HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

ANNUAL REPORT

FOR THE PERIOD
1 JULY 2013 TO 30 JUNE 2014

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

open FOR BETTER CARE
Hāpai ake te toiora

KELVIN TWIST — **A TRIBUTE**

Kelvin Twist was 40 and fit. He had a high-powered job and a passion for motor racing. Then, in January 2008, he found himself short of breath during exercise. He was diagnosed with a rare form of cancer. Kelvin survived the intensive surgery and chemotherapy that followed, as well as a severe blood infection and a medication error. In his experience of illness and the health care system, he developed, in his own words, 'a huge passion to help others travelling the cancer and general health system journey, to try and improve the services as much as I can.'

Despite the seriousness of his illness, Kelvin was incredibly active in consumer participation. Kelvin represented the interests of consumers as a member of the Northern regional lung cancer work stream, the Northern network consumer group and the Auckland District Health Board cancer control steering group. Nationally, he was an inaugural member of the National Cancer Consumer Representative Advisory Group and a member of the Health Quality & Safety Commission consumer network.

Kelvin was also part of the original start-up team for Dry July NZ. He helped raise more than $550,000 in the first year, $1 million in the second and $800,000 in the third. All of this money went to improving patient and whānau experience.

Dr Richard Sullivan was Kelvin's oncologist and they had a strong relationship. Over the five years of Kelvin's illness, Dr Sullivan watched Kelvin's work in consumer participation in health care. He saw Kelvin's drive to change the system, to ensure that the patient was at the centre of care, to improve health literacy, and ultimately to change patient outcomes for the better. 'Kelvin was very clever and very influential in driving change,' remembers Dr Sullivan.

Sadly, Kelvin passed away on 26 July 2014. We will miss Kelvin – but he has left a legacy. Engaging consumers in their own health care decisions improves health quality and patient safety. It's the right thing to do.

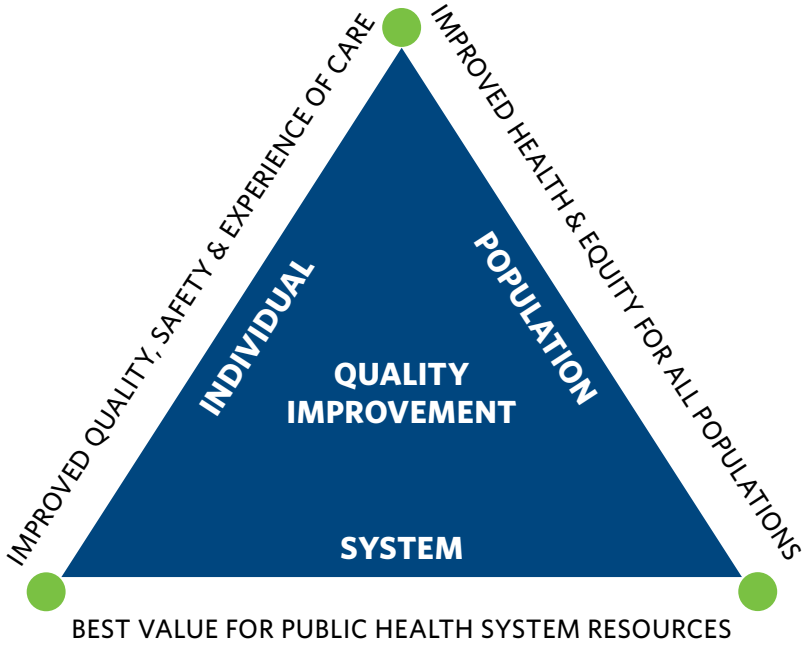
OUR VALUES

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

OUR OUTCOMES

The New Zealand Triple Aim[1]

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



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

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CHAIR'S FOREWORD

The Health Quality & Safety Commission (the Commission) is a national agency that plays an integral role in improving the quality and safety across all New Zealand health care and disability services. Our overarching goal is the New Zealand Triple Aim, the simultaneous pursuit of three dimensions:

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

Achieving the Triple Aim depends on two fundamental things. First: doing the right things. Second: ensuring these things are done correctly, first time. These fundamental drivers mean providing care based on integrating the best available external clinical evidence with the needs and values of each individual patient. There is, unfortunately, substantial variation in care that does not reflect differences between patients or even differences in resource. 'Overtreatment' represents a serious opportunity cost and creates risk to patients without the prospect of benefit. 'Undertreatment' is an equally critical issue that means other patients are failing to receive treatment that is effective and that meets their real needs. The New Zealand Atlas of Healthcare Variation is a powerful new tool, introduced by the Commission in 2012, that identifies areas of variation to stimulate thinking and action about the right things to do.

Most people who work in health care in New Zealand are already highly motivated in both regards – the Commission's role is to make the efforts of front-line workers more effective and safer. To this end, we bring together internal and external expert advisors, clinicians, academics and local champions to inform and educate our initiatives with the best possible and most up-to-date science and clinical experience from around the world.

Take, for example, a well-trained and highly skilled team of a surgeon, an anaesthetist, nurses, allied health professionals and pharmacists undertaking a technically demanding total knee replacement in an older female patient with multiple co-morbidities. The benefit of all this technical expertise is wasted if the outcome is not of value to the patient. A knee replacement may be the very thing needed to improve her quality of life – or it may not: other aspects of her condition or situation may be dominant, and problems with her knee may make only a small contribution to the problems that really matter to her. Procedures that are not truly effective or indicated are at best an opportunity cost, and at worst an unnecessary risk to the patient. Having decided that it is appropriate to proceed, success hinges not only on the highly developed skills of all members of the team but also on some really simple aspects of process – operating on the right side of the right patient, and administering the correct dose of the correct prophylactic antibiotic at the correct time, for example. The operation may be a technical triumph, but that work and success can be jeopardised many days later by a failure in hand hygiene on the part of just one of any number of individuals who interact with the patient postoperatively, or in the care with which an unnecessary fall is avoided as she mobilises.

The latter point became very real to me personally, after my broken leg had been surgically repaired some years ago. When I was discharged, the meticulous care taken by the attendant who pushed my wheelchair through the corridors of Middlemore Hospital and then ensured that my transfer from the wheelchair into a waiting car was done carefully and safely is still something I think back on with great appreciation.

This, the 2013–14 annual report of the Commission, describes what we have achieved over the last year through projects that address the simple but essential processes that underpin our complex medical services. People learn by doing, so the direct benefits of specific projects are just part of a wider objective – to enhance the sector's capacity and capability to effect improvement. These projects spread and embed principles of quality improvement that apply generally.

This report also describes our work to improve the experience of care for patients and consumers. Our health and disability support services exist for the people they serve. There is growing evidence demonstrating the benefits of partnerships between health services and patients (along with their families/whānau and carers), including improved outcomes, enhanced experience of care, lower costs per case and increased workforce satisfaction.

During 2013–14 eight more teams – consisting of a staff member and a consumer – completed the Commission's Partners in Care co-design programme, started in 2012. Sometimes a small change makes a

vital difference to the patient. One of the co-design projects involved a patient and radiotherapist nurse working together to understand the experience of using a radiotherapy mask designed to immobilise the patient during treatment. This mask is large – it covers the shoulders. It turned out, to the surprise of many of their carers, that many patients find the experience troubling, alienating and claustrophobic during an already stressful period. Furthermore, these effects are often lingering. As a result, carers are now giving better, more compassionate advice to patients. Funding has been provided to make a video for patients and staff to help them better understand and prepare for this experience.

This year, the Commission and the Ministry of Health, in partnership with consumers and the sector, have developed a rigorous patient experience survey. For the first time ever in New Zealand, feedback from patients in our hospitals will be collected and measured in the same way throughout the country. In this context, patient experience is more objective to measure and more readily addressed than patient satisfaction. District health boards will survey experiences related to communication, partnership, coordination, and physical and emotional needs, three-monthly, using randomly selected samples of patients. The aim is to understand how well hospital services are working for patients and their families/whānau, and thereby to improve them.

Other work in measurement and evaluation, including our reports on adverse events and the work of the mortality review committees, continues to provide us with ongoing critical data to monitor our health care system in general and, more specifically, the role our programmes play in improving it. This information informs the quality and safety improvement agenda, measures its effects and catalyses further improvement.

We are now well into our *Open for better care* national patient safety campaign, raising the profile of quality and safety issues in the sector and identifying and spreading the simple changes in practice that make a big difference to the safety and quality of patient care. The message of the campaign is that we need to work together to nurture our world-class, innovative, patient and family/whānau-centred health and disability system and to continue to improve outcomes for everyone.

Everyone involved in providing or receiving health and disability support services has a role in ensuring their quality and safety. The Commission functions as a hub and connector, maintaining an overview, building knowledge, forming partnerships and leading, promoting and integrating initiatives to improve both. New Zealand is a small country – we can and must work together to agreed common ends to ensure that our patients receive high quality care, safely.

I thank the many agencies and the diverse, committed and hardworking individuals we collaborate with. In the end, the quality and safety of New Zealand's health and disability services depend on all of us.

Professor Alan Merry, ONZM
Chair
Health Quality & Safety Commission

PART ONE

1.0 The Health Quality & Safety Commission

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.[2] It was established in November 2010.

Our objectives, as set out in the Act, are to lead and coordinate work in quality and safety across the health and disability sector, to measure, monitor and improve the quality and safety of health and disability support services and to help providers across the sector improve these services.

We exist to improve the safety and quality of our health and disability services. Our goal is that fewer patients are harmed and more patients get care they actually need and value, regardless of where they live, their ability to pay, and their gender, ethnicity or age. Health and productivity are inextricably linked and a high-quality, safe health system is vital for a high-performing economy and growing our gross domestic product.

To achieve this goal, we need a health and disability sector that does the right things, and does those things right, first time.

The New Zealand Triple Aim provides the framework for our work. It simultaneously addresses the individual, the population and the system.

The individual – improved quality, safety and experience of care:

We focus strongly on improving the experience of care for consumers, as well as providing safe, high quality services that meet individual needs. Our improvement programmes focus on reducing death and harm for individuals; we have developed measures for investigating and understanding more clearly the individual patient experience of our services; and our strong Partners in Care programme encourages participation and engagement of consumers in the system and in their own care.

The population – improved health and equity for all populations:

Step one in reducing inequalities is understanding the extent and nature of the associated disparities. All our quality and safety reports now include demographic information, such as gender, ethnicity and age, which:

- describes health disparities in key areas, including reasons for those disparities
- informs and assists the prioritisation of our programmes
- informs our discussions and work with partners
- measures our progress in reducing health disparities as new programmes are implemented.

As an example, the third annual report of the Family Violence Death Review Committee[3] presented information on ethnic-specific family violence mortality rates. The report's chapter on cultural and spiritual issues explored reasons for higher rates amongst Māori and resulted in work with the Māori reference group of the cross-government Taskforce for Action on Violence within Families.

Shining a light – measuring and identifying areas for quality and safety improvement

Being an intelligent commentator and advocate for change

Lending a hand – providing expertise, guidance and advice to support improvement and spread good practice

2 A Crown agent is required to give effect to government policy when directed by the responsible Minister.
3 Family Violence Death Review Committee. 2013. *Third Annual Report: December 2011 to December 2012.* Wellington: Health Quality & Safety Commission.

The system – best value for public health system resources:

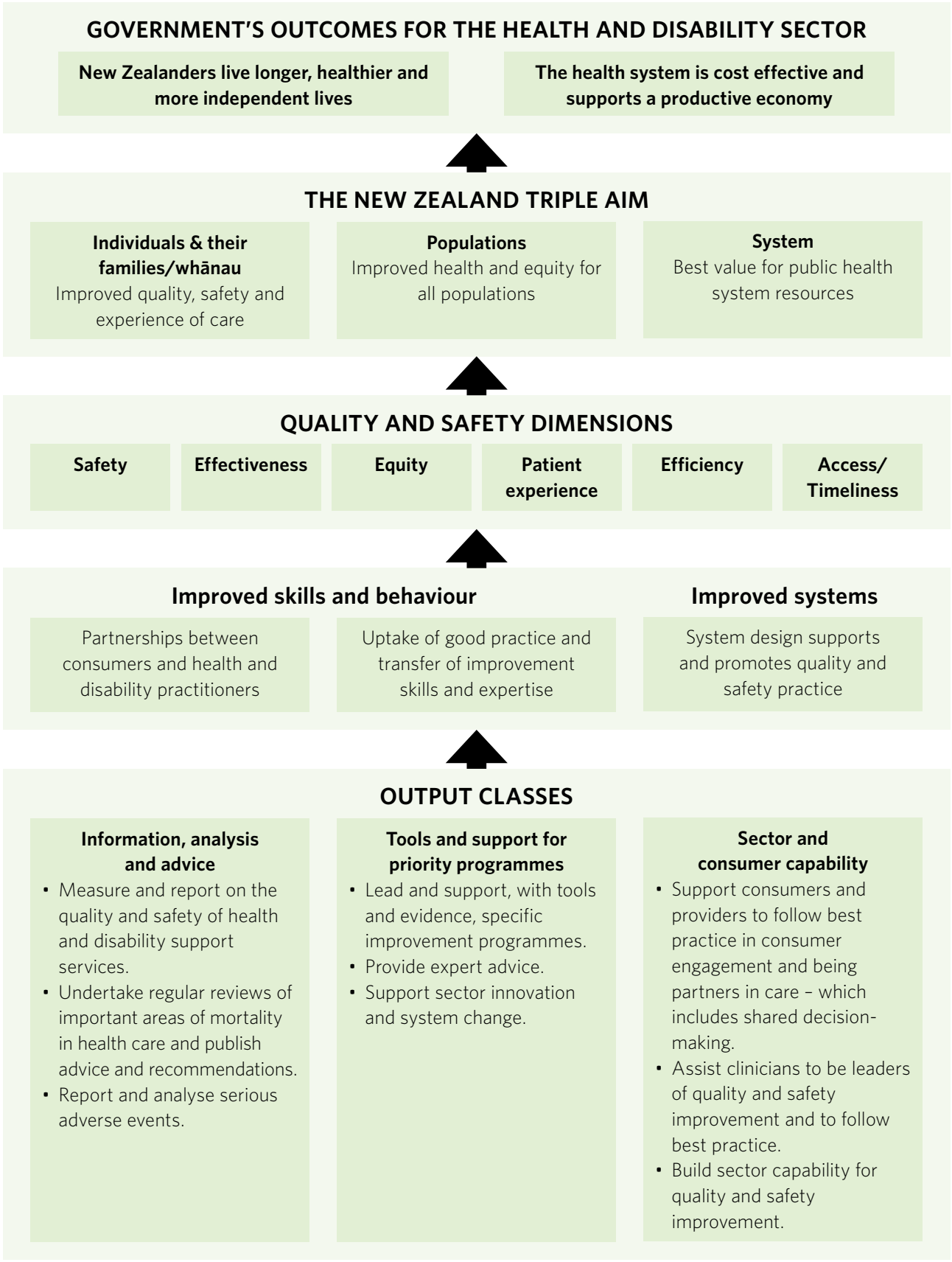
The Commission's role in improving the system and getting better value for patients for public health system resources is challenging for an agency receiving less than 0.1 percent of Vote Health; that is, around $13 million annually. However, by working collaboratively with the sector and making the best use of our combined resources, we have reduced harm and waste, and made cost savings to the system over the nearly four years we have been in existence.

A clear example of improvement that has saved money, resources and patient lives has is the sustained near-eradication of infection related to central venous catheterisation (central line associated bacteraemia, or CLAB) in New Zealand. CLAB infections, despite their high mortality and costs, were a problem previously thought to be inherent in the practice of central line insertion, but turned out to be entirely amenable to a simple, systematic, measurable, process-oriented intervention. In just under two years an estimated saving of over $4.0 million has been made due to avoided CLAB infections.

