit actions in their annual plans to address specific results of the patient experience survey(s) • Improvements in reported patient experience maintained	• Improving consumer and whānau experience • Advancing Māori health
3	Publish at least two mortality review committee reports	• Evidence-based reports are published and recommendations for improvement are made by June 2020 • Recommendations for improvement from previous reports are implemented by DHBs/health providers/professionals and monitored over 5 years	• Advancing Māori health • Achieving health equity • Improving patient safety and reducing mortality
4	Publish four updates of the quality and safety markers	• Performance against process level thresholds maintained across QSMs • Improvements in outcome markers maintained	• Improving patient safety and reducing mortality • Reducing unwarranted variation in patterns of care
5	Six Atlas domains and updates will be published	• Website hits to the Atlas remain at current high levels (an average of more than 1,500 page views a month) • The % of DHBs who have explicit actions in their annual plans to address specific findings (with a focus on equity) of the Atlas of Healthcare Variation.	• Achieving health equity • Reducing unwarranted variation in health services

Output class 2: Improvement

Background

One of our key statutory roles is to ‘lend a helping hand’ to the sector in improving the quality and safety of services. The Commission’s improvement work advances our strategic priorities in tangible ways. There is an increasing focus on partnering with Māori leaders, NGOs, consumers and whānau. We work with our intelligence hub to guide specific indicators and measures to help test and implement our improvement work.[17]

This work includes:

- building the capability of providers, consumers, families and whānau to work together as partners in care
- increasing the number of health professionals who take up evidence-based practice by translating evidence into tools and resources for frontline staff
- supporting networks to build momentum, champion and lead quality improvement, and sustain change in the longer term
- building quality improvement and clinical leadership capability.

We use expertise in New Zealand and overseas to identify and learn from innovative quality and safety practices. We use a variety of approaches to share these practices with the sector, including establishing expert advisory groups with clinical leaders, and enlisting the expertise of consumers and others as needed for our programmes. These groups are vital for linking with the sector, guiding the direction of programmes and providing clinical, consumer and/or technical advice.

We will seek to understand health inequities for Māori and other populations. We will partner with consumers and whānau and use co-design and kaupapa Māori improvement methods in our improvement programmes.

Our 2019/20 work to help the sector achieve change

Advancing Māori health

We work to improve the identification, interpretation and recommendations for improvement for whānau, hāpū and Iwi by having specifically tailored reports by mortality review committees that respond to the issues facing Māori in our health and social system. The committees will respond to the guidance of Ngā Pou Arawhenua (the mortality review committees’ Māori caucus).

Developing engagement and partnerships with consumers and whānau

Through our Partners in Care programme, we work to improve the experience of care and participation of consumers, families and whānau, and develop the leadership capability of providers and consumers.

We will support another Partners in Care co-design education and training programme for teams of consumers and health care personnel. We will also support the implementation of the quality and safety marker for consumer engagement (see output class 1).

[17] See Appendix 3 for measures and outcomes.

Patient safety

During 2018/19 we continued to support the health and disability sector and consumers in improving patient safety and reducing preventable harm associated with health care. The focus was on high harm areas such as medication safety, adverse events, falls and pressure injuries. In 2019/20 we will have an increased focus on resilient health care and building capability.

We will continue to develop and promote education, guidance and resources to support the national adverse events reporting policy across the whole health sector, encouraging providers to adopt their practices consistently. We are seeking to understand the experience of Māori and their whānau when a serious adverse event occurs.

Each year we coordinate Patient Safety Week, which focuses on a topical patient safety issue. The 2018 topic was hand hygiene and the 2019 topic will be communication, with a focus on unconscious bias.

Improvements in hospital practice

Supporting the sector to make improvements in the hospital setting has been a core function for the Commission since its establishment. Support is focused on specific harm reduction programmes and working with networks and key stakeholders to encourage improvements more broadly.

Healthcare associated infections

This cross-agency programme promotes culture change and provides guidance on practice improvements to reduce infections. The programme will expand from this year to develop a healthcare associated infections hub in partnership with DHBs. We will continue to support activities to reduce surgical site infections and improve hand hygiene.

This programme contributes to the Government's Antimicrobial Resistance Action Plan. Antimicrobial resistance is a growing global public health threat which affects patients, communities and threatens to undermine the modern health system. Antimicrobial resistance can also have serious negative impacts on animal health, welfare and production. The New Zealand Antimicrobial Resistance Action Plan was jointly developed by the Ministry of Health, Ministry for Primary Industries and representatives from across the human health, animal health and agriculture sectors.[18]

Patient deterioration

The patient deterioration programme supports nationally consistent recognition and response systems in all DHBs, continued spread of the Kōrero mai programme for patient and whānau escalation, and testing and rollout of resources to support improved shared goals of care conversations.

