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

ANNUAL REPORT

FOR THE PERIOD
1 JULY 2014 TO 30 JUNE 2015

Presented to the House of Representatives pursuant to section 44 of the Public Finance Act 1989

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Health Quality & Safety Commission New Zealand
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open FOR BETTER CARE
Hāpai ake te toiora

OUR VALUES

- **Person-centred:** We support individual and family/whānau participation and decision-making about health and disability support services by putting the 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 diverse cultures and opinions.
- **Open and transparent:** We encourage the sharing of ideas, knowledge and information in plain language 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.

He aha te mea nui o te ao
What is the most important thing in the world?
He tāngata, he tāngata, he tāngata
It is the people, it is the people, it is the people

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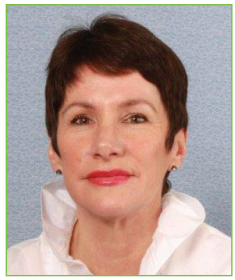
FOREWORD



In 2014–15 the Health Quality & Safety Commission (the Commission) continued to advance the cause of quality and safety in the health and disability sector in New Zealand. New Zealanders expect and deserve a safe, high-quality health system. In general our health and disability services perform very well by international standards and provide outstanding value for money. This is a testimony to the expertise and commitment of the people who work in them. The Commission's role is to support and collaborate with clinicians; CEOs and those in governance; agencies such as the Ministry of Health and Accident Compensation Coporation; and consumers of health care to maintain and improve upon this excellence, because despite all our efforts, too many people still suffer avoidable harm during their care, or fail to get essential care.

We undertake a wide range of quality and safety activities, including our key improvement programmes: reducing harm from falls in care settings, reducing surgical site infections (SSIs), reducing harm related to surgery, and reducing harm from high-risk medicines. These programmes aim to produce sustained systemic change in areas where there is clearly room for improvement. In addition, our programmes are a ground-up way of building enduring improvement capability in the health workforce. This is important because while New Zealand enjoys high quality care from its health and disability services, substantial unwarranted variation in care and outcomes remain.

In 2014–15:

- we held another successful 'April Falls' national promotion to raise awareness and spread knowledge of the Commission's new falls approach for the sector. This year 27 fewer falls resulted in a broken hip, a 25 percent reduction since 2012. At least $1.2 million of additional hospital costs and substantial patient suffering has been avoided in 2014–15.
- we helped district health boards (DHBs) across the country to reduce SSIs by promoting a 'bundle' of interventions proven to reduce infections, and establishing a new online data repository to track SSI rates nationwide, thus informing DHBs about how their work is affecting their local outcomes. In the first quarter of 2015 there were 2502 hip and knee arthroplasty procedures performed by DHBs. Across the nation New Zealand patients received the right skin antisepsis, known to reduce SSIs, 99 percent of the time, up 12 percentage points from baseline.
- we engaged in initiatives from Auckland and other DHBs to use the World Health Organization surgical safety checklist more effectively, as a teamwork and communication tool rather than a set of boxes to tick. We quickly adapted our reporting to reward this thoughtful initiative.
- our national patient safety campaign, *Open for better care*, focused for six months on high-risk medicines, and in particular the safe use of opioids, raising awareness of the harm they can cause and promoting ways to reduce this harm.

All the Commission's work is guided by a strong focus on involving consumers and their families/whānau in decisions about their own care, and at every level of the system. Through our Partners in Care programme we recently released a national guide for DHBs to promote consumer engagement in the design and delivery of services, and the development of policy and governance