Another example from our most recent quality and safety marker (QSM) report shows that there has been a reduction in additional bed-days associated with reduced perioperative harm – resulting in an estimated saving of $0.9 million for the year. The report also shows that there have been 17 fewer falls resulting in fractured neck of femur in hospitals since October 2012 than would have been expected.

2.0 Our contribution to government priorities

The Commission supports the Government's priorities for the health and disability sector (see diagram below). Our work is structured such that we directly contribute to these priorities and also to broader government priorities (see Appendix 3).



3.0 Measuring our achievements

Four themes arise from the diagram in section 2.0 that are useful in evaluating the impact of the Commission's achievements. We highlight our key results in these areas:

- achieving the New Zealand Triple Aim
- uptake of good practice
- improved skills and expertise
- system design and supports.

Progress against the full set of quality and safety markers, which measure changes in practice and outcomes for a number of priority Commission programmes over time, can be found in Appendix 2.

3.1 Achieving the New Zealand Triple Aim

All Commission activities aim to improve the quality of New Zealand's health care, addressing the individual, the population and the system, as measured by the Triple Aim.

Highlights in this area:

- **180 cases of CLAB** in intensive care units **avoided** since March 2012.
- At least **$3.6 million in costs** associated with CLAB **avoided** since March 2012.
- Avoidance of 17 in-hospital falls and fractured neck of femurs since October 2012, saving $0.45 million.
- A noticeable **reduction in rates** of sudden unexpected death in infancy from 55 in 2008 to 36 in 2012.

(See Appendix 2, Table 1 for further detail about CLAB rates, and Appendix 2, Table 3 for further detail about reducing harm from falls.)

3.2 Uptake of good practice

Our programmes assist the sector to make changes in practice where there is convincing evidence those changes will result in improved outcomes over time, and that those changes and outcomes are, where possible, measurable and provable. Using quality and safety markers (QSMs), we track the progress of our interventions to improve practice by measuring these ultimate results (or outcomes) as well as the uptake of the changes in practice (known as process) that bring them about.

Highlights in this area:

- **Improved observed compliance** with all five moments for **hand hygiene** – 73.6 percent in June 2014 compared with 62.1 percent in October 2012.
- **Improved compliance** with **CLAB** bundle of procedures for inserting central line catheters – 95 percent in June 2014 compared with 77 percent in April 2012.
- **Increase** in use of all three parts of the **surgical safety checklist** – 95 percent in June 2014 compared with 71 percent in March 2013.
- **Increase** in number of older patients being **assessed for the risk of falling** – 89 percent in June 2014 compared with 77 percent in March 2013.

(See Appendix 2, Tables 1 and 2 for further detail about improved compliance with hand hygiene, CLAB and surgical safety best practice, and Appendix 2, Table 3 for further detail about falls risk assessment.)

3.3 Improved skills and expertise

We have a key role in sharing, promoting and helping to embed the skills and expertise the sector needs to improve itself. In the long term, this promulgation of expertise spills over, raising awareness of quality and safety issues in other areas.

Highlights in this area:

- **Improved reporting and review** of serious adverse **events** showing a greater willingness to report and learn from these events.
- **Increased awareness** and **changed attitudes and behaviours** in relation to **falls** prevention and reduction of patient harm.
- **Increased** numbers of providers and consumers in the sector with skills and expertise in **co-design of services** (that is, providers and consumers designing services changes in partnership).
- **Increased** numbers of **improvement advisors** in the sector (people who can identify, plan and execute improvement projects throughout their organisation, deliver successful results and promote changes throughout the entire system).

3.4 Improved system design

The Commission advocates for system changes to support and promote quality and safety practice.

Highlights in this area:

Findings from mortality review committee reports have:

- **influenced** the development of a new national drug policy (report on *Unintentional Deaths from Poisoning in Young People*)
- resulted in a **trial of an intensive case management service for family violence** victims at risk of serious harm or death (*Third Family Violence Death Review Committee Report*)
- resulted in **support** by the Minister of Justice for amendments to the Crimes Act 1961 – the Minister has asked Ministry of Justice officials to **consider** the viability of creating a non-fatal strangulation offence (*Fourth Family Violence Death Review Committee Report*)
- **resulted in 10 wide-ranging recommendations being implemented** by Counties Manukau District Health Board (DHB) to improve its above-average perinatal mortality rates (*external review by the Perinatal and Maternal Mortality Review Committee*).

THE YEAR IN REVIEW

For 2013–14, the Commission grouped its activities into three output classes:

Output class 1: Information, analysis and advice

Output class 2: Tools and support for priority programmes

Output class 3: Sector and consumer capability

4.0 Output class 1: Information, analysis and advice

International literature shows that measurement of the quality and safety of health care and publication of the findings in considered ways and settings stimulates improvement.

Used wisely, measurement and reporting on quality and safety engages clinicians, managers and consumers, generates informed discussion, and improves the efficiency of the sector. Measurement and evaluation allow problems and key improvement opportunities to be identified, and examples of good practice to be provided, assessed and shared. Without good measurement and evaluation we do not know where waste due to poor quality lies or whether interventions to reduce waste have worked.

> 'We can only be sure to improve what we can actually measure.'
> *– High Quality Care For All: NHS Next Stage Review Final Report, 2008*

4.1 Measurement and evaluation

In the last three years the Commission has overseen the introduction of a measurement architecture designed to present a precise and comprehensible picture over time of the quality and safety of our fluid, multi-layered system. During 2013–14, our measurement and evaluation activities included the following.

Quality and safety indicators (QSIs) – QSIs are a set of whole-system summary indicators which provide a detailed picture of the quality and safety of the entire New Zealand health care system. QSIs provide the public and sector a mathematically robust, clear and comprehensible understanding of the overall state of the quality and safety of health and disability support services, including changes over time and comparisons with other countries.

Nationwide patient experience indicators, developed with the sector during 2013–14 and derived from rigorous patient survey methodology, are to be included in QSI reporting for the first time in 2014–15. These indicators will be used to understand how patients experience the care they receive, and make health care more responsive to their needs. The information gathered at local, regional and national levels can be used to benchmark patient experience across the country and improve services locally. The indicators are collected by DHBs via questionnaires completed by patients, carers and family/whānau.

Quality and safety markers (QSMs) – Each QSM is a targeted set of process and outcome measures designed to track progress in uptake of interventions supporting the Commission's key priority programmes, measure their effect on the outcomes desired and, through public reporting, stimulate further improvement. Two national QSM progress reports were published during 2013–14. DHB-specific QSM reports were also published. There have been significant improvements across most of the process markers and we are also now starting to see improvements in outcomes. During the year, new QSMs were developed for surgical site infection and baseline data established. Appendix 2 contains details of changes in the QSMs for priority programmes.

The New Zealand Atlas of Healthcare Variation – The Atlas measures variation by geographic area in the provision and use of specific health services and outcomes. This variation can be warranted, by case mix and demography, or unwarranted. For example, the Atlas shows that medical-surgical bed-days occupied by people with diabetes ranges from eight to 25 percent. What does this large difference mean, and does it reflect diabetes prevalence? Presented as an interactive web tool with easy-to-use maps, graphs, tables and commentary, the Atlas is designed to stimulate improvement through prompting of debate

and raising questions among clinicians, users and providers of health services about why regional differences in health service use and provision are occurring.

During 2013–14, six new Atlas domains were published. Five were made available on the Commission's website – well child, trauma, diabetes, asthma and mental health key performance indicators. The suicide domain was completed and sent to DHBs and primary health organisations (PHOs).

A recent addition to the Atlas, and a worldwide innovation in variation work, is 'Find My Patients.' This button on the Atlas page links to patient management systems in general practice offices. It enables the GP to see if their district is less likely to provide a given treatment, and click to run a query in the system identifying patients in their practice who might benefit from review. Gout is a good example of the potential use of 'Find My Patients.' In New Zealand, on average only 2 in 5 people with gout regularly receive the first-choice therapy. And although gout affects up to one-third of Māori and Pacific males over 65 years, data show that Pacific people receive the least first-choice therapy. By searching for patients who would benefit from review, those who may benefit from treatment can be identified and offered it – and equity of treatment improved.

4.2 Reporting and management of health care incidents

Dr David Sage is clinical lead for the Commission's reportable events work. An experienced clinician with a long-standing interest in health system performance, he spent nine years as the Chief Medical Officer at Auckland DHB.

Reportable events

Most patients are treated safely and successfully, but some still suffer serious harm or even die from preventable adverse events in our hospitals. In New Zealand we have reported these adverse events in DHBs openly since 2006 and in other providers since 2013. The reporting process includes analysis of the causes of events so we can learn from them and identify opportunities to reduce event recurrence throughout the country. By reporting adverse events we promote a culture of openness and transparency and trust, in which improvement can flourish and where the public can have confidence such events are used to improve services.

During 2013–14, the Commission published two serious adverse events reports. These reports continue to inform our programmes. Some key findings (relating to information between 1 July 2012 and 30 June 2013) included:

- 177 serious adverse events affecting patients of mental health and addictions services. Of these, 134 were death by suspected suicide. The report noted the Commission is leading a trial of a suicide mortality review to improve knowledge of contributing factors and patterns of suicidal behaviours, and to better identify key intervention points for suicide prevention. This trial is being carried out as part of the New Zealand Suicide Prevention Action Plan 2013–2017 through a contract with the Ministry of Health, with the Director of Mental Health involved as an *ex officio* member of the Commission's Suicide Mortality Review Committee.
- 489 serious adverse events (excluding mental health and addictions services patients). Of these, 437 events were reported by DHBs and 52 by other health providers.[4] This represents a 21 percent increase in the number of events reported by DHBs.

4 This was the first report to include events reported by non-DHB providers, including private surgical hospitals, rest homes, hospices, disability services, ambulance services, PHOs, the National Screening Unit and primary care providers.

Adverse events reported for 2012–13 included:

- 253 instances of serious harm from falls
- 179 clinical management events, including delays in treatment, concerns about accuracy of diagnoses, inadequate patient monitoring in hospital, and near misses
- 24 medication events, with 11 of these related to administration of an incorrectly prescribed drug or drug dose.

'The overall increase in serious adverse events represents improved reporting and a greater willingness within the health and disability sector to learn from incidents. This is about having a culture of transparency and openness in the health system, as any instance of harm to a patient is serious and should be reviewed. The increase in events reported since 2006–07, when reporting began, shows a steady improvement in methods used to identify adverse events, rather than a sign the number of events themselves have been increasing.

'We expect increases in reported events to continue in the next few years as our reporting systems continue to improve. For example, DHBs are increasingly cross-checking their events with other sources of information, such as ACC claims.'

– Professor Alan Merry,
Health Quality & Safety Commission Chair

During the year, the Commission worked with the sector to develop a framework for reviewing and reporting 'never events' – adverse events that should never occur. The Commission will integrate this work into the review of the national reportable event policy during 2014–15.

Supporting trigger tool surveillance

Gillian Robb is clinical lead for the Commission's global trigger tool (GTT) work. She is a professional teaching fellow at the University of Auckland.

Health care organisations need effective ways to identify adverse events so they can prioritise action to reduce harm and improve patient safety. The GTT methodology is a powerful way to quantify harm in health care organisations, influence where improvement work should be targeted, and track improvements in the quality of care over time.[5] Random samples of patient medical records are reviewed for 'triggers' (or clues) indicating the likelihood of specific adverse events. The tool complements other sources of information about patient harm and should form part of an integrated approach to measuring and monitoring patient harm.

During 2013–14, the Commission continued to provide clinical leadership and encourage use of GTT methodology through training, visits and information-sharing via the national network. From an initial group of six DHBs in 2011–13, there are now 14 DHBs using the GTT methodology. Several now have sufficient data to guide improvement activities.

The second national GTT workshop on using data for improvement was held in April 2014 (a partnership between the Commission and *First, Do No Harm*). Around 50 participants from 11 DHBs attended. Representatives from Counties Manukau, Auckland, Lakes and Hawke's Bay DHBs gave presentations on the challenges and successes of the GTT process and how it is contributing to improving care.

The Commission produced a guide for DHBs on using trigger tools, which included managing data, standard operating procedures, reporting, triggers, performance indicators and identifying opportunities for improvement. E-learning GTT modules further support the guide.

The Commission established the national GTT network in 2012–13, and will further enhance the network by addition of a dedicated, secure portal on the Commission website as a discussion forum on GTT methodology to share learning among DHBs.

In Counties Manukau DHB, use of trigger tools identified constipation as a significant harm relating to administration of opioids. A project was undertaken on a ward to identify contributing factors and to develop and test potential solutions.

5 Classen DC, Resar R, Griffen F, et al. 2011. Global trigger tool shows that adverse events in hospitals may be ten times greater than previously measured. *Health Affairs* 30(4): 581–9.

4.3 Quality Accounts

The introduction of Quality Accounts has been a successful new initiative over the past year and is becoming a powerful tool for improvement. Quality Accounts are designed to be both retrospective and forward-looking reports, presenting an honest and balanced picture of the quality of service being delivered and the improvement plans each provider has in place. All DHBs now produce and publish them annually, and actively engage with their communities to find out what their quality priorities are.

The introduction of Quality Accounts was an important step in putting quality at the heart of all health care activity. Quality Accounts can catalyse improvement and provide an opportunity for organisations to demonstrate measurable improvements in their quality of care over the coming years. They also provide a great opportunity for meaningful community engagement.

The *Quality Accounts Guidance Manual* published by the Commission in May 2014 provides guidance for the production and publication of DHB Quality Accounts for the 2014–15 financial year. It sets out the purpose of Quality Accounts and guides their development based on best practice and feedback gained from the sector.

4.4 Mortality review committees[6]

Mortality review is used to identify and address systemic issues relating to any type of death or morbidity, with the aim of improving systems and practice within services and communities. Every preventable death matters, but deaths occurring in a pattern are usually indicative of larger system failures. Every effort should be made to identify and address these failures.

A mortality review committee is a statutory body appointed by the Commission board. Committees are empowered by legislation to review and analyse the circumstances resulting in preventable deaths to provide evidence-based advice on how these deaths can be avoided.

Mortality review committees focus intensively on specific events, so they are powerful tools for improving the quality and safety of services and systems locally and nationally.

There are four ongoing mortality review committees. During 2013–14, each published at least one substantial report. Based on learning from review, these reports made specific recommendations on how to improve systems and practice to reduce mortality and related harm. These recommendations are developed in consultation with key stakeholders able to directly influence their implementation and encourage ownership of and commitment to the change. After reporting, committees also continue to work with key stakeholders across sectors to encourage and monitor the uptake of recommendations made.

The Child and Youth Mortality Review Committee (CYMRC) reviews deaths of children and young people aged 28 days to the day before their 25th birthday, and advises on how to reduce such deaths.

Dr Nick Baker was Chair of the CYMRC during 2013–14. Previously a general and community paediatrician in the Nelson area, he was recently appointed Chief Medical Officer at Nelson Marlborough DHB.

The CYMRC published two reports during 2013–14.

- *The Child and Youth Mortality Review Committee Ninth Data Report,* reporting on mortality up to and including 2012.
- *Special Report: Unintentional deaths from poisoning in young people.*

Over the past few years, the work of the CYMRC has stimulated action in a number of key areas.

- The *Special Report: Unintentional suffocation, foreign body inhalation and strangulation* was released in March 2013. This report identified that an average of 19 children per annum between 2002 and 2009 died by accidental suffocation and strangulation in bed. Since publication, the CYMRC has actively promoted development of safe sleep policies for infants in every DHB, widely disseminated advice on safe sleep practices and hosted meetings with key stakeholders involved with infant product safety.
- The CYMRC's *Special Report: Unintentional deaths from poisoning in young people* reported on poisoning-related deaths, generally due to volatile solvent abuse and prescription drug abuse. Dr Nick Baker presented the report at the 2013 International Drug

6 Section 50D(3b) of the New Zealand Public Health and Disability Act 2000 requires the Commission to, at least annually, provide the Minister of Health with a report on the progress of mortality review committees, and must include each such report in the Commission's next annual report. This section of the annual report, along with section 9.5, fulfils that obligation.