Surgical safety

This programme aims to reduce harm during the perioperative period by encouraging teams to consistently apply evidence-based practices and to improve teamwork and communication. It has a particular focus on surgical safety checklists, briefings and debriefings.

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[18] www.health.govt.nz/publication/new-zealand-antimicrobial-resistance-action-plan

Building leadership and capability in quality improvement and patient safety

The Commission is focused on building leadership capability in quality improvement and patient safety with the aim of improving the quality and safety of health and disability support services. This aligns with the Government priority of supporting a collaborative learning approach to enhance capacity and capability for quality improvement and patient safety in the health sector.

Significant progress has been made on building quality improvement knowledge and skills in the sector. We will continue building capability by being more responsive to consumers and patients' needs, reducing unwarranted variation and working towards the Commission's priorities through providers improving their processes and systems.

In 2019/20, a priority is developing a culture across all levels within the health and disability sector where quality improvement and patient safety are the central focus. This includes providing the health and disability workforce with quality improvement and safety knowledge and skills appropriate to their role, and professional development and opportunities for shared learning. We will continue to engage with governing boards of health providers. This will include scientific symposiums and workshops featuring international speakers.

Community improvement

Primary care

We have supported the implementation of two tranches of primary care-led projects selected in our Whakakotahi primary care improvement challenge.[19] We will be supporting a third tranche of initiatives during 2019/20.

The Whakakotahi 2019 intake has achieved increased reach into Māori health providers with a deliberate focus on reducing disparities. All the 2019 project topics are centred around improving health outcomes for disadvantaged poulations. Three kaupapa Māori organisations, one Pacific peoples organisation and one remote/rural primary health care organisation are participating. We are partnering with PHARMAC on three projects which have a focus on medicines access equity.

The programme is being independently evaluated, and while work has focussed on small scale sector-led projects, early results show positive gains in capability building, Commission profiling and engagement, project achievements and clinical outcomes.

Building capability is a critical part of this work, and we continue to strengthen sector linkages through supporting the PHO Quality Improvement Network and sponsoring quality improvement training opportunities for the primary care workforce.

During 2019/20, we will plan the next phase of the programme to achieve spread, scale and sustainability of our improvement work. A priority will be to partner with Māori and focus on improving outcomes for Māori and equity of all populations.

Aged residential care

The Commission, in partnership with the ARC sector, is taking a system-wide approach to developing a quality improvement programme and building on the good work already in progress across the sector. A key opportunity is to explore how we analyse and use the data available in the sector, eg, interRAI is used to identify priority areas, with a focus on

[19] Whakakotahi ('to be as one') is a programme of work that identifies primary care-led quality improvement initiatives. Projects are submitted through an expressions of interest process and selected against agreed criteria with a focus on equity, integration and consumer engagement. Projects have been identified in 2017/18, 2018/19, and 2019/20.

developing metrics to inform quality of life measures to show the residents' experience of care.

Our work will also be informed by the information we have about unwarranted variation or harm affecting the quality of care being delivered. Early indications will see us supporting initiatives to improve medicines management, identifying and responding to the unexpected or preventable deterioration of residents, and learning from adverse events. We will partner with the larger providers in sector-led initiatives and work more closely with smaller providers who may benefit from more targeted assistance and support.

Building the workforce capability in quality improvement is critical to our work and will advance improvement and ensure it can be sustained in the long term. The Commission has a long-term commitment to supporting one of our most vulnerable population groups.

Output class 2: Improvement

SPE #no	Deliverable/activity/output	Performance measure	Alignment to Commission's strategic and Statement of Intent priorities
6	Advancing Māori health – strengthen partnership with Māori and develop kaupapa Māori improvement methods that will improve the quality and safety of health and disability services for Māori	• Develop a kaupapa Māori quality improvement framework and resources that can guide improvement initiatives	• Advancing Māori health • Achieving health equity
7	Improve Māori experience of adverse events within a hospital environment	• Complete the report on Māori experience of adverse events • Quality improvement actions identified	• Advancing Māori health • Improving consumer and whānau experience • Achieving health equity • Improving patient safety and reducing mortality
8	Expand and spread the Kōrero Mai programme for patient and whānau escalation in DHBs	• Two additional cohorts of the Kōrero mai programme are underway in DHBs • DHBs measure the impact of Kōrero mai • Evaluation report due 30 June 2020	• Improving consumer and whānau experience • Achieving health equity • Improving patient safety and reducing mortality
9	Deliver a co-design programme nationally for consumer–provider teams focused on cancer	• Teams will report on how the learnings from their co-design projects have contributed to improving services for consumers and whānau	• Advancing Māori health • Improving consumer and whānau experience • Improving patient safety and reducing mortality
10	Implement the chosen Whakakotahi 2019 primary care improvement projects	• An evaluation demonstrates the impact of the initial 3-year phase of the programme and informs the future design and options for scale and spread in primary care by 30 June 2020 • Final evaluation report due 30 June 2020	• Advancing Māori health • Improving consumer and whānau experience • Achieving health equity

SPE #no	Deliverable/activity/output	Performance measure	Alignment to Commission's strategic and Statement of Intent priorities
11	Implement mental health and addiction improvement programmes with a focus on zero seclusion, connecting care and the start of learning from adverse events	• Sustainable approach to zero seclusion, delivery of connecting care collaborative and initiation of learning from adverse events improvement activity • DHB engagement framework shows achievement against milestones (eg, attendance at events, key documents and plan–do–study–act (PDSA) testing of change ideas) • Measurement framework in place for zero seclusion and connecting care, which includes outcome, process and balancing measures	• Advancing Māori health • Improving consumer and whānau experience • Achieving health equity • Improving patient safety and reducing mortality • Reducing unwarranted variation in patterns of care
12	Development of the healthcare associated infection hub in partnership with DHBs	• Continued implementation of evidence-informed process improvements to reduce surgical site infections • Point prevalence survey implemented and agreement on priorities for the healthcare associated infection hub	• Improving consumer and whānau experience • Achieving health equity • Improving patient safety and reducing mortality • Reducing unwarranted variation in patterns of care
13	Strengthen improvement science capability in primary and secondary care settings	• Sponsor participation in improvement advisor and improvement facilitator training programmes for primary care and mental health and addiction services • Scope a programme aimed at developing senior clinician leadership capability for quality and safety	• Improving consumer and whānau experience • Improving patient safety and reducing mortality

Quality improvement and intelligence initiatives with third parties

In addition to our work funded directly by government, the Commission partners with third parties when improvement goals fit with our priorities and mandate. Third party revenue projects have been funded by DHBs, ACC and the Ministry of Health. These programmes have helped the Commission expand the scope and scale of improvement work in specific areas.

The Commission brings a focus on improving outcomes for Māori, equity for all and partnerships with consumers. This level of expansion within specific areas is an indication of how highly our role and work is valued by sector agencies. The current projects supported with third party revenue are outlined below.

Mental health and addiction improvement

The Commission's DHB-funded national mental health and addiction quality improvement programme started in July 2017. In 2019/20 we will work more closely with DHB project teams to implement two improvement projects:

- Zero seclusion: Towards eliminating seclusion by 2020
- Connecting care: Improving service transitions.

We will begin the project on learning from adverse events and whānau experience. This improvement work will have a strong focus on identifying and reducing inequity. It will additionally include specific kaupapa Māori mental health and addiction projects. These will begin in 2019/20.

We will partner with the Ministry of Health to consider how best to respond to the mental health inquiry, and how to support the implementation of recommendations across the health sector.

Major Trauma Network

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

Advance care planning

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

Healthcare associated infections

The Commission has led a national programme, in partnership with DHBs and more recently, ACC since 2011. Initially the programme focused on a central line associated infection (CLAB) quality collaborative and improving health care worker compliance with the World Health Organization's '5 moments for hand hygiene'. The New Zealand Surgical Site

Infection Improvement programme was added in 2012. DHBs have agreed to partner with the Commission to support a sustainable extension of the programme's scale and spread from July 2019.[20]

Suicide Mortality Review Committee (SuMRC)

The SuMRC was re-established in late 2017. While mortality review committees are funded from our baseline, the SuMRC is funded by the Ministry of Health through a separate contract. The SuMRC will establish a suicide mortality review database and design and implement a kaupapa Māori death review process.

SuMRC is also focused on developing cross-sector relationships due to the nature and complexity of suicide. To date, SuMRC has established partnerships to receive data from ACC, the Ministry of Education, the Ministry of Health and the coroner's office. The SuMRC is also developing a kaupapa Māori death review process that will prioritise whānau voice but enable reviews to produce recomendations and outcomes to be developed using a by-Māori-for-Māori approach where applicable.

Maternal morbidity

In 2015 the Commission was funded by the Ministry of Health to support the transition of the severe acute maternal morbidity (SAMM) research programme to implement a sustainable approach. The available funding has been spread across five years and has been used to support national, regional and local maternal morbidity review and quality improvements.