Policy Symposium. The report was used by the Ministry of Health and other agencies involved in the 2013 National Drug Policy review.

The Perinatal and Maternal Mortality Review Committee (PMMRC) reviews deaths of babies and mothers, and advises on how to reduce such deaths.

Dr Sue Belgrave is Chair of the PMMRC. She is an obstetrician and gynaecologist, a Royal Australian and New Zealand College of Obstetricians and Gynaecologists training supervisor and Chair of their Auckland training committee.

In June 2014 the *Eighth Annual Report of the Perinatal Mortality Review Committee* was published.

Over the past few years, the PMMRC's work has brought about some significant changes.

- As a result of the PMMRC review of maternal and perinatal mental health services, a review was undertaken by the Ministry of Health. In 2012 the Ministry report, *Healthy Beginnings,* recommended measures to improve these services and new funding was made available in the 2013 Budget. Work is underway to enhance these services further.
- Counties Manukau was identified as a DHB with a perinatal mortality rate above the national average, and an independent review was carried out. The DHB has been implementing the wide-ranging recommendations from that review.
- The Ministry of Health's maternity quality and safety programme, launched in 2011, and the establishment of the National Maternity Monitoring Group in 2012, were informed by the work of the PMMRC. The quality and safety programme addresses many aspects of maternity care identified by the PMMRC, including improving maternity records, developing a national electronic maternity record, establishing standards for provision of health care, developing clinical governance processes and a requirement for DHBs to improve access to maternity care for all women.

The Family Violence Death Review Committee (FVDRC) reviews deaths from family violence in New Zealand and provides advice on how to reduce such deaths.

Associate Professor Julia Tolmie is Chair of the FVDRC, an associate professor in law at the University of Auckland and has researched and published on family violence issues for more than 20 years.

In June 2014 the FVDRC's *Fourth Annual Report: January 2013 to December 2013* was published.

In the few years that it has been operating, the FVDRC's work has already had significant impact.

- In its *Third Annual Report* the FVDRC recommended the development of a nationally consistent high-risk case management process. In July 2014, the Prime Minister announced the trial of an intensive case management service for family violence victims at risk of serious harm or death.
- In its *Fourth Annual Report* the FVDRC recommended the Government considers an amendment to the Crimes Act 1961 to include non-fatal strangulation as a separate crime under part 8 of the Act. The Minister of Justice has been supportive of this recommendation and asked Ministry of Justice officials to consider it. It also recommended legal changes to protect the victims of family violence, including those who retaliate against their abuser after years of violence.

The Perioperative Mortality Review Committee (POMRC) reviews deaths relating to surgery and anaesthesia occurring within 30 days of an operative procedure and provides advice on how to reduce such deaths.

Dr Leona Wilson, ONZM, is Chair of the POMRC and a specialist anaesthetist. She has also completed a Master of Public Health and a Fellowship of the Australian Institute of Company Directors.

In June 2014 *Perioperative Mortality in New Zealand: Third Report of the Perioperative Mortality Review Committee* was published.

Prior to the formation of the POMRC, there was a gap in consistently reported national perioperative mortality data. The data reported in the first three POMRC reports now form a national picture, for the first time.

The Suicide Mortality Review Committee (SuMRC): As part of implementing the New Zealand Suicide Prevention Action Plan 2013–2017, the Ministry of Health is funding the Commission from September 2013 to June 2015 to trial a suicide mortality review mechanism. The time-limited SuMRC was established in April 2014 and is reviewing deaths relating to suicide in three selected sub-groups: Māori youth, users of mental health and addictions services, and men aged 25–64.

Professor Rob Kydd is Chair of the SuMRC and Professor of Psychiatry at the University of Auckland. He works clinically at a community mental health centre in South Auckland and has a small private consulting practice.

5.0 Output class 2: Tools and support for priority programmes

One of the Commission's key roles is to lend a hand – that is, to help the sector improve the quality and safety of services. This includes:

- identifying, sharing and promoting examples of excellence in health and disability support services
- identifying and supporting implementation of effective improvement programmes across the sector, with a focus on the Government's priorities
- providing expert advice to the sector, and tools and guidance based on evidence; sharing information and aligning activities
- supporting sector innovation and system change.

Our view encompasses the whole sector. This means we can identify strong improvement initiatives and best practices across the country; understand why things are working well; work with the sector to extend and disseminate initiatives that are making a real difference; and identify international best practices and work to introduce those relevant to New Zealand.

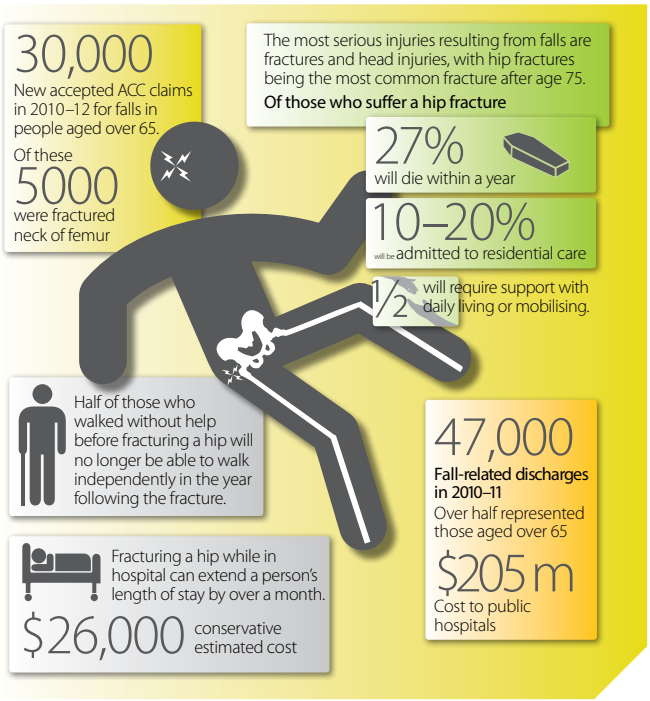
5.1 Reducing harm from falls

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

Reducing harm from falls is a national multi-agency programme led by the Commission to reduce personal costs faced by individuals who fall and harm themselves, and reduce the costs of treatment, rehabilitation and care. An expert advisory group supports the programme, comprising individuals from a broad base representing service, practice, professional, research and consumer perspectives.

During 2013–14 the falls programme provided resources, tools, information and ongoing support for the sector to build capability (across primary and secondary care, aged care and community settings). It also ran the second annual, regionally driven 'April Falls' quiz and survey.

Success of the reducing harm from falls programme is measured through the falls QSM set. Baseline data was released in June 2013 and regular quarterly reports were published during 2013–14.



The reducing harm from falls QSM showed:

- risk assessments of older patients rose from 76 percent in the baseline period to 89 percent in the quarter ending June 2014
- 90 percent of patients identified at risk of falling received an individualised care plan in the quarter ending June 2014 compared with 80 percent a year earlier
- there have been 17 fewer falls in hospital resulting in a fractured neck of femur since October 2012 than would have been the case had there been no change from the previous year's rate
- additional bed-days (and hence cost) associated with falling appears to be lower now than during the baseline period. If this is a genuine change rather than a data artefact, it represents reduced harm and a cost saving.

Attitudes and knowledge were surveyed in an April Falls 2014 quiz. A total of 1516 people completed the quiz. Agreement that falls are preventable remains high at around 97 percent. But the most significant change from 2013 is the increase in the percentage of respondents who consider that risk assessments for people aged 75+ 'almost always' take place in their workplace – from 53 percent in 2013 to 68 percent in 2014.

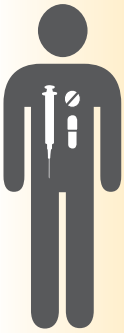
5.2 Medication safety programme

Dr Mary Seddon was national clinical lead for medication safety during 2013–14. She holds fellowships in general medicine and public health and is Chair of the Medication Safety Expert Advisory Group.

The administration of medicines is one of the most common therapeutic interventions used in health care, and medicines impact the lives of every New Zealander at some point. The scale of medicine use means that reducing adverse drug events (ADEs) has the potential to make the health system substantially safer. The goal is to ensure 'the right patient gets the right medicine, in the right dose, at the right time, by the right route and correctly recorded.'

The Commission works in four broad priority areas:

- reducing harm from high-risk medicines
- improving prescribing, dispensing and administration of medicines
- improving the transfer of medicine-related information
- informing consumers.



ADE collaborative

The medicines that were most commonly implicated for causing an ADE were:*

33% opioids

10% anticoagulants

* Seddon ME, Jackson A, Cameron C et al. The Adverse Drug Event Collaborative: a joint venture to measure medication-related patient harm. NZMJ 25 January 2013, Vol 126: 9–20.

Reducing harm from high-risk medicines

National programme: During 2013–14 the Commission scoped and developed an implementation plan for a nationally coordinated, three-year programme to reduce harm from high-risk medicines. The programme will initially focus on reducing harm from opioids in secondary care.

The plan includes:

- the *Open for better care* campaign (October 2014 to March 2015), with activities and resources related to the case for change, identifying medication errors and harm, partnering with patients and families/whānau, preventing and mitigating medication errors and harm relating to high-risk medicines, and the safe use of opioids.
- the safe use of opioids collaborative (October 2014 to May 2016), involving national and regional learning sessions and support for local DHB action periods where agreed interventions are tested.

High-risk medicines and situations: The Commission issued four *Medication Safety Watch* bulletins during the year. These provided timely information about medicine-related incidents, errors and adverse drug events and their implications, and offered recommendations on how to improve medication safety. The sector contributes information for these bulletins.

We also issued two alerts to health care providers on:

- transdermal patches
- inadvertent metoprolol overdose (draft sent to the sector for comment).

Alerts included recommendations relating to either internationally recognised or locally identified high-risk medicines or situations.

A New Zealand Tall Man lettering report and list, which addresses and distinguishes look-alike, sound-alike medicine names that pose the greatest risk to patient safety, was published after extensive consultation nationally and internationally.

Hospital eMedicines Management (eMM)

The eMM programme is a partnership between the Commission and the National Health Board/National Health IT Board. eMM is an electronic system giving all health care providers access to a person's medication information, enabling more effective medicines management. This includes prescribing, administering, reconciling, dispensing and tracking medicines.

During 2013–14, the Commission and the National Health IT Board helped DHBs achieve the *Go for Gold* targets for eMedicine Reconciliation (eMR) and ePrescribing and Administration (ePA).

eMR is an electronic system for hospitals that ensures a patient's medication information is accurate on admission, transfer and discharge. The *Go for Gold* target is for at least 15 DHBs to adopt eMR in at least one clinical area by the end of December 2014. Six DHBs implemented eMR by 30 June 2014, which is encouraging but may not be sufficient to meet the target. DHBs not yet using eMR are required to use paper-based medicine reconciliation.

ePA allows medication prescribing and administration to be recorded electronically in hospitals, aided by decision support. The *Go for Gold* target is for 6–8 DHBs to implement ePA in at least one clinical area by the end of December 2014, and all DHBs by the end of 2016. Five DHBs implemented ePA by 30 June 2014. DHBs not yet using ePA are required to use the national paper medication chart.

Aged residential care (ARC) medication chart

The ARC medication chart and process, piloted at six ARC facilities during 2012–13, continued to be used in five of the pilot sites during 2013–14. The pilots were evaluated in 2013–14, and the evaluation will inform next steps.

5.3 Infection prevention and control programme

Dr Sally Roberts is clinical lead for the infection prevention and control programme and an infectious diseases physician and Clinical Head of Microbiology at Auckland DHB.

The infection prevention and control programme aims to significantly reduce the harm and costs associated with preventable healthcare associated infections. The Commission leads various national quality improvement initiatives, including:

- improving the hand hygiene practice of DHB health care workers
- reducing central line associated bacteraemia (CLAB)
- surgical site infection (SSI) surveillance.

Our programmes have initially focused on hospital-level care where vulnerable patients have a higher risk of infection.

Hand hygiene

Dr Joshua Freeman is clinical lead for the Hand Hygiene New Zealand programme and a clinical microbiologist at Auckland DHB.

This programme aims to reduce healthcare associated infections by improving hand hygiene best practice across all DHB health care worker groups. Auckland DHB was contracted by the Commission to lead the Hand Hygiene New Zealand programme, which is bringing about a culture change and improving hand hygiene compliance among health care workers.

The hand hygiene QSM process measure shows national compliance with best-practice guidelines in public hospitals improved from 70.5 percent in the quarter to June 2013 to 73 percent in the quarter to June 2014. The target for 2013–14 was 75 percent. The Commission will continue to focus on increasing hand hygiene compliance to 80 percent by the end of June 2015.

The QSM's outcome measure is the reported rate of *Staphylococcus aureus,* which is associated with poor hand hygiene. The rate for 2013–14 was 0.12 *S. aureus* bacteraemia per 1000 bed-days. This compares well with the target of 0.07–0.11 per 1000 bed-days set for 2013–14 to 2015–16.

Central line associated bacteraemia (CLAB)

Dr Shawn Sturland is clinical lead for the CLAB programme and Clinical Leader for Intensive Care at Wellington Regional Hospital Intensive Care Services.

In 2011, Ko Awatea at Counties Manukau DHB was contracted by the Commission to achieve a sustainable reduction in CLAB episodes in intensive care units through a national programme of leadership, training and coordination. The *Target CLAB Zero* collaborative has had significant success, with intensive care unit CLAB rates reducing from an estimated 3.32 per 1000 central line days prior to implementation to a sustained rate of less than 1 per 1000 line days. This meets the target for the programme, and is now 'business as usual' in the sector.

Based on initial estimates of CLAB prevalence prior to the introduction of the programme, over 200 cases of CLAB are estimated to have been avoided in just under two years – with an associated saving of over $4.0 million.

The very high level of compliance with the insertion bundle continued during 2013–14, with 95 percent of insertions being compliant with the bundle in the quarter ending 30 June 2014.

Reducing surgical site infections (SSIs)

Infections of surgical wounds, or SSIs, are the second most common form of healthcare associated infection. They are costly to treat, associated with increased mortality and can have a significant impact on quality of life.

During 2012–13, a joint venture between Auckland and Canterbury DHBs was contracted to support implementation of a sustainable national SSI quality improvement programme for DHB-funded surgery (including within the private sector).

In 2013–14 the SSI programme:

- established baselines and measures for tracking reduction of SSIs, in consultation with the sector
- established a system for collecting high-quality data
- developed a bundle of quality improvement interventions
- highlighted and raised national awareness of evidence-based interventions through the *Open for better care* campaign on SSIs, running from October 2013 to March 2014
- developed a consumer resource to inform patients about preventing SSIs after surgery.