Implementation of a nationally consistent maternal early warning system in all DHB hospitals will be completed during 2019/20, the fifth and final year of this programme. Review of maternal morbidity data will continue to be an ongoing responsibility of the Perinatal and Maternal Mortality Review Committee.

ANZICS – clinical register

We hold the contract for the Australia and New Zealand Intensive Care Society (ANZICS) clinical register. This is funded by the Ministry of Health and goes directly and in total to ANZICS for the provision of the register to New Zealand intensive care units.

Patient experience surveys

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

[20] The funding mechanism for this is still to be confirmed by DHBs.

Organisational health and capability

Fulfilling our obligations under Te Tiriti o Waitangi

Te Whai Oranga, the Commission's Māori advancement framework, creates a common understanding and language as we focus on improving the quality and safety of health and disability services for Māori. Mahi ngātahi (partnership) is a key feature in the Commission's work. We ensure Māori world views and values, including rangatiratanga, mātauranga, wairuatanga and tikanga, are reflected in the Commission's whai hua (strategic priorities).

We are continually building and improving cultural knowledge, skills and competencies that are required for the Commission to undertake its mandated role in government and in its obligation to Te Tiriti o Waitangi.[21]

Achieving health equity

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

We are working to ensure diversity and inclusion lenses are applied across all our work to support the changing health needs of different communities.

Performance improvement framework

The Commission is committed to delivering better outcomes for New Zealand, responding to challenges and expectations and improving as an agency. To assist us we are conducting a performance improvement framework (PIF) self-review during 2019/20. We are using the State Services Commission PIF framework and will include a specific focus on how well placed we are to contribute to achieving health equity for Māori within the scope of our mandated role. Three external reviewers have been engaged to develop the Four-year Excellence Horizon. The PIF is due to be completed by mid-2019 and will inform the 2020–24 Statement of Intent.

The impact of change on our people

Significant changes have already occurred across the public sector that have affected those tasked with delivering services in the health sector. This means the Commission's work is more important than ever. The Commission cannot deliver on a large, challenging and rapidly evolving work programme without changes in the way it works and in the working environment provided for our people. It is the Commission's people who will deliver on the business strategy.

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

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[21] A performance improvement framework (PIF) self-review is underway. The insights and recommendations from the PIF review will form part of a comprehensive review of Te Whai Oranga, the Commission's Māori advancement framework. Any review of Te Whai Oranga will be completed by December 2019.

State sector reform

We note the proposed changes to the State Sector Act 1988 and will include our response in future plans.

Governance and strategic advisory

The board of the Commission has at least seven members appointed under section 28 of the Crown Entities Act 2004. They provide advice and direction on the Commission’s strategic intentions and future direction.

In addition to our board governance, governance and strategic advice is supported by:

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

Sustainability

The Commission will continue our efforts to improve our sustainability. This will include continuing to reduce carbon emissions by focusing actively on transport in particular. We will look to consider adopting sustainable strategies used by other organisations including the Ministry of Health.

Forecast financial statements

Expected revenue and proposed expenses to be incurred in 2019/20

Expected revenue and proposed expenses for 2019/20

	Output class 1 Intelligence $000s	Output class 2 Improvement $000s	Total $000s
Revenue			
Crown revenue	8,541	5,713	14,254
Interest revenue	18	22	40
Other revenue	52	4,365	4,417
Total revenue	8,611	10,100	18,711
Expenditure			
Operational and internal programme costs	6,112	7,383	13,495
External programme cost	2,824	3,011	5,835
Total expenditure	8,936	10,394	19,330
Surplus/(deficit)	(325)	(294)	(619)

Note: Numbers are rounded. See ‘Key assumptions for proposed budget in 2019/20 and outyears’ later in this document for explanations.

Prospective financial statements for the four years ending 30 June 2022

Prospective statement of comprehensive revenue and expense

	Planned 12 months to 30 June 2019 $000	Forecast 12 months to 30 June 2019 $000	Planned 2019/20 $000	Planned 2020/21 $000	Planned 2021/22 $000
Revenue					
Revenue from Crown	14,490	14,565	14,254	14,254	14,254
Interest revenue	40	55	40	40	40
Other revenue	2,659	2,903	4,417	3,696	3,696
Total operating revenue	**17,189**	**17,523**	**18,711**	**17,990**	**17,990**
Expenditure					
Salaries	9,594	9,447	10,885	10,260	10,281
Travel	393	382	369	347	347
Consultant and contractors	148	348	214	184	184
Board/fees/committees	679	744	578	499	499
Printing/communication	249	216	224	199	199
Overhead and IT expenses	973	1,131	1,051	946	946
Other expenses	8	35	8	8	8
Total internal programme and operating expenditure	**12,044**	**12,303**	**13,329**	**12,443**	**12,422**
External programmes					
Quality and safety programmes	3,391	3,760	4,051	3,810	3,810
Mortality review programmes	1,954	1,894	1,784	1,574	1,574
Total external programme expenses	**5,345**	**5,654**	**5,835**	**5,384**	**5,384**
Depreciation and amortisation	150	175	166	163	142
Total expenditure	**17,539**	**18,132**	**19,330**	**17,990**	**17,990**
Operating surplus/deficit	**(350)**	**(609)**	**(619)**	**0**	**0**

Note: Numbers are rounded.

The 2019/20 planned deficit of $0.619 million relates to revenue received in prior years for suicide mortality review ($0.255m) and the maternal morbidity improvement programme ($0.208m) where activity is to be delivered in 2019/20 rather than 2018/19. The balance of $0.156 million is a call on historical balance sheet equity.

For 2019/20, revenue assumptions include:

- $12.976 million core Crown revenue
- $0.308 million from the Ministry of Health per year for the primary care patient experience survey
- $0.750 million from the Ministry of Health for suicide mortality review
- $0.220 million from the Ministry of Health for the Australia and New Zealand Intensive Care Society Centre for Outcome and Resource Evaluation (ANZICS CORE) registry
- $1.500 million per year from DHBs as revenue associated with mental health quality improvement
- $1.228 million for DHB funding of the national data warehouse and expansion of the Surgical Site Infection Improvement programme
- $0.791 million from ACC for provision of support for a major trauma network
- $0.721 million from DHBs as revenue associated with advance care planning (outyear revenue is still to be negotiated)
- $0.130 million from adverse event and leadership workshops
- $0.052 million per year for the primary care patient experience survey from DHBs
- $0.040 million interest.

Draft prospective statement of changes in equity

	Planned 12 months to 30 June 2019 **$000**	**Forecast 12 months to 30 June 2019** **$000**	**Planned 2019/20** **$000**	**Planned 2020/21** **$000**	**Planned 2021/22** **$000**
Opening balance	**1,406**	**2,222**	**1,613**	**994**	**994**
Equity injection	0	0	0	0	0
Total comprehensive income:					
Net surplus / (deficit)	(350)	(609)	(619)	0	0
Balance at 30 June	**1,056**	**1,613**	**994**	**994**	**994**

Note: Numbers are rounded.

Draft prospective statement of financial position

	Planned 12 months to 30 June 2019 $000	Forecast 12 months to 30 June 2019 $000	Planned 2019/20 $000	Planned 2020/21 $000	Planned 2021/22 $000
Accumulated funds	**1,056**	**1,613**	**994**	**994**	**994**
Represented by current assets					
Cash and cash equivalents	1,715	2,415	1,858	1,744	1,777
GST receivable	290	328	317	290	289
Debtors and other receivables	354	230	261	261	261
Prepayments	52	55	56	56	57
Total current assets	**2,411**	**3,028**	**2,492**	**2,351**	**2,384**
Non-current assets					
Property, plant and equipment	198	328	192	259	227
Intangible assets	64	0	0	0	0
Total non-current assets	**262**	**328**	**192**	**259**	**227**
Total assets	**2,673**	**3,356**	**2,684**	**2,610**	**2,611**
Current liabilities					
Creditors	1,066	1,189	1,136	1,024	1,024
Employee benefit liabilities	487	554	554	592	593
Total current liabilities	**1,553**	**1,743**	**1,690**	**1,616**	**1,617**
Total liabilities	**1,553**	**1,743**	**1,690**	**1,616**	**1,617**
Net assets	**1,120**	**1,613**	**994**	**994**	**994**

Note: Numbers are rounded.

Draft prospective statement of cash flows

	Planned 12 months to 30 June 2019 $000	Forecast 12 months to 30 June 2019 $000	Planned 2019/20 $000	Planned 2020/21 $000	Planned 2021/22 $000
Cash flows used in operating activities					
Cash provided from:					
Crown revenue	13,740	14,565	14,254	14,254	14,254
Interest received	40	55	40	40	40
Other income	2,552	3,213	4,386	3,696	3,696
Cash disbursed to:					
Payments to suppliers	(7,698)	(8,287)	(8,323)	(7,679)	(7,568)
Payments to employees	(8,311)	(9,357)	(10,885)	(10,222)	(10,280)
Net goods and services tax	37	(102)	11	27	1
Net cash flows from (used in) operating activities	**360**	**87**	**(517)**	**116**	**143**
Cash flows used in investing activities					
Cash disbursed to:					
Purchase of property, plant, equipment & intangibles	(150)	(117)	(40)	(230)	(110)
Net cash flows (used in) investing activities	**(150)**	**(117)**	**(40)**	**(230)**	**(110)**
Cash flows used in financing activity					
Equity injection	0	0	0	0	0
Net cash flows (used in) finance activities	**0**	**0**	**0**	**0**	**0**
Net increase/(decrease) in cash and cash equivalents	210	(30)	(557)	(114)	33
Plus, projected opening cash and cash equivalents	1,505	2,445	2,415	1,858	1,744
Closing cash and cash equivalents	**1,715**	**2,415**	**1,858**	**1,744**	**1,777**

Note: Numbers are rounded.

Declaration by the board

The board acknowledges its responsibility for the information contained in the Commission's forecast financial statements. The financial statements should also be read in conjunction with the statement of accounting policies on page 35.

Key assumptions for proposed budget in 2019/20 and outyears

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

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

Each year when developing the SPE the board and management continue to look for savings, re-prioritisation and compromises to match programme activity to Crown funding levels and absorb any cost pressures. We have a consistent record of delivering our outputs while remaining within budget. Crown revenue baselines have remained unchanged over the past seven years.

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

Key assumptions are listed below.

- While personnel costs have been assessed on the basis of expected staff mix and seniority, these may vary. Total expenditure will be maintained within forecast estimates, even if individual line items vary. In particular, there may be movements between salary, contractor and programme costs.
- Outyear costs in the operating budget are based on a mix of both no and limited general inflationary adjustment.
- The timing of the receipt of Crown revenue is based on quarterly payments made at the beginning of the quarter on the fourth of the month.
- Salaries include up to a 2 percent provision for an annual increase.
- The 2019/20 planned deficit of $0.619 million relates to revenue received in prior years for suicide mortality review ($0.255m) and the maternal morbidity improvement programme ($0.208m) where activity is to be delivered in 2019/20 rather than 2018/19. The balance of $0.156 million is a call on historical balance sheet equity.
- The Commission has previously worked within the assumption of keeping reserve levels of around $1.1 million to $1.3 million. The proposed approach for this SPE reduces historic reserves to $0.994 million.
- Hardware and software replacement is planned for each of the three financial years.

Statement of accounting policies

Reporting entity

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

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

Basis of preparation

Statement of compliance

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

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

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

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

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

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

Measurement system

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

Functional and presentation currency

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

Significant accounting policies

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

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

Budget figures

The Commission has authorised these prospective financial statements for issue in June 2019.

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

Revenue

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

Revenue from the Crown

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

Interest

Interest income is recognised using the effective interest method.

Operating leases

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

Cash and cash equivalents

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

Debtors and other receivables

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

Bank deposits

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

Inventories

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

Property, plant and equipment

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

- Property, plant and equipment are shown at cost, less any accumulated depreciation and impairment losses.
- The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the Commission and the cost of the item can be measured reliably.
- Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are included in the prospective statement of financial performance.
- Costs incurred after initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the Commission and the cost of the item can be measured reliably.
- The costs of day-to-day servicing of property, plant and equipment are recognised in the prospective statement of financial performance as they are incurred.

Depreciation

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

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

Intangibles

- Software acquisition: Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.
- Costs associated with maintaining computer software are recognised as an expense when incurred.
- Costs associated with developing and maintaining the Commission's website are recognised as an expense when incurred.
- Amortisation: Amortisation begins when the asset is available for use and ceases at the date the asset is derecognised.
- The amortisation charge for each period is recognised in the prospective statement of financial performance.
- The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:
- Acquired computer software 3 years 33% SL

Impairment of non-financial assets

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

Appendix 1: Commission objectives and functions

Objectives of HQSC[22]

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

(a) monitoring and improving the quality and safety of health and disability support services; and

(b) helping providers across the health and disability sector to improve the quality and safety of health and disability support services.

Functions of HQSC

The functions of HQSC are —

(a) to advise the Minister on how quality and safety in health and disability support services may be improved; and

(b) to advise the Minister on any matter relating to —

- health epidemiology and quality assurance; or
- mortality; and

(c) to determine quality and safety indicators (such as serious and sentinel events) for use in measuring the quality and safety of health and disability support services; and

(d) to provide public reports on the quality and safety of health and disability support services as measured against —

- the quality and safety indicators; and
- any other information that HQSC considers relevant for the purpose of the report; and

(e) to promote and support better quality and safety in health and disability support services; and

(f) to disseminate information about the quality and safety of health and disability support services; and

(g) to perform any other function that —

- relates to the quality and safety of health and disability support services; and
- HQSC is for the time being authorised to perform by the Minister by written notice to HQSC after consultation with it.