Results demonstrated during the first year of measurement are encouraging with increases in:

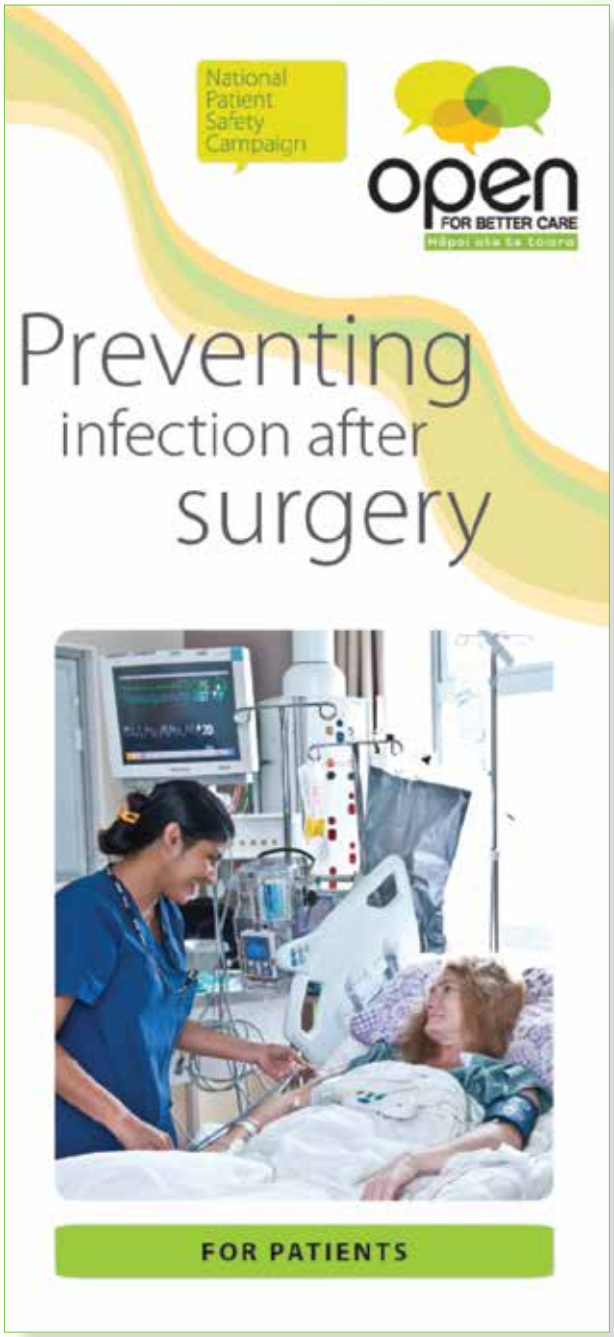
- antibiotics given at the right time (a 7 percent increase)
- the right antibiotic and right dose (a 23 percent increase)
- the right skin preparation (a 7 percent increase).

3–4 x $

An **SSI** following hip or knee replacement costs three to four times as much as the original surgery.

2–5%

Surgical site infections (SSIs) occur in approximately 2–5 percent of patients undergoing inpatient surgery.



5.4 Reducing perioperative harm (improving surgical safety)

Mr Ian Civil is clinical lead of the reducing perioperative harm programme and a trauma surgeon and Director of Surgery at Auckland DHB.

Over 300,000 publicly funded surgical operations are performed in New Zealand each year. Potentially preventable complications arise in 10–15 percent of all New Zealand surgical procedures. Perioperative harm includes:

- deep vein thrombosis/pulmonary embolism
- surgical site infection
- medication error
- wrong side/site surgery
- retained objects
- falls and other complications.

'It is not the act of ticking off a checklist that reduces complications – the checklist is merely a tool for ensuring that communication occurs.'
– *Lucian L. Leape MD*

Even routine surgery requires the complex coordination of surgeons, anaesthetists, nurses and support staff to provide timely and effective care.

The World Health Organization Surgical Safety Checklist has been used in New Zealand hospitals since the pilot in 2008. Internationally, the checklist has been shown to dramatically reduce surgical mortality and morbidity. However, the checklist's role has sometimes been misunderstood: it is not a compliance tool but a tool to generate better teamwork and communication in theatre teams.

The Commission's improvement programme is focused on reducing perioperative harm through:

- effective teamwork and communication through briefings and debriefings
- proper use of the Surgical Safety Checklist to generate more effective communication and team cohesion.

During 2013–14, the Commission's reducing perioperative harm programme included:

- commencing a proof of concept demonstration involving three surgical providers, which is focused on improving teamwork and communication through use of the surgical safety checklist, briefing and debriefing
- our *Open for better care* campaign, which raised awareness throughout the sector of how teamwork and communication improves patient safety in the operating theatre
- providing a resource for patients, *Keeping you safe during surgery,* available in English and Māori.

Results demonstrated by the most recent perioperative harm QSM report are encouraging: there was an increase in the use of all three parts of the checklist from 71 percent in the quarter from January to March 2013 to 95 percent in the quarter from April to June 2014.

Theatre staff at Counties Manukau Health are getting involved with the focus on reducing perioperative harm.

6.0 Output class 3: Sector and consumer capability

Improving sector knowledge and skills in quality improvement and patient safety methods is a key element in delivering better outcomes and a more systematic and predictable quality and safety response across the system. Our aim is to achieve and surpass internationally accepted quality and safety measures for every New Zealander, and to make this a self-sustaining process. To help achieve this, the Commission's focus during 2013–14 was to increase:

- the number of people in the sector with the capability to drive improvement effectively
- partnerships between health service organisations/health professionals and patients, families/whānau and carers.

6.1 Developing consumer and family/whānau engagement and partnership

Our health and disability support services exist for the patients and consumers they serve. There is growing evidence that demonstrates the importance of partnerships between health service organisations/health professionals and patients, families/whānau and carers. The potential benefits include improved outcomes, enhanced experience of care, lower costs per case and increased workforce satisfaction. Given this, working with providers and consumers to increase engagement and partnerships has become one of the Commission's key strategic priorities.

Consumer representation is mandatory in all Commission work programmes and we have an active consumer network that supports and guides us.

The vehicle for the Commission's consumer work is its four-year Partners in Care co-design programme, which began in 2012–13. The programme's three streams aim to:

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

2013–14 was year 2 of the Partners in Care programme – focused on collaboration. We developed and produced useful resources for consumers and providers working together and for consumers having surgery. During 2013–14 another eight teams – consisting of a provider staff member and a consumer – completed the Commission's Partners in Care co-design programme. The purpose of the programme is for teams to share the role of improving care through co-design of services.

The Commission also finalised a new patient experience survey across the country, which will be used to understand, quantify, explore and improve patients' experience of our services.

6.2 Developing people capability in the sector

Improvement science

Our health care professionals are very well trained in the science of their own fields – medicine, nursing, pharmacy and so on – but the delivery of health care is itself a science. Knowledge and expertise in the science of system improvement is less well developed (in New Zealand and in most countries).

The Commission has an important role to play in providing the education and training required to successfully achieve system and clinical practice change.

Activities during 2013–14 included the following:

- Sponsoring health professionals to attend the Institute for Healthcare Improvement and Ko Awatea 10-month improvement advisor course. In May 2014, the first time the programme has been held in New Zealand, 16 graduated as improvement advisors. The programme is designed to create a network of skilled and experienced improvement advisors who can identify, plan and execute improvement projects throughout their organisation, deliver successful results and promote changes throughout the entire system.
- Establishing a national network of people with expertise in improvement methodology. A shared web workspace with 70 members was set up and populated with links, notices of events and relevant documents. (See section 9.13 of the Statement of Performance for more details.)
- Providing web-based learning packages, videos, interactive PDFs, tools and links to learning resources produced by the Commission and by other agencies on a range of issues.
- Providing regional and national workshops for the sector in many areas of interest including QSIs;

provider/consumer co-design of services; learnings from the National Health Service campaign and the Mid-Staffordshire inquiry; equity; primary care and integrated care; reducing costs; and Quality Accounts. Workshops were held for consumers on quality systems and local and regional developments in consumer engagement and participation initiatives. Many workshops featured leading international and national presenters.

Feet for life

Prem Kumar was sponsored by the Commission to attend the Institute for Healthcare Improvement and Ko Awatea 10-month improvement advisor course. The course included the identification, planning and execution of an improvement project.

Before Prem's project started, there was no formal process at Counties Manukau DHB to identify foot complications in diabetic patients receiving dialysis. Such complications were typically noticed too late – when wounds were already badly infected. Prem and the team (including patients and their families/whānau) created a foot assessment tool and used plan-do-study-act cycles to test the tool on a number of patients in different settings. The tool identified patients at risk of skin breaking down and resulted in early preventive treatment.

To increase patient access to care, the team set up a new clinic, brought in an on-site podiatrist and developed a new referral system – they reduced wait times for patients from six weeks to just three days.

The project has led to a significant reduction in skin breakdown – a really good example of how simple changes can be tested quickly, and how those simple changes can result in a big difference to safety and to quality health care.

Clinical leadership

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

All key Commission programmes have clinical leads who are well respected in their fields. Their role is to ensure our work is grounded in the most up-to-date, evidence-based knowledge, is translated into tools, techniques and methodologies, and is promoted and implemented across the sector.

The Commission holds regular meetings of the clinical leads to support their work in leading change. (See section 9.11 of the Statement of Performance for more details.)

6.3 The *Open for better care* campaign

The Commission leads and coordinates *Open for better care*, a national patient safety campaign to inform and mobilise the New Zealand population to ensure safety and quality improvement in health care by preventing harm, avoiding waste and getting better value from resources.

The campaign is a call to action for all health professionals, asking them to make a commitment to patient-centred safety. It takes a 'learning by doing' approach – identifying simple changes in practice that can make a big difference to patient safety. Tools, interventions, networks, collaborations, promotions, resources and workforce development opportunities provided by the campaign make it easier to do the right thing.

The campaign has focused on one topic at a time. In 2013–14, reducing harm from falls and reducing SSIs were completed and reducing perioperative harm launched. Planning for the fourth topic, high-risk medicines, started.

More information about the campaign topics is found in sections 9.6 (reducing harm from falls), 9.7 (healthcare associated infections) and 9.8 (perioperative harm).

7.0 Maintaining and developing organisational capability

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

7.1 Governance

The Commission is governed by a board of eight members appointed by the Minister of Health. There were seven board meetings during the year in addition to meetings related to strategic planning, governance development and the Commission's *Open for better care* campaign. Membership of the board changed during the year, with Robert Henderson, Heather Shotter and Gwendoline Tepania-Palmer joining the board in February 2014. Professor Alan Merry (Chair), Shelley Frost (Deputy Chair), Alison Paterson, David Galler and Dale Bramley were reappointed at the same time, and Geraint Martin and Anthea Penny finished their terms.

Three board committees supported the board's work in 2013–14.

The Finance and Audit Committee (which includes an independent member, Andrew Boyd from Healthshare) provided assurance and assistance to the board on:

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

The Capability Committee (which operated until May 2014) provided advice to the board on developing quality improvement capability in the sector and supporting clinical and consumer leadership. The Capability Committee will be replaced by an expert advisory group with a broader mix of participants.

From left: Shelley Frost (Deputy Chair), Robert Henderson, Alan Merry (Chair), Heather Shotter, Gwendoline Tepania-Palmer, Alison Paterson, Dale Bramley. Absent (inset): David Galler.

The Communications and Engagement Committee provided strategic-level advice on the communications and stakeholder engagement the Commission undertakes.

Te Roopū Māori provided advice to the board and Chief Executive of the Commission on strategic issues, priorities and frameworks from a Māori world view and identified key quality and safety issues for Māori patients and organisations.

Full board and committee membership is in Appendix 1.

Crown entity boards are required to develop a strong strategic direction for their organisation. A strategic planning day was held in September 2013 which, along with regular strategic discussions at board meetings formed the basis of the 2014–18 Statement of Intent. These discussions included review of the environment in which the Commission operates and future risks and opportunities.

In line with the Minister of Health's expectations and good practice, a self-assessment was carried out, formally reviewing the performance of individual members, the Chair and the board as a whole against meaningful, good practice standards of board performance. Board members also continued to attend director training provided by the New Zealand Institute of Directors.

During 2012–13 an independent review by the Institute of Directors provided advice to the Commission on how to improve its board papers. A follow-up review in 2013–14 concluded papers are now of a very high standard.

7.2 Staff

During 2013–14, 35 to 40 staff carried out the work of the Commission. This was in addition to our sector-based clinical leaders for each programme area, lead agencies for some programmes, and a number of expert committees.

7.3 Good employer obligations

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

The Commission wants to attract and retain productive, talented staff. All positions have competency requirements, and all staff have an annually reviewed personal development plan. We have implemented an online performance review and development system, which includes competencies, goals and objectives for all staff.

The Commission has a dedicated staff training budget and staff are encouraged to identify future training needs and undertake relevant training. The Commission arranged regular education and training opportunities for staff during 2013–14, covering areas such as consumer engagement, health literacy, creating narratives, and inequalities for Māori. Some staff attended extended training courses such as the improvement advisor training and management/leadership training.

Several staff have also been provided the opportunity to develop their management skills by acting in more senior positions as vacancies arise, or when senior staff are on leave.

Flexibility and work design

The Commission recognises that at different life stages staff may seek to balance their work and outside commitments by using flexible work practices. Our policy is to support flexible work arrangements for employees who have carer responsibilities under the provisions of Part 6AA of the Employment Relations Act 2000, and also for employees who require flexible work opportunities for a variety of other reasons, including further study and career development.

By flexible work practices, we mean arrangements which include:

- changes to hours of work
- part-time work (for example, to accommodate partial retirement or further study)
- working from home.

A number of staff work shorter days to accommodate school hours and some work from home when necessary (with technology to support this).

Support and culture

Staff meetings are held in Wellington (with Auckland staff videoconferencing in) each week for staff to talk about their work and current issues, to recognise staff and team successes and, from time to time, to hear from external speakers. All staff are expected to attend.

We have a very active health, safety and wellness committee which manages areas such as workplace hazards and other safety issues as well as arranging activities to promote a healthy and joined-up

workplace. The Commission funds an Employment Assistance Programme, a professional counselling service to help staff and/or their families/whānau with work or personal issues.

As an employer the Commission will not tolerate harassment or bullying in the workplace and takes all practical steps to manage hazards and avoid exposing employees to unnecessary risk.

Safe accommodation

During the year, the earthquake rating of the Commission's accommodation in Classic House, Murphy Street, was reassessed, identifying that the building was a high risk. As soon as this risk was identified the board decided that staff should not return to the building – to ensure staff safety. For a few months while new accommodation was found and made ready for use, staff used a combination of Ministry of Health accommodation and working from home. Commission staff are now comfortably housed in 17–21 Whitmore Street.

7.4 Equal employment opportunities (EEO)

Workplace profile as at 30 June 2014

As at 30 June 2014 there were 34 staff. Twenty-nine were full time and five part time. Fifty-nine percent had more than two years of service.

EEO policies

We have a specific policy on equality and diversity, which includes a firm commitment to the principles of EEO and ensures that no discriminatory policies or practices exist in any aspect of employment, including harassment and bullying.

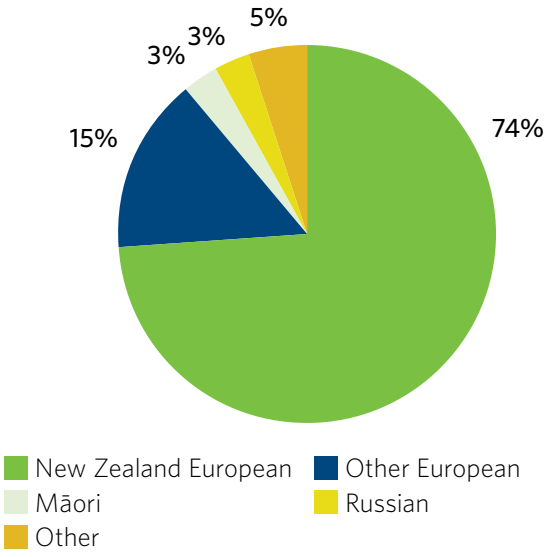
Treating people fairly and with respect is at the heart of the way we want to work. Understanding, appreciating and realising the benefits of individual differences will not only enhance the quality of our work environment but enable the Commission to better reflect the diversity of the community we serve.

EEO/diversity practices include hiring on merit, fairness at work, flexible working options and promotion based on talent. They relate to all aspects of employment including recruitment, pay and other rewards, career development and work conditions. All staff involved in recruitment and management of staff are made aware of the requirements of the Commission's EEO policy. The Commission is actively seeking and targeting diversity in recruiting for current vacancies.

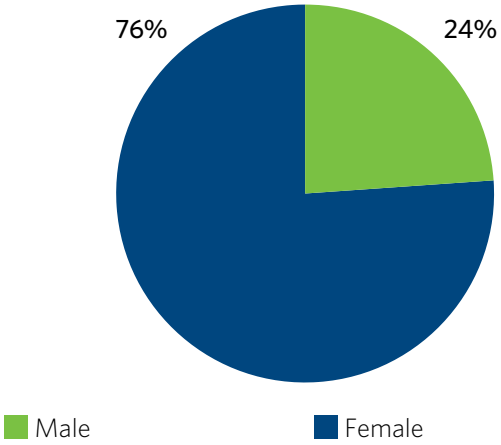
Remuneration

We work closely with the Ministry of Health as our monitoring agency and to obtain agreement around annual remuneration levels. We do not discriminate based on age, disability, gender, sexual identity, religious beliefs or ethnicity.

Breakdown of staff by ethnicity



Breakdown of staff by gender



All Commission internal policies, including those for EEO, are to be reviewed and updated during 2014–15 in consultation with staff.

7.5 External relationships

Engagement with the Minister(s) and Ministry of Health

During 2013–14 the Commission provided monthly update reports to the Minister with delegated responsibility for the Commission and provided quarterly update reports on performance against the Statement of Intent. We met with Ministers on a regular and as-needed basis and kept both the Minister and Ministry of Health apprised of any potentially contentious events or issues in a timely manner.

Collaboration and partnerships with stakeholders

New Zealand is a small country – we can and must work with others to agreed common ends. Partners are vital to a small agency like the Commission and we have endeavoured to tap into the considerable expertise in the sector and overseas, and identify and learn from existing innovative quality and safety practice.

Of particular importance are our partnerships with DHBs, the Ministry of Health, the Health and Disability Commissioner, the Accident Compensation Corporation (ACC), professional colleges and associations, clinical leaders, consumers and consumer groups, and our developing partnership with Māori. We also continue to develop strong international links, so we are well connected to innovation, evidence and advice from our colleagues overseas.

We also focus on work in priority areas where our investment will be supplemented by investment by other agencies; for example, our work on reducing harm from falls and neonatal encephalopathy, where ACC provided additional resources.

During 2013–14 we routinely engaged with the Ministry of Health in joint strategic planning and liaison over joint work programmes. In addition, the Commission, the Ministry of Health, the Health and Disability Commissioner and ACC established a regular quality forum to support collaboration and joint planning. The four agencies work collaboratively on sharing and using the different information received by each agency more effectively.

Communication with stakeholders and the public

Our communications function helps to:

- ensure the sector and stakeholders are aware of our activities, and understand and support our efforts to catalyse and invigorate change
- ensure engagement with our priority areas of activity
- raise the profile and therefore the influence of the Commission
- establish the Commission as the 'go to' body for support and advice on improving the quality and safety of New Zealand health and disability support services
- promote to the sector the benefits of increasing quality and safety, and encourage the sector to place quality and safety at the centre of all its work.

During 2013–14, our communications team continued to:

- keep our website up-to-date and useful
- ensure our publications were of a high standard and easy to understand
- help us contribute visibly to conferences and events promoting quality and safety
- proactively manage interaction with the media to ensure our key messages were promoted effectively
- identify and manage communications risks.

Having an effective website is an important communications tool for the Commission. It provides a cost-effective way to communicate health quality and safety improvement information, projects and contacts. It also presents our work as part of a coordinated suite of activities occurring across the sector, and offers opportunities for direct dialogue and engagement with stakeholders. During 2013–14, hits on our website increased to 63,864 unique visits and 437,956 page views compared with 15,672 unique visits and 121,802 page views in 2011–12 (when the website was established).

During 2013–14 significant communications effort was focused on supporting the *Open for better care* campaign.

7.6 Financial and resource management

Financial management

Maintaining financial sustainability is a critical part of the Commission's strategy and we have continued our record of remaining within budget.

We maintain sound management of public funding through our compliance with relevant requirements under the State Sector and Public Finance Acts and applicable Crown entity legislation. During 2013–14, we built on the recommendations of the 2012–13 audit review by Audit New Zealand. This was overseen by the Commission's Finance and Audit Committee.

The audit results for 2013–14 are in section 13.0 of this report.

Improving internal efficiency

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

Payroll functions and payments to Committee members have been outsourced to a third-party specialist payroll provider able to provide services more economically than the Commission could provide in-house. We keep abreast of and participate in the sector-wide functional leadership programme.

Improving effectiveness of our work

Every Commission improvement project has a clear focus on its value proposition, both human and economic. There is now a clear life-cycle for projects to ensure they are designed to become sustainable and 'business as usual' in the sector, allowing the Commission to redirect investment to emerging priorities. We also find willing partners to help us leverage our relatively small investment capability.

During 2013–14, the Commission contracted with Victoria University of Wellington and the University of Otago research centres (jointly) to evaluate the national *Open for better care* campaign, the overall impact of the Commission's work and the improvement advisor development programme.

Meeting our legal responsibilities

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

We undertake regular *ComplyWith* surveys (six-monthly for staff and annually for board members). These continue to show a high level of overall legislative compliance with no material breaches. Records management remains a priority; the Commission signed up to an All-of-Government records management retention and disposals contract, which will mean we remain compliant with records management requirements into the future.

Risk management

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

7.7 Permission to act despite being interested in a matter

For the period covered by this report, permission was given to act despite being interested in a matter on the following occasions:

Board member having interest	Item under discussion and date	Particulars of interest	Board action/resolution
Shelley Frost, David Galler and Geraint Martin	Integrated Performance and Incentive Framework, 30 August 2013	Not specified	All three members were given permission to remain in the meeting and participate in the discussion.
David Galler	APAC forum 2014 – discussion arising from Chief Executive's report, 23 May 2014	Programme director for the forum	Dr Galler was given permission not to absent himself from the meeting during any discussion.
David Galler	APAC forum 2014 proposal letter, 26 June 2014	Programme director for the forum and wrote the funding proposal	Dr Galler was asked to absent himself from the meeting for the APAC funding discussion.

PART TWO

8.0 Reporting

The Commission provided the Ministry of Health and the Minister of Health (through the Ministry) with information to enable monitoring of our performance including:

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

Section 50D(3b) of the New Zealand Public Health and Disability Act 2000 requires the Commission to, at least annually, provide the Minister of Health with a report on the progress of mortality review committees, and must include each such report in the Commission's next annual report. The report on progress of mortality review committees is included in this report in sections 4.4 and 9.5.

9.0 Report against the Statement of Performance

This Statement of Performance has been prepared in accordance with generally accepted accounting practice. It describes each reportable class of outputs supplied by the Commission during 2013–14 and includes, for each class of outputs:

- the standards of delivery performance achieved by the Commission, as compared with the forecast standards included in the Commission's statement of forecast performance for 2013–14
- the actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the Commission's statement of forecast performance for 2013–14.

OUTPUT CLASS 1: INFORMATION, ANALYSIS AND ADVICE

9.1 Progress reports to the Ministry of Health and DHBs against quality and safety markers (QSMs) for patient falls, healthcare associated infections and surgical harm – achieved

Measure	2013–14 performance
Deliverable dates: • QSM reports due January 2014 and April 2014 • baseline data for surgical site infection (SSI) markers due 30 June 2014.	
Two QSM reports provided	Two national progress reports were published – one in December 2013 and one in April 2014 (with a third published on 3 July 2014). DHB-specific reports were also published.
Baseline data established for SSI markers	Measures and baseline data were established relating to appropriate pre-operative antibiotic use, skin preparation and post-operative infections for hip and knee replacement patients. The April 2014 report included the baseline data and a further report was delivered on 3 July 2014 showing progress against the baselines.
Reports and data are subject to expert clinical and technical peer review	The falls, healthcare associated infections and surgical harm expert advisory groups developed the QSMs and review reports and data related to their particular area. These expert advisory groups include clinical expertise and some technical expertise. Additional technical peer review was provided by the Commission's internal technical expertise and by DHB review of all data and reports.

2012–13 performance: QSM sets finalised and first report published

9.2 Report against the full set of national and international measures of quality and safety – achieved

Measure	2013–14 performance
Deliverable date: 30 June 2014	
At least one report published	The national quality and safety indicators (QSIs) report was published on the Commission's website on 25 June with international data included wherever possible. A new national patient survey was developed during 2013–14 and was implemented in inpatient settings in all 20 DHBs by the start of July 2014. The first results will be published in November 2014.
Report and data is subject to expert clinical and technical peer review	All measures used in the QSI set were developed in consultation with the QSI expert advisory group. Technical peer review is provided by the Commission's internal technical expertise.

2011–12 performance: First indicators report published

2012–13 performance: Indicators report and update published

9.3 New Atlas domains – achieved

Measure	2013–14 performance
Deliverable date: 30 June 2014	
At least six domains published	Six new Atlas domains were published by 30 June 2014. Five were made available on the Commission's website – well child, trauma, diabetes, asthma and mental health key performance indicators. The suicide domain was completed and sent to DHBs and PHOs.
Reports and data are subject to expert clinical and technical peer review	An overarching Atlas steering group provides advice on topic selection, presentation and data matters. For each Atlas domain an expert advisory sub-group is established. Additional technical peer review is provided by the Commission's internal technical expertise and by DHB review of all data and reports.

2011–12 performance: First Atlas domain published

2012–13 performance: Seven Atlas domains published

9.4 Serious adverse event report, to include serious incidents involving mental health service consumers – achieved

Measure	2013–14 performance
Deliverable date: 30 December 2013	
One report published.	Two reports were published: • *District health board mental health and addictions services: serious adverse events reported to the Health Quality & Safety Commission 1 July 2012 to 30 June 2013* was published 26 September 2013. • *Making health and disability services safer – serious adverse events report 2012–13* was published 21 November 2013. (See Section 4.2 for details.)
Within six months of publication, stakeholder feedback indicates that at least 75% consider that the report was useful and 80% that it was well presented.	A survey of *Making health and disability services safer* was completed in May 2014. Twelve responses were received, a response rate of 27%. Ninety-two percent of respondents stated that the report was either very useful or useful and 92% stated that the report was very well presented or well presented. Due to the small numbers of completed interviews, the results are indicative only.

2011–12 performance: One report published

2012–13 performance: One report published

9.5 Mortality review committee reports – achieved

Child and youth mortality review

Measure	2013–14 performance
Deliverable date: 31 March 2014	
At least one review of child and youth mortality published.	Two reports were published: • The *Special Report: Unintentional deaths from poisoning in young people* was published in August 2013. • The *New Zealand Child and Youth Mortality Review Committee Ninth Data Report,* reporting on mortality up to and including 2012, was published January 2014.
All reports include priorities for action.	Priorities for action in relation to volatile substance abuse were included in the report on deaths from poisoning, including reducing attractiveness and demand, reducing access, and screening and intervention.
Within six months of publication, stakeholder feedback indicates that at least 75% consider that the report was useful and 80% that it was well presented.	A survey of the *Special Report* was undertaken 10 months after publication. Eighteen responses were received, a response rate of 21%. Due to the small numbers the results are indicative only. Ninety-two percent found the report to be either very useful or quite useful to their work and all respondents found it relevant. Eighty-six percent felt that it was either highly likely or likely that unintentional deaths from poisoning in young people would reduce if the recommendations were implemented. All respondents thought that the report was well presented.

2011–12 performance: Two reports published

2012–13 performance One report published

Perinatal and maternal mortality review

Measure	2013–14 performance
Deliverable date: 30 June 2014	
At least one review of perinatal and maternal mortality published.	The *Eighth Annual Report of the Perinatal and Maternal Mortality Review Committee* was published on 17 June 2014.
All reports include priorities for action.	The report included priorities for action for perinatal-related mortality, maternal mortality and neonatal encephalopathy.
Within six months of publication, stakeholder feedback indicates that at least 75% consider that the report was useful and 80% that it was well presented.	A survey of the eighth annual report will be completed within six months of publishing (that is, by 17 December 2014). The survey of the seventh annual report (published in June 2013) met the quality requirements. Fifty-four responses were received, a response rate of 21%. Ninety-six percent found the report both relevant to their work and well presented. Sixty-one percent indicated that the report had assisted them to improve their practice or service. A further 24% indicated that the report reinforced their current good practice or service.

2011–12 performance: Two reports published

2012–13 performance: One report published

Family violence death review

Measure	2013–14 performance
Deliverable date: 30 June 2014	
At least one review of family violence deaths published.	The Family Violence Death Review Committee's *Fourth Annual Report: January 2013 to December 2013* was published on 26 June 2014.
All reports include priorities for action.	The report included priorities for action for a number of different agencies, including legislative changes (see section 4.4 for more detail).
Within six months of publication, stakeholder feedback indicates that at least 75% consider that the report was useful and 80% that it was well presented.	A survey will be completed within six months of publishing (that is, by 31 December 2014). The survey for the third annual report (published in June 2013) met the quality requirements. Fifty-two responses were received, a response rate of 23%. Ninety-five percent found the report useful and 79% thought it was well presented.

2011–12 performance: One review published

2012–13 performance: One review published

Perioperative mortality review

Measure	2013–14 performance
Deliverable date: 31 March 2014	
At least one review of perioperative deaths published.	Two reports were published: • The *Progress Report of the Perioperative Mortality Review Committee* was published in March 2014. • *Perioperative Mortality in New Zealand: Third Report of the Perioperative Mortality Review Committee* was published in June 2014.
All reports include priorities for action.	The *Progress Report* included priorities for improving perioperative care, system development and areas for further action. The *Third Report* included priorities for action including use of American Society of Anesthesiologists (ASA) scores, which assess a patient's physical status before surgery, developing standardised mortality reporting and exploring WHO measures to make it possible to compare statistics between countries.
Within six months of publication, stakeholder feedback indicates that at least 75% consider that the report was useful and 80% that it was well presented.	A survey will be completed within six months of publishing (that is, by 30 September 2014). The survey for the *Second Report* (published in March 2013) met the quality requirements. Thirty-one responses were received, a response rate of 33%. Due to the small number of responses, the results are indicative only. Eighty-one percent found the report helpful as a tool to inform practice and 93% found the report well presented. Importantly, half of respondents stated that the report had assisted in improving practice and service.

2011–12 performance:	One report published
2012–13 performance:	One report published

OUTPUT CLASS 2: TOOLS AND SUPPORT FOR PRIORITY PROGRAMMES

9.6 A nationally coordinated programme to reduce harm from falls in care settings – achieved

Measure	2013–14 performance
Deliverable date: 30 June 2014	
The programme includes: • recommendations for the sector on essential elements, initially on risk assessment and individualised care plans	During 2013–14, the Commission published *Ask, assess, act* – a tool comprising simple screening questions to find which older person is at risk of falling in order to target for a fuller assessment. We also published *10 Topics,* a comprehensive falls screening resource in interactive PDF form, covering impacts, prevention and interventions and using the most up-to-date evidence; resources on falls risk assessment in TrendCare; a review and discussion document on falls risk assessment tools and care plans in New Zealand DHBs; a comparison of current guidelines; and questions and answers about the QSMs for falls.
• a set of resources, tools and information	In addition to those relating to risk assessment and individual care plans, other resources, tools and information were provided as part of the national programme, the *Open for better care* campaign and the April Falls quiz and survey: • *Safe environment and safe care* • *Why hip fracture prevention and care matters* • *Vitamin D and falls* • *Improving balance and strength to prevent falls* • *Medicines: balancing benefits and falls risks* • *Signalling system: a system to indicate level of assistance needed with mobility* • An audit tool for safe care environments • *After a fall, what should happen* • *The Dame Kate Harcourt Storybook and Photo Album* • Dr Frances Healey workshops and resources with a focus on turning knowledge into action in falls prevention across the continuum of care • *April Audit: How safe is the care environment today?*
• falls networks to promote integration and support.	Falls networks include: • a national falls network made up of leads from each region • regional programme level networks • an aged residential care working group to build connections and share learning across the aged residential care sector. • a Commission and ACC co-sponsored quality improvement collaborative (across the three Wellington sub-regional DHBs), which works closely with their respective aged care facilities.
A clinical leader and an expert advisory group informs the programme.	The clinical leader, Sandy Blake, and the falls expert advisory group consider all aspects of the programme and provide expert advice. The expert advisory group met quarterly during the year.