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

(a) the Ministry of Health; and

(b) the Health and Disability Commissioner; and

(c) providers; and

(d) any groups representing the interests of consumers of health or disability support services; and

[22] Source: section 59B–C, New Zealand Public Health and Disability Act 2000.

(e) any other organisations, groups, or individuals that HQSC considers have an interest in, or will be affected by, its work.

Appendix 2: Alignment between our work and the Letter of Expectations

Statement of Performance Expectations (SPE) Deliverables for 2019/20		
Minister's Letter of Expectations	**Deliv-erable #no**	**Commission SPE deliverables**
Continuing to perform its core work with clinicians, providers and consumers to improve health and disability support services	**SPE 9** **SPE 12** **SPE 13**	- Deliver a co-design programme nationally for consumer–provider teams focused on cancer - Development of the HAI hub in partnership with DHBs - Investigate the use of antibiotics, to analyse prescribed medicines to consumers during trial period
Supporting the implementation of system level measures in the health sector, by raising improvement science capability, in both primary and secondary care settings	**SPE 2** **SPE 5** **SPE 14**	- Publish four reports on patient experience of hospital services and four reports on patient experience in primary care - Six Atlas domains and updates will be published - Enhance capacity and capability for quality improvement across the health and disability sector and support the development of a collaborative learning platform
Developing and implementing quality improvement programmes to reduce health inequities	**SPE 4** **SPE 6** **SPE 7** **SPE 8** **SPE 10** **SPE 11**	- Publish four updates of the quality and safety markers - Advancing Māori health – strengthen partnership with Māori and develop kaupapa Māori improvement methods that will improve the quality and safety of health and disability services for Māori - Improve Māori experience of adverse events within a hospital environment - Expand and spread the Kōrero mai programme for patient and whānau escalation in DHBs - Implement the chosen Whakakotahi 2019 primary care improvement projects - Implement mental health and addiction improvement programmes with a focus on zero seclusion, connecting care and the start of learning from adverse events
Supporting a collaborative learning platform to enhance capacity and capability for quality improvement in the health sector, including the integration of primary and secondary care services	**SPE 13**	- Enhance capacity and capability for quality improvement across the health and disability sector and support the development of a collaborative learning platform
Providing governance, analysis and monitoring of patient experience surveys in primary and secondary care settings	**SPE 2**	- Publish four reports on patient experience of hospital services and four reports on patient experience in primary care

Actively supporting and contributing to the Ministry of Health's work on better capturing performance information about the quality and safety of New Zealand's health services, including work related to the eventual publication of health data	**SPE 1** **SPE 3**	- Implement the new consumer engagement quality and safety marker - Publish at least two mortality review committee reports
Working with the Ministry of Health to respond to the Health and Disability System Review, and implementing the resulting recommendations		- Working with the Ministry of Health to respond to the Health and Disability System Review, and implementing the resulting recommendations
Working collaboratively across the sector to ensure all proposed publications reflect a comprehensive, contextualised and joined-up picture of the New Zealand health system	**SPE 3** **SPE 4** **SPE 5**	- Publish at least two mortality review committee reports - Publish four updates of the quality and safety markers - Six Atlas domains and updates will be published

Appendix 3: How we measure improvement

Draft

The Health Quality & Safety Commission exists to lead and coordinate work across the health and disability sector, to improve quality and safety of care by those organisations providing health care services in New Zealand.

Our deliverables are listed above, but we also track the effect these have on practice within the sector (impact) and the results of these changes (outcome) in our biannual outcome matrix. As all our deliverables relate to one (or more than one) of our strategic priorities we can demonstrate the effects of our programmes on these priorities in terms of changed practice, outcomes for consumers and populations, and costs to the system.
The following table shows examples across our priorities.