Measure	2013–14 performance
Guidance, information and resources are evidence-based.	Reviews of the latest literature and evidence underpin each of the campaign topic areas. The literature review references are included at the end of each topic area on the Commission's website.
Annual measurement of changes in attitude and knowledge in the sector is undertaken by an independent party with baselines being established in 2013–14.	Attitudes and knowledge were surveyed in an April Falls 2014 quiz undertaken by an external survey company. This was the second annual quiz. A number of new questions were included which tested knowledge and form a baseline for future annual surveys. Key results are included in section 5.1 of this report.
The QSM reports include quarterly measurement of uptake of good practice and outcomes.	QSM reports were published in December 2013 and April and July 2014. They include measurement of uptake of good practice through process measures and the results through outcome measures (see section 5.1 and Appendix 2 for results).

2012–13 performance: Baseline information completed about prevalence of falls and harm from falls

9.7 A nationally coordinated programme to reduce surgical site infections (SSI) by achieving culture and practice change – achieved

Measure	Progress report
Deliverable date: 30 June 2014	
The programme includes: • provision of best practice guidelines for prevention of SSIs	The second *Open for better care* focus (surgical site infections) ran from October 2013 to March 2014. It provided a platform to highlight evidence-based interventions including: • streamlining the surveillance programme • appropriate use of prophylactic antibiotics (correct antimicrobial choice and dose, correct antimicrobial timing, correct duration) • appropriate skin preparation • clipping, not shaving, of intended surgical wound site. There were five webinars, which are on the Commission's website. Consumers took the lead in one of the webinars, discussing the impact of SSIs on their recovery and lives. A consumer resource was developed to give patients information about what they can do post-surgery to prevent SSIs, information to 'spot an SSI' and how to react. This has been well received and utilised.
• implementation of a national SSI IT system for monitoring, analysis and reporting.	The programme, in collaboration with DHBs, has developed and implemented a consistent, evidence-based approach to collecting and reporting data on SSIs. This will give health care professionals access to verifiable information to drive practice change and continuous quality improvement. The Commission, through Canterbury DHB, is funding the use of an ICNet online data collection form for manual entry of DHB SSI surveillance data until March 2015. All 20 DHBs are now submitting data to ICNet.

Measure	Progress report
A clinical leader and an external steering group informs the programme.	The clinical lead, Arthur Morris, and an external steering group and clinical leadership group inform the SSI improvement programme.
The QSM reports include quarterly measurement of uptake of good practice and outcomes.	The confirmed set of QSMs includes three process measures and outcomes data relating to the number and rate of SSIs following total hip and knee joint replacements (see section 5.3 and Appendix 2 for results).

2012–13 performance: Surgical site surveillance piloted in eight DHBs

9.8 A nationally coordinated programme to reduce perioperative harm – achieved

Measure	2013–14 performance
Deliverable date: 30 June 2014	
The programme includes: • implementation of improvement strategies and activities initially focused on use of the surgical safety checklist and including venous thromboembolism on the checklist • educational and training opportunities • provision of resources on the website.	During 2013–14, the Commission: • encouraged inclusion of risk assessment for blood clots and appropriate treatments in local versions of checklists • commenced a proof of concept demonstration involving three surgical providers, which focused on improving teamwork and communication through use of the surgical safety checklist, briefings and debriefings. The demonstration has started testing guidelines and toolkits. They are also trialling a real-time observational data collection application aimed at reducing the reporting burden on DHBs • ran an *Open for better care* campaign, which focused on raising awareness of teamwork and communication improving patient safety in the operating theatre • provided a resource for patients, *Keeping you safe during surgery,* available in English and Māori.
A clinical leader and an expert advisory group informs the programme.	The clinical leads, Ian Civil (Medical Clinical Lead) and Miranda Pope (Nurse Clinical Lead) and the Perioperative Harm Advisory Group inform the programme. An expert working group is also in place to support the teamwork and communication work – this group has led the development of the clinical, behavioural and improvement approach being tested in the proof of concept project.
The QSM reports include quarterly measurement of uptake of good practice and outcomes.	QSM reports were published in April and July 2014. They include measurement of uptake of good practice through process measures and the results through outcome measures (see section 5.4 and Appendix 2 for results).

2012–13 performance: Baseline data collected on percentage of operations where the surgical checklist was used properly

9.9 A nationally coordinated programme to reduce harm from high-risk medicines – partly achieved

- *Scope:* achieved within the period of the Statement of Intent, but five months later than the deliverable date.
- *Agreed set of interventions and QSMs:* partly achieved. Interventions to be tested and refined in the formative collaborative have been identified, but QSMs for high-risk medicines cannot be finalised at this stage.

Measure	2013–14 performance
Deliverable dates: • Scope due 30 December 2013 • Agreed set of interventions and QSMs due 30 June 2014.	
The scope for the programme on high-risk medicines is finalised.	The high-risk medicines programme scope was finalised in May 2014. It will be a three-year programme with an initial focus on reducing harm from opioids in secondary care. The scope includes: • *Safe use of opioids collaborative* from October 2014 to May 2016, which will involve regional and national learning sessions and supporting local DHB action where agreed interventions are tested • *Open for better care* campaign from October 2014 to March 2015, with activities and resources related to the case for change, identifying medication errors and harm, partnering with patients and families/whānau, preventing and mitigating medication errors and harm, and the safe use of opioids.
An agreed set of interventions and related QSMs is finalised.	Agreed set of interventions: • A potential list of interventions was developed on the basis of evidence or current knowledge. The *Safe use of opioids collaborative* participants will trial these by undertaking rapid cycles of change. At the end of the collaborative it is expected that a best practice 'bundle' for the safe use of opioids will be confirmed. QSMs: • Selecting a marker for specific high-risk medicines (opioid focus) was difficult because of the limitations in detecting harm from any single high-risk medicine in volumes sufficient for a viable QSM. An alternative approach has been adopted, with markers being developed for electronic medicine reconciliation instead. These are scheduled for completion by 31 July 2014 for inclusion in the December 2014 QSM report.
An expert advisory group informs the programme.	The medication safety expert advisory group meets regularly to inform the programme. Key medication safety cross-sector expertise from a range of disciplines is represented.
The scope is based on a literature review of high-risk medicines.	A literature review on high-risk medicines was completed for the Commission in July 2013. This, together with other evidence, informs the high-risk medicines programme and the focus on opioids for the collaborative.
The sector is engaged in developing the interventions and related QSMs.	The expert advisory group (which has cross-sector representation) has been involved in identifying potential QSMs, the potential scope of the high-risk medicines programme and the campaign topic for 2014–15. A sector collaborative is being established for the development of the opioids interventions and related measures.

Previous years' measures for medication safety have focused on use of paper-based medication charts (in hospitals and aged residential care), paper-based medicine reconciliation (in hospitals) and trialling electronic medicines management.

9.10 A framework and implementation plan for 'never events' – those adverse events that should never occur – substantially achieved

Measure	2013–14 performance
Deliverable date: 30 June 2014	
Framework and implementation plan is completed.	A framework and implementation plan was substantially completed by 30 June 2014. The framework to date includes: • objectives • criteria for the selection of 'never events' • process for amending the list of 'never events' in future. This work will be finalised as part of the review of the national reportable event policy during 2014–15.
An expert advisory group informs the range of adverse events that should never occur, the framework and implementation plan.	The expert advisory group and clinical lead have been engaged on this work and will have further engagement in preparing future advice for the board.

This was a new performance measure for 2013–14.

OUTPUT CLASS 3: SECTOR AND CONSUMER CAPABILITY

9.11 Clinical leadership development – achieved

Measure	2013–14 performance
Deliverable date: 30 June 2014	
At least two meetings of the Commission's clinical leads and other identified clinical leaders are held.	Four meetings were held. The clinical leads met in August and December 2013. They were joined by the chairs of the mortality review committees for the March and June 2014 meetings.
Meeting agendas will include: • sharing any new evidence • peer review of a particular programme • learning opportunities.	Clinical leads shared new evidence, peer reviewed programmes and participated in learning opportunities through: • updates and discussions provided by clinical leads on their programmes, such as discussion of issues around involving consumers in programmes and measuring success, serious adverse events, key learnings from the CLAB programme and from the falls *Open for better care* campaign and discussions on consumer engagement • specific learning sessions, such as formal training on leadership during change, quality improvement methodology and practice, performance improvement interventions that work in health care settings, and discussion of the King's Fund report *Developing Collective Leadership for Health Care.*

This was a new performance measure for 2013–14.

9.12 A national quality and safety campaign – *Open for better care* – with a focus on falls, perioperative harm, healthcare associated infections and medication safety – achieved

Measure	2013–14 performance
Deliverable date: 30 June 2014	
Two campaign topics are launched.	Two campaign topics were launched: • reducing surgical site infections (launched October 2013 and completed March 2014) • reducing perioperative harm (launched April 2014; to be completed October 2014) The reducing harm from falls campaign was launched in the previous financial year (May 2013) and was completed in October 2013. More information about the campaign topics is found in sections 9.6 (reducing harm from falls), 9.7 (healthcare associated infections) and 9.8 (perioperative harm).
Evaluation of the first two campaign topics includes analysis of their success in brand recognition and visibility, increasing engagement and motivation and uptake of evidence-based practice.	A contract with Victoria University and Otago University research centres (jointly) has commenced evaluating the national *Open for better care* campaign[7] and will include brand recognition and visibility, and engagement and motivation. DHB results against the QSMs specific to each campaign topic are being used to evaluate the campaign's success in increasing uptake of evidence-based practice. During the year, the process markers have shown continuing improvement or, where results were already high, maintenance of those high rates (see Appendix 2 for results).

This was a new performance measure for 2013–14.

7 The contract also includes evaluation of the overall impact of the Commission's work and the improvement advisor development programme.

9.13 A national network of people with expertise in improvement methodology – achieved

Measure	2013–14 performance
Deliverable dates: • national network established by 30 December 2013 • survey results available by 30 June 2014	
A national network of people with expertise in improvement methodology is established.	By 30 December 2013, a shared web workspace was set up. It has been populated with links, notices of 2014 events and relevant documents. There are 70 members.
Survey of members of the network includes analysis of how well members are linked with their peers and sharing of knowledge and skills both within the group and with other providers.	The survey of members of the network and other improvement experts (120 people in total) was completed by 30 June 2014. Some of the key findings included: • 69% are well linked with their peers and able to share knowledge and skills with them. • 57% are able to share knowledge and skills with frontline staff. • 69% are well linked with senior clinicians and managers. The survey also provided other useful information about the best sources of quality improvement knowledge and what the Commission could do to support them to maintain knowledge and skills.

This was a new performance measure for 2013–14.

9.14 Resources and training to assist providers and consumers to work together as partners in care – achieved

Measure	Progress report
Deliverable date: 30 June 2014	
Resources are developed on: • providers working with consumers • consumers working with providers.	Resources for providers working with consumers: • health literacy resources for community pharmacy providers (due to high demand this was reprinted) • surgical site infection webinar (also published on the website) • A2 poster for health and disability providers setting out the why, when, who, how – to involve consumers in health and disability services. Resources for consumers working with providers: • pamphlets – keeping you safe during surgery and preventing infection after surgery. Resources aimed at both providers and consumers: • videos of key speakers at the Partners in Care Show and Tell Symposium in Wellington. The Commission also published on its website useful resources for consumers that had been developed by other agencies including: • *Ask Me 3* – a patient education programme developed by the National Patient Safety Foundation in Boston • *Ask, Share, Know* (ASK) – developed by Sydney University and Family Planning NSW to help people become involved in decisions about their health.
At least two training days are held for consumers and providers.	Training included: • Partners in Care programme, which included webinars (eight in total) where consumers and providers share the role of improving care through co-design of services • presentations/training with pharmacy students and staff at Auckland and Otago Schools of Pharmacy • three Show and Tell symposia held in Auckland, Wellington and Christchurch for providers and consumers on co-design (with a total attendance for all three of around 265).

Measure	Progress report
Evaluation of resources and training indicates that 80% of users/participants are satisfied.	A survey of resources was carried out. There were 201 responses received, a response rate of 17%. Seventy-four percent of respondents found the *Health and Disability Providers Partnering with Consumers* toolkit poster either useful or very useful (a margin of error of 6.91%). Eighty-seven percent of respondents found the *Three Steps to Better Health Literacy* booklet (published in 2013) either useful or very useful. Evaluation of health literacy training for students at the Auckland and Otago Schools of Pharmacy indicated that participants had a clear idea of changes to their practice that they would consider as a result of the training. One hundred and forty-three attendees filled out evaluation forms for the Show and Tell symposia held in Auckland, Wellington and Christchurch, a response rate of 54%. The evaluations were very positive and demonstrated significant learning. Participants' overall view of the Partners in Care programme is very positive, with 88% stating that they have been very motivated by the programme. The same number (88%) also said that their confidence in engaging with consumers had increased as a result of this programme.

2011–12 performance:	Register of consumer organisations, groups and individuals undertaking advisory and/or representative roles in the health and disability sector was published
2012–13 performance:	Ninety percent of the milestones in the 2012–13 Partners in Care action plan were implemented, including those relating to health literacy, consumer register, resources for consumers, consumer narratives and co-design

10.0 Revenue/expenses for output classes

	Output class 1 Information, analysis and advice		Output class 2 Tools and support for priority programmes		Output class 3 Sector and consumer capability		Total	
	Actual $000	Budget $000	Actual $000	Budget $000	Actual $000	Budget $000	Actual $000	Budget $000
Income								
Crown and other revenue	6,166	5,976	5,042	5,042	1,958	1,958	13,166	12,976
Interest income	47	33	39	27	15	10	100	70
Other income	84	0	263	350	22	0	368	350
Total income	**6,296**	**6,009**	**5,343**	**5,419**	**1,995**	**1,968**	**13,634**	**13,396**
Expenditure								
Operational and internal programme costs	3,304	2,859	3,036	3,019	956	936	7,296	6,814
External programme cost	3,007	3,150	2,734	3,000	1,063	1,032	6,804	7,182
Total expenditure	**6,311**	**6,009**	**5,770**	**6,019**	**2,019**	**1,968**	**14,100**	**13,996**
Surplus/(deficit)	**(15)**	**0**	**(427)**	**(600)**	**(24)**	**0**	**(466)**	**(600)**

11.0 Financial statements

11.1 Statement of comprehensive income for the year ended 30 June 2014

Actual 2013 $000		Notes	Actual 2014 $000	Budget 2014 $000
	Income			
12,996	Revenue from Crown	2	13,166	12,976
164	Interest income		100	70
355	Other income	3	368	350
13,515	**Total income**		**13,634**	**13,396**
	Expenditure			
4,036	Personnel costs	4	4,148	4,255
131	Depreciation and amortisation	12,13	143	135
2,746	Other expenses	6	3,004	2,424
5,969	Quality and safety programmes		4,566	4,812
2,387	Mortality programmes		2,239	2,370
15,269	Total expenditure		**14,100**	**13,996**
(1,754)	**Surplus/(deficit)**		**(466)**	**(600)**
0	Other comprehensive income		**0**	**0**
(1,754)	**Total comprehensive income**		**(466)**	**(600)**

Explanations of major variances against budget are provided in note 27.
The accompanying notes form part of these financial statements.

11.2 Statement of financial position as at 30 June 2014

Actual 2013 $000		Notes	Actual 2014 $000	Budget 2014 $000
	Assets			
	Current assets			
2,303	Cash and cash equivalents	7	2,151	2,417
520	GST receivable		381	122
252	Debtors and other receivables	8	125	100
163	Prepayments		158	42
3,238	**Total current assets**		**2,816**	**2,681**
	Non-current assets			
246	Property, plant and equipment	12	99	153
64	Intangible assets	13	24	21
310	**Total non-current assets**		**123**	**174**
3,548	**Total assets**		**2,938**	**2,855**
	Liabilities			
	Current liabilities			
1,489	Creditors and other payables	14	1,341	1,393
282	Employee entitlements	16	287	153
1,771	**Total current liabilities**		**1,628**	**1,546**
1,771	**Total liabilities**		**1,628**	**1,546**
1,777	**Net assets**		**1,311**	**1,309**
	Equity			
3,531	General funds July		1,777	1,909
0	Contributed capital	17	0	0
(1,754)	Surplus/(deficit)		(466)	(600)
1,777	**Total equity**		**1,311**	**1,309**

Explanations of major variances against budget are provided in note 27.
The accompanying notes form part of these financial statements.

11.3 Statement of changes in equity for the year ended 30 June 2014

Actual 2013 $000		Notes	Actual 2014 $000	Budget 2014 $000
3,531	Balance at 1 July		1,777	1,909
	Comprehensive income			
(1,754)	Surplus/(deficit)		(466)	(600)
0	Other comprehensive income		0	0
(1,754)	Total comprehensive income		(466)	(600)
	Owner transactions			
0	Capital contribution		0	0
1,777	**Balance at 30 June**	**17**	**1,311**	**1,309**

Explanations of major variances against budget are provided in note 27.
The accompanying notes form part of these financial statements.

11.4 Statement of cash flows for the year ended 30 June 2014

Actual 2013 $000		Notes	Actual 2014 $000	Budget 2014 $000
	Cash flows from operating activities			
12,996	Receipts from Crown		13,166	12,976
115	Other revenue		495	350
160	Interest received		100	70
(11,499)	Payments to suppliers		(9,955)	(9,733)
(3,927)	Payments to employees		(4,142)	(4,254)
(206)	Goods and services tax (net)		140	5
(2,361)	Net cash flow from operating activities	12	(196)	(586)
	Cash flows from investing activities			
(32)	Purchase of property, plant and equipment		44	0
(28)	Purchase of intangible assets		0	0
(60)	Net cash flow from investing activities		44	0
	Capital flows from financing activities			
0	Capital contribution		0	0
0	Net cash flows from financing activities	17	0	0
(2,421)	**Net (decrease)/increase in cash and cash equivalents**		**(152)**	**(586)**
4,724	Cash and cash equivalents at the beginning of the year		2,303	3,003
2,303	**Cash and cash equivalents at the end of the year**	7	**2,151**	**2,417**

Explanations of major variances against budget are provided in note 27.
The accompanying notes form part of these financial statements.

11.5 Notes to the financial statements

Note 1: Statement of accounting policies

REPORTING ENTITY

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

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

The financial statements for the Commission are for the year ended 30 June 2014, and were approved by the board on 23 October 2014.

BASIS OF PREPARATION

Statement of compliance

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

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

Measurement base

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

Functional and presentation currency

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

Changes in accounting policies

There have been no changes in accounting policies.

The Commission has adopted the following revision to accounting standards, which has had only a presentational effect:

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

Standards, amendments and interpretations issued that are not yet effective and have not been early adopted

Standards, amendments and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the Commission are:

- NZ IFRS 9 *Financial Instruments* will eventually replace NZ IAS 39 *Financial Instruments: Recognition and Measurement*. NZ IAS 39 is being replaced through the following three main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the Commission will be required to apply the Public Benefit Entity (Tier 2 reporting entity) of the

public sector Public Benefit Entity Accounting Standards. The effective date for the new standards for public sector entities is for reporting periods beginning on or after 1 July 2014. Therefore, the Commission will transition to the new standards in preparing its 30 June 2015 financial statements. The Commission has not assessed the implications of the new Accounting Standards Framework at this time.

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

SIGNIFICANT ACCOUNTING POLICIES

Revenue

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

Revenue from the Crown

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

Interest

Interest income is recognised using the effective interest method.

Foreign currency transactions

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

Operating leases

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

Cash and cash equivalents

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

Debtors and other receivables

Debtors and other receivables are measured at face value less any provision for impairment. There are no provisions for impairment in 2013–14.

Bank deposits

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

Inventories

Inventories held for sale are measured at the lower of cost (calculated using the First In First Out basis) and net realisable value. There are no inventories held for sale in 2013–14.

Property, plant and equipment

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

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

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

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

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

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

Depreciation

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

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

Intangibles

Software acquisition

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with the development and maintenance of the Commission's website are recognised as an expense when incurred.

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

Amortisation

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

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

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

Acquired computer software	3 years	33% SL

Impairment of property, plant and equipment, and intangible assets

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Creditors and other payables

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

Employee entitlements

Short-term employee entitlements

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

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Note 2: Revenue from the Crown

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

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

Note 3: Other income

An additional $0.26m ($0.35m 2013) was received from Hutt Valley DHB associated with the joint electronic medicines management programme.

Note 4: Personnel costs

	Actual 2013 $000	Actual 2014 $000
Salaries and wages	3,725	3,924
Recruitment	35	22
Temporary personnel	0	11
Membership, professional fees and staff	115	63
Training and development		
Defined contribution plan employer contributions	87	129
Increase/(decrease) in employee entitlements	74	(1)
Total personnel costs	**4,036**	**4,148**

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

Note 5: Capital charge

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

Note 6: Other expenses

	Actual 2013 $000	Actual 2014 $000
Audit fees to Audit NZ for financial audit	29	29
Staff travel and accommodation	314	317
Printing/communications	258	253
Consultants and contractors	1,038	1,002
Board costs/mortality committees	493	510
Outsourced corporate services and overhead	591	667
Onerous contracts	0	126
Loss on property, plant and equipment	0	87
Other expenses	23	13
Total other expenses	**2,746**	**3,004**

Note 7: Cash and equivalents

	Actual 2013 $000	Actual 2014 $000
Cash at bank and on hand	2,303	2,151
Total cash and cash equivalents	**2,303**	**2,151**

The carrying value of cash at bank and short-term deposits with maturities less than three months approximates their fair value.

Note 8: Debtors and other receivables

	Actual 2013 $000	Actual 2014 $000
Debtors and other receivables	252	125
Less: provision for impairment	0	0
Total debtors and other receivables	**252**	**125**

FAIR VALUE

The carrying value of receivables approximates their fair value.

IMPAIRMENT

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

Note 9: Investments

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

Note 10: Inventories

The Commission has no inventories for sale in 2013–14.

Note 11: Non-current assets held for sale

The Commission has no current or non-current assets held for sale in 2013–14.

Note 12: Property, plant and equipment

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

	Computer $000	Furniture and office equipment $000	Leasehold improvements $000	Total $000
Cost or valuation				
Balance at 1 July 2012	143	129	115	387
Additions	9	15	8	32
Balance at 30 June 2013/July 2013	152	144	123	419
Additions	26	13	0	39
Disposals	0	0	(87)	(87)
Balance at 30 June 2014	178	157	36	371
Accumulated depreciation and impairment losses				
Balance at 1 July 2012	46	24	11	81
Depreciation expense	49	36	7	92
Balance at 30 June 2013	95	60	18	173
Balance at 1 July 2013	95	60	18	173
Depreciation expense	49	32	17	98
Balance at 30 June 2014	144	92	35	272
Carrying amounts				
At 1 July 2012	97	105	104	306
At 30 June and 1 July 2013	57	84	105	246
At 30 June 2014	34	64	1	99

The Commission does not own any buildings or motor vehicles.

Note 13: Intangible assets

Movements for each class of intangible asset are as follows:

	Acquired software $000
Cost	
Balance at 1 July 2012	100
Additions	28
Balance at 30 June 2013/1 July 2013	128
Additions	4
Balance at 30 June 2014	132
Accumulated amortisation and impairment losses	
Balance at 1 July 2012	24
Amortisation expenses	39
Balance at 30 June 2013/1 July 2013	63
Amortisation expenses	45
Balance at 30 June 2014	108
Carrying amounts	
At 1 July 2012	76
At 30 June and 1 July 2013	64
At 30 June 2014	24

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 2013 $000	Actual 2014 $000
Creditors	705	510
Accrued expenses	784	705
Other payables	0	126
Total creditors and other payables	**1,489**	**1,341**

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. The Commission has a non-cancellable lease for office space previously occupied.

Note 15: Borrowings (NZ IAS 1.77)

The Commission does not have any borrowings.

Note 16: Employee entitlements

	Actual 2013 $000	Actual 2014 $000
Current portion		
Accrued salaries and wages	136	142
Annual leave	146	145
Total current portion	282	287
Non-current portion	0	0
Total employee entitlements	**282**	**287**

No provisions for sick leave, retirement or long service have been made in 2013–14.

Note 17: Equity

	Actual 2013 $000	Actual 2014 $000
General funds		
Balance at 1 July	3,531	1,777
Surplus/(deficit) for the year	(1,754)	(466)
Capital contributions	0	0
Balance at 30 June	**1,777**	**1,311**

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

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

	Actual 2013 $000	Actual 2014 $000
Net surplus/(deficit)	(1,754)	(466)
Add/(less) movements in statement of financial position items		
Debtors and other receivables	(450)	267
Creditors and other payables	(266)	(150)
Depreciation	131	143
Prepayments	(132)	5
Employee entitlements	109	5
Net movements in working capital		
Net cash flow from operating activities	(2,362)	(196)

Note 19: Capital commitments and operating leases

CAPITAL COMMITMENTS

There were no capital commitments at balance date.

OPERATING LEASES AS LESSEE

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

	Actual 2013 $000	Actual 2014 $000
Not later than one year	161	320
Later than one year and not later than five years	192	30
Later than five years	0	0
Total non-cancellable operating leases	**353**	**350**

The Commission leases a property (from 1 March 2014) at Level 1 and 8, Whitmore Street, Wellington. The lease expires in March 2015 with an option for two rights of renewal of six months each. The Commission does not have the option to purchase the asset at the end of the lease term.

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

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

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

Note 20: Contingencies

CONTINGENT LIABILITIES

The Commission has no contingent liabilities.

CONTINGENT ASSETS

The Commission has no contingent assets.

Note 21: Related party transactions

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

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

SIGNIFICANT TRANSACTIONS WITH GOVERNMENT-RELATED ENTITIES

The Commission has been provided with funding from the Crown of $13.2m ($13.0m 2013) for specific purposes as set out in its founding legislation and the scope of relevant government appropriations. The Commission purchased goods or services from a number of DHBs and universities. Significant transactions were: Auckland DHB $1.01m ($0.84m 2013), Canterbury DHB $0.53m ($0.46m 2013), Counties Manukau DHB $0.41m ($1.1m 2013), The University of Otago $0.63m ($0.57m 2013), Air New Zealand $0.47m ($0.41m 2013), Uniservices Limited $0.40m ($0.36m 2013) and Waitemata DHB$0.12m ($0.56m 2013).

COLLECTIVELY, BUT NOT INDIVIDUALLY, SIGNIFICANT TRANSACTIONS WITH GOVERNMENT-RELATED ENTITIES

In conducting its activities, the Commission is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The Commission is exempt from paying income tax.

The Commission also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2014 totalled $5.0m ($5.8m 2013), which included DHBs (additional to those noted above), Air New Zealand, universities and other government Crown entities and departments.

KEY MANAGEMENT PERSONNEL

Salaries and other short-term employee benefits to key management personnel[8] totalled $1.04m ($1.01m 2013).

The Commission contracted with Counties Manukau DHB, a Crown entity where one current and one previous Commission board member hold senior positions. The value of the contract/work was $0.41m ($1.1m 2013). The Commission contracted with Waitemata DHB $0.12m ($0.56m 2013) where a board member holds a senior position. The Commission contracted with Canterbury DHB $0.53m ($0.46m 2013) where a board member is a member of the DHB clinical board.

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

The total value of remuneration paid or payable to each board member (or their employing organisation*) during the full 2013–14 year was:

	Actual 2013 $000	Actual 2014 $000
Professor Alan Merry* (Chair)	29	29
Dr Peter Foley	14	0
Mrs Shelley Frost* (Deputy Chair)	15	18
Dr David Galler*	15	15
Dr Peter Jansen*	8	0
Mr Geraint Martin*	15	7
Mrs Anthea Penny	15	11
Dame Alison Paterson	1	15
Dr Dale Bramley*	0	15
Mr Robert Henderson	0	7
Ms Heather Shotter	0	5
Ms Gwendoline Tepania-Palmer	0	5
Total board member remuneration	**112**	**127**

Fees were in accordance with the Cabinet Fees Framework.

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

The Commission has effected Directors' and Officers' Liability and Professional Indemnity Insurance cover during the financial year in respect of the liability or costs of board members and employees.

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

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

8 Key management personnel for 2013–14 include the CEO, General Manager, Director of Measurement and Evaluation, and Chief Financial Officer. Board members have been reported separately.

Note 23: Employee remuneration

Total remuneration paid or payable:

	Employees 2013	Employees 2014
$100,000–$109,999	2	4
$110,000–$119,999		2
$120,000–$129,999	1	1
$130,000–$139,999	3	2
$140,000–$149,999		1
$150,000–$159,999	2	1
$160,000–$169,999		2
$180,000–$189,999	2	
$190,000–$199,999		1
$210,000–$219,999	1	
$220,000–$229,999		1
$230,000–$239,999	1	1
$360,000–$369,999		
$370,000–$379,999	1	
$380,000–$389,999		1
Total employees	**13**	**17**

During the year ended 30 June 2014 no employees received compensation and other benefits in relation to cessation.

Note 24: Events after the balance date

There were no significant events after the balance date.

Note 25: Financial instruments

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

Note 26: Capital management

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

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

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

Note 27: Explanation of major variances against budget

Explanations for major variances from the Commission's budgeted figures in the 2013–14 Statement of Intent are as follows:

STATEMENT OF COMPREHENSIVE INCOME

The year-end result for the year to 30 June 2014 is $0.466m deficit against a planned Statement of Intent deficit of $0.600m.

The main variance to budget relates to the decision not to progress a public-facing hand hygiene campaign during 2013–14.

Programme expenditure has also not been required for the 'Productive Series' in 2013–14 and tier one mortality review information activity will now occur in the 2014–15 work programme. These differences are offset by additional programme activity and expenditure (mainly within the falls programme) and the inclusion of a provision for future lease obligations and write-off of historic fit-out costs of Level 6, Classic House.

The Commission has ended the year within Statement of Intent budgeted expenditure levels and has addressed the re-application and use of prior year surpluses. This means equity levels now align with those signalled in future planning documents.

STATEMENT OF FINANCIAL POSITION

GST receivable is high in the final quarter as a number of contract payment terms are agreed three months in arrears and were received at the end of June.

Prepayments include work on progress payments for the development of a consumer experience patient survey tool. This tool was completed in July–August 2014. DHBs will be funding the support and use of this tool in 2014–15.