Table: Examples of how we measure the impact of our work

Strategic priority	SPE deliverable #no	Programme area	Aim	Impacts Change of practice	Outcomes (including avoided costs of harm)	Value
1: Advancing Māori health 4: Improving patient safety and reducing mortality	3	Child and Youth Mortality Review Committee	To reduce deaths of children and young people aged 28 days to 24 years	• From 1 July 2011 to 30 June 2016, the CYMRC made 112 recommendations across six special topic reports. Of these 85 were achieved, mostly achieved or achieved in part	• Reduced numbers of annual deaths from 638 in 2002 to 483 in 2016 • The greatest reduction in deaths has been in SUDI and motor vehicle crashes	Equates to $271 million cumulative value to date*
1: Advancing Māori health 4: Improving patient safety and reducing mortality	3	Perinatal and Maternal Mortality Review Committee	To reduce maternal deaths and deaths of infants after 20 weeks gestation up to and including 28 days of life or 400 grams weight	• DHBs are providing multidisciplinary training in management of obstetric emergencies; provided in-house for all but one secondary hospital • DHBs with high perinatal or neonatal rates have introduced initiatives to improve pregnancy care	• A significant decrease between 2007 and 2016 in the stillbirth rate, from 369 deaths to 310 deaths • A significant reduction in fetal deaths from 2007 to 2016 from 513 to 458 • A significant reduction in maternal mortality from 2006 to 2016 from 15 to 2	Equates to $40.5 million cumulative value to date*
2: Improving consumer and whānau experience	1 and 2	Partners in Care	Improve inpatient experience of care	• 14/20 DHBs have planned interventions specifically designed to improve the patient experience • 90% of DHBs have a consumer council (cf. target of 75% by 2018/19)	• 13% of inpatient experience indicators in the inpatient experience survey show a significant, sustained increase from the baseline of 2014 • This equates to: 30,000 more hospital inpatients who felt they were definitely involved in decisions about their care and treatment	

Strategic priority	SPE deliverable #no	Programme area	Aim	Impacts Change of practice	Outcomes (including avoided costs of harm)	Value
					• 25,000 more who felt they were always treated with respect and dignity	
2: Improving consumer and whānau experience 3: Achieving health equity for all	2	Partners in Care/ Measurement and evaluation	Improve patient experience of primary care	• Health alliances take action to reduce the inequity between different age, ethnic and health status groups as measured by the primary care survey	• Baseline data (2017) shows o 10 questions with systematic ethnic inequity o 15 with systematic age inequity • Improvements will be measured by the number of these questions where significant, sustained reductions in inequity are recorded. We will only have sufficient data to measure this by late 2020.	
3: Achieving health equity for all 5: Reducing unwarranted variation in patterns of care	5	Measurement and evaluation	Stimulate improvements through the use and publication of information	• 5/7 updated Atlas domains showed either a significant reduction in variation or an improvement at an overall national level for at least one measure	• 12,000 more people with diabetes regularly receiving metformin or insulin • 15,000 fewer people 65+ dispensed 5 or more medications • 250 fewer infections following major surgery • 550 fewer admissions for asthma and wheeze in children • 350 fewer admissions for asthma in adults	

Strategic priority	SPE deliverable #no	Programme area	Aim	Impacts Change of practice	Outcomes (including avoided costs of harm)	Value
4: Improving patient safety and reducing mortality	4 and 12	Healthcare associated infections	To reduce the incidence and impact healthcare associated infections in New Zealand	• 85% compliance with WHO hand hygiene guidelines quarter 1, 2018 • SSI 97% compliance with antibiotic dose and 98% compliance with antibiotic timing quarter 4, 2017	• SSI rates have reduced from 1.2% to 0.9% since Aug 2015 resulting in 94 fewer infections and $3.8 million in avoided costs	• Equates to 47 additional years of healthy life from avoided SSIs worth $8.5 million
4: Improving patient safety and reducing mortality	4	Falls	The original aim of the programme was to achieve and sustain a 20% reduction in the number of inpatient fractured necks of femur (FNOF)	• Improved processes for falls risk assessments in hospitals for older people (92% in quarter 1, 2018) • Increased completion of individual care plans (93% in quarter 1, 2018)	• 144 fewer falls with FNOF (Sept 2014–Mar 2018). • $6.8 million in avoided costs (Sept 2014–Mar 2018) • 4311 avoided bed-days. • A 33% reduction was achieved	• 236 additional years of healthy life from avoided FNOF • $42.7 million value gained for healthy years of life
4: Improving patient safety and reducing mortality 5: Reducing unwarranted variation in patterns of care	4 and 8	Patient deterioration	Reduce harm from failures to recognise or respond to physical deterioration nationally for all adult inpatients (excl maternity) by July 2021	• 18/20 DHBs using the New Zealand early warning score through the national vital signs chart or electronic system (15/20 at baseline January 2018) • 84% of patients correctly escalated (58% at baseline April 2018)	In-hospital cardiopulmonary arrests 1.7 per 1,000 admissions	

* based on the value of a statistical life ($4m) discounted across average life expectancy