Employee entitlements are higher than budgeted levels as year-end budgets did not include an estimate for the provision of the final payroll accrual for the year.

STATEMENT OF CHANGES IN CASHFLOW

Cash and cash equivalents at the beginning of the year were lower than budgeted due to the final results for 2012–13 being different to what was forecast at the time. Net cash flow from operating activities was lower than budget in 2013–14 due to expenditure during the year being less than the planned $0.6m deficit.

Note 28: Acquisition of shares

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

12.0 Statement of responsibility

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

The board of the Health Quality & Safety Commission has the responsibility for establishing and maintaining a system of internal controls designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the board's opinion, these financial statements and statement of service performance fairly reflect the financial position and operations of the Health Quality & Safety Commission for the year ended 30 June 2014.

Signed on behalf of the board:

Professor Alan Merry, ONZM
Chair
23 October 2014

Shelley Frost
Deputy Chair
23 October 2014

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

13.0 Auditor's report

Independent Auditor's Report

To the readers of Health Quality and Safety Commission's financial statements and non-financial performance information for the year ended 30 June 2014

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

We have audited:

- the financial statements of the Commission on pages 50 to 65 that comprise the statement of financial position as at 30 June 2014, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and notes to the financial statements that include accounting policies and other explanatory information; and
- the non-financial performance information of the Commission that comprises the statement of service performance on pages 35 to 49 and the report about outcomes on pages 72 to 75.

Opinion

In our opinion:

- the financial statements of the Commission on pages 50 to 65:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Commission's:
    - financial position as at 30 June 2014; and
    - financial performance and cash flows for the year ended on that date.
- the non-financial performance information of the Commission on pages 35 to 49 and 72 to 75:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects the Commission's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:
    - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 23 October 2014. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and we explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and non-financial performance information are free from material misstatement.

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and non-financial performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and non-financial performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Commission's financial statements and non-financial performance information that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Commission's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported non-financial performance information within the Commission's framework for reporting performance;
- the adequacy of all disclosures in the financial statements and non-financial performance information; and
- the overall presentation of the financial statements and non-financial performance information.

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

We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Board

The Board is responsible for preparing financial statements and non-financial performance information that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Commission's financial position, financial performance and cash flows; and
- fairly reflect the Commission's service performance and outcomes.

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

The Board's responsibilities arise from the Crown Entities Act 2004.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and non-financial performance information and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

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

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

Appendix 1: Board and committee membership

Board members

Prof Alan Merry (Chair)

Shelley Frost (Deputy Chair)

Dr David Galler

Geraint Martin (term expired 6 March 2014)

Anthea Penny (term expired 6 March 2014)

Dame Alison Paterson

Dr Dale Bramley

Robert Henderson (term commenced 6 March 2014)

Heather Shotter (term commenced 6 March 2014)

Gwendoline Tepania-Palmer (term commenced 6 March 2014)

Board committees

Finance and Audit Committee:

Geraint Martin (Chair – till 6 March 2014)

Alison Paterson (Chair from 23 May 2014)

Anthea Penny (till 6 March 2014)

Andrew Boyd

Dale Bramley (from 23 May 2014)

Heather Shotter (from 23 May 2014)

Capability Committee (to 23 May 2014):

Shelley Frost (Chair)

David Galler

Anthea Penny (till 6 March 2014)

Kathy Kane

Communication and Engagement Committee:

Heather Shotter (Chair from 23 May 2014)

Gwendoline Tepania-Palmer (from 23 May 2014)

Alan Merry (acting Chair till 23 May 2014)

Shelley Frost

David Galler (till 23 May 2014)

Mortality review committee members

Perinatal and Maternal Mortality Review Committee	Perioperative Mortality Review Committee	Child and Youth Mortality Review Committee	Family Violence Death Review Committee
Dr Sue Belgrave (Chair)	Dr Leona Wilson (Chair)	Dr Nicholas Baker (Chair)	Assoc Prof Julia Tolmie (Chair)
Dr Beverley Lawton (term expired 5 November 2013)	Dr Jonathan Koea	Prof Edwin Mitchell	Ngaroma Grant (Co-Deputy Chair)
Susan Bree (term expired 5 November 2013)	Teena Robinson	Dr Sharon Wong (term expired 1 July 2013)	Assoc Prof Dawn Elder (Co-Deputy Chair)
Dr Margaret Meeks	Dr Philip Hider	Susan Matthews (term expired 1 July 2013)	Miranda Ritchie
Dr Graham Sharpe (term expired 5 November 2013)	Dr Catherine (Cathy) Ferguson (Deputy Chair)	Anthea Simcock (term expired 1 July 2013)	Prof Barry Taylor (term expired 25 September 2013)
Dr Suzanne Crengle	Dr Digby Ngan Kee	Tamati Cairns (term expired 23 April 2014)	Fia Turner-Tupou
Gail McIver	Dr Anthony Williams	Paul Nixon	Paul von Dadelszen
Linda Penlington	Rosaleen Robertson	Dr Pat Tuohy	Assoc Prof Denise Wilson
Alison Eddy (Deputy Chair)	Dr Michal Kluger	Dr Terryann Clark	
	Prof Jean-Claude Theis	Dr Stuart Dalziel	
		Dr Felicity Dumble (appointed 7 November 2013) – Chair elect	

A time-limited Suicide Mortality Review Committee was appointed in May 2014:

Prof Robert Kydd (Chair)

Dr Sarah Fortune (Deputy Chair)

Maria Baker

Prof Roger Mulder

Dr Deborah Peterson

Dr Jemaima Tiatia-Seath

Dr John Crawshaw (ex officio member)

Roopū Māori members

Tuwhakairiora (Tu) Williams (Chair)

Dr Rees Tapsell (till September 2014)

Riripeta Haretuku (till September 2014)

Leanne Te Karu

Dr Lance O'Sullivan (till September 2014)

Assoc Prof Denise Wilson

Dr George Laking (from February 2014)

Marama Parore (from February 2014)

Consumer network

Kelvin Twist
Gary Sutcliffe
Vicki Culling
Kula Alapaki
Ivan Yeo
Martine Abel
Allison Franklin
James Ahipene
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Auditor

Audit New Zealand on behalf of the Auditor-General

Appendix 2: Measuring progress against the quality and safety markers

The quality and safety markers measure changes in practice and outcomes for priority programmes. Baselines against which progress is being measured are highlighted in bold.

Table 1: Reducing harm from healthcare associated infections

Measure	Actual 2011–12	Actual 2012–13	Target 2013–14	Actual 2013–14	Expected outcomes over the next four years	Data source
	Process measures					
Percentage observed compliance with all '5 moments for hand hygiene'	**62.1%** **(October 2012)**	70.5% (June 2013)	75%	73%	The target is 80%	Hand Hygiene New Zealand programme
Compliance with bundle of procedures for inserting central line catheters in intensive care units	**77%** **(April 2012)**	82% (whole year)	Not specified	95%	Maintain at least 90%	*Target CLAB Zero* programme
	Outcome measures					
Rate of healthcare associated *Staphylococcus aureus* bacteraemia[9] per 1000 inpatient days	0.14	**0.11**	Reduction of 20–50% over three years	0.12	Maintenance of rate between 0.07 infections and 0.11 per 1000 bed-days would be consistent with literature suggesting that a reduction of 20–50% should be possible[10 11 12]	Hand Hygiene New Zealand programme
Rate of central line associated bacteraemia (CLAB) per 1000 line days	**3.5**[13]	0.49	<1	0.52	Maintain <1 per 1000 line days	*Target CLAB Zero* programme
Rate of surgical site infection per 100 procedures for total hip and knee joint replacements		**1.9** (based on the initial four months from the eight pilot sites)	Not specified	1.3 (March 2013 to March 2014)	Literature suggests that a reduction of 25–27% should be possible[14 15]	National Minimum Dataset (NMDS)[16]

9 A bacterial infection, which can result from poor hand hygiene practices.

10 Grayson ML, Jarvie LJ, Martin R, et al. 2008. Significant reductions in methicillin-resistant *Staphylococcus aureus* bacteraemia and clinical isolates associated with a multisite hand hygiene culture-change programme and subsequent successful statewide roll-out. *Medical Journal of Australia* 188(11): 6336–40.

11 Harrington G, Watson K, Bailey M, et al. 2007. Reduction in hospitalwide incidence of infection and colonization with methicillin-resistant *Staphylococcus aureus* with use of antimicrobial hand hygiene gel and statistical process control charts. *Infection Control and Hospital Epidemiology* 28: 837–44.

12 Achievement of reduction needs to be considered alongside implementation of actions to reduce this harm.

13 *Target CLAB Zero* final report.

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

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

16 The Ministry of Health has quality control processes in place in relation to NMDS data. The Commission relies on these processes to ensure data quality, supported by detailed analytics and review to confirm the reported results are in line with clinical expectations. The Commission uses the data, as extracted from the NMDS, after considering which measures are deemed most reliable.

Table 2: Reducing perioperative harm[17]

Marker	Actual 2010–11	Actual 2011–12	Actual 2012–13	Target 2013–14	Actual 2013–14[18]	Expected outcomes over the next four years	Data source
Process markers							
Percentage of operations where all three parts of the WHO surgical safety checklist are used			**71.2%**	Not specified	95% (April to June 2014)	Target is 90%	Chart reviews[19]
Outcome markers							
Postoperative sepsis rate[20] per 1000 surgical episodes	8.37[21]	8.9	**10.77**	Reduction of around 30% over three years	12.3 (see Note 1)	Reductions in rates of deep vein thrombosis (DVT) and pulmonary embolism (PE) over two years and maintained in future years. Literature suggests that a reduction of around 30% should be possible.[22] This would equate to: • postoperative sepsis: 6.3 per 1000 episodes • postoperative sepsis (elective): 3.5 per 1000 episodes • postoperative DVT/PE: 2.8 per 1000 episodes.[23] Associated reduction in additional occupied bed-days and cost will be measured.	National Minimum Dataset (NMDS)
Postoperative sepsis rate (elective) per 1000 surgical episodes	3.68[24]	4.08	**3.66**		5.89		NMDS
Postoperative DVT/PE rate per 1000 surgical episodes	3.94[25]	3.97	**3.81**		4.18		NMDS

Note 1: A significant driver of the increased sepsis rate is that more complex cases (thus at greater risk of sepsis) are being undertaken more frequently.

17 Called 'surgical safety' in the 2012–15 Statement of Intent.
18 The estimates based on the NMDS use actual data for a calendar year. Validated NMDS data for the full year are not available until at least three months after the end of the period.
19 Based on chart reviews – we are working towards observer-based data in future.
20 Calculated as the number of surgical admissions where postoperative sepsis and postoperative DVT/PE was recorded within the initial surgical episode or where a readmission was associated with postoperative sepsis and DVT/PE occurred within 28 days of discharge from an initial surgical episode per 1000 surgical episodes.
21 The numbers for 2010–11 to 2012–13 differ from those previously reported due to an improved definition of readmission being used in the context of the markers. The new definition has been used to recalculate the numbers for those years.
22 Haynes AB, Weiser TG, Berry WR, et al. 2008. A surgical safety checklist to reduce morbidity and mortality in a global population. *New England Journal of Medicine* 360(5): 491–9.
23 Achievement of reduction needs to be considered alongside implementation of actions to reduce this harm.
24 As per footnote 22.
25 As per footnote 22.
26 Across the four years, there has been no statistically significant change.

Table 3: Reducing harm from falls

Marker	Actual 2010–11	Actual 2011–12	Actual 2012–13	Target 2013–14	Actual 2013–14	Expected outcomes over the next four years	Data source
Process markers							
Percentage of older patients given a falls risk assessment			**77%**	No target identified	90%	The target is 90%	DHB audits of patients aged 75+
Percentage of older patients assessed as at risk of falling who received an individualised care plan that addressed these risks			**80%**	No target identified	90%		DHB audits of patient aged 75+
Outcome markers							
In-hospital fractured neck of femur (FNOF)	111	91	**97**	Reduction of falls with FNOF of 10–30% over three years	92	Reduction of falls with FNOF to 75–95 falls would be consistent with literature which suggests that a reduction of 10–30% is possible.[27]	National Minimum Dataset (NMDS)
Additional occupied bed-days (OBDs) following in-hospital FNOF	4124	3944	**2677**	Measurement of associated reduction in additional OBDs and cost	513[28]		NMDS
Cost of additional OBDs associated with FNOF			**$2.06 million**		$0.4 million		NMDS/ cost data from New Zealand Institute of Economic Research (NZIER)
Mortality following in-hospital FNOF			Numbers are too small to be reliable				

27 Beasley B, Patatanian E. 2009. Development and implementation of a pharmacy fall prevention program. *Hospital Pharmacy* 44(12): 1095–102.

28 The large reduction in additional OBDs (and cost of additional OBDs) was caused by a small number of very long stay patients present in 2012–13, but not in 2013–14, so should not be seen as a genuine reduction of this magnitude.

29 De Raad JP. 2012. *Towards a value proposition... scoping the cost of falls. NZIER scoping report to Health Quality and Safety Commission NZ.* Wellington: NZIER.

Table 4: Reducing surgical site infections

Marker	Target 2013–14	Actual July–September 2013	Actual January–March 2014	Expected outcome over the next four years (target)	Data source
Process markers					
Antibiotic given at right time	No targets identified for 2013–14	**85%**	92% (see Note 1)	100%	ICNet
Right antibiotic and right dose (2g cefazolin)		**55%**	78% (see Note 2)	95%[30]	
Right skin preparation		**91%**	98% (see Note 3)	100%	
Outcome markers					
Infections per 1000 hip and knee operations	No targets identified for 2013–14	**13**	10	To be confirmed	
Sum of estimated cost ($)		**$0.53 million**	$0.425 million	To be confirmed	
Surgical site infections		**30**	24	To be confirmed	

Note 1: We have taken a strict approach to recording, so that 'not recorded' is counted as 'not done'. As a result, only two DHBs reached the 100% threshold.

Note 2: In nearly all DHBs where this level was not met, the issue was of a lower dose (1g) of cefazolin being given. In one DHB another antibiotic was used and two other DHBs have started switching to cefazolin.

Note 3: The 100% target was met by 13 DHBs.

30 Cefazolin 2g is recommended for routine antibiotic prophylaxis for hip and knee replacements unless the patient has a beta-lactam allergy and requires a non-beta-lactam antimicrobial agent, or is colonised with multi-resistant *Staphylococcus aureus,* in which case they should receive both cefazolin and vancomycin. To allow for these relatively rare instances, the threshold is set at 95%.

Appendix 3: Contribution to broader government priorities

The Commission contributes to two of Government's four main priorities:

- delivering Better Public Services within tight financial constraints
- responsibly managing Government's finances.

The Government has committed to delivering a set of 10 Better Public Services results, chosen for their importance in improving the lives of New Zealanders. The Commission contributes to two Better Public Services results:

- supporting vulnerable children, which includes increasing infant immunisation rates and reducing the number of assaults on children
- reducing the rates of total crime, violent crime and youth crime.

The Commission also contributes to government priorities through its joint work with other agencies, involving:

- the Children's Action Plan
- youth mental health, including suicide prevention.

The Commission contributes to a number of other sector priorities articulated by Government for achieving quality improvement in health and disability support services, including:

- Ministry of Health
  - health targets – in particular, improved access to elective surgery and increased immunisation
  - supporting the health of older people
  - making the best use of information technology and ensuring security of patients' records
  - strengthening the health workforce
  - regional and national collaboration
- DHBs
  - Quality Accounts
  - patient experience surveys
  - regional and national collaboration
  - clinical leadership development
  - 'Living within our means'
  - achieving targets, including the health targets and those covered by the health quality and safety markers
- Accident Compensation Corporation (ACC)
  - prevention of treatment injuries
  - falls prevention programme.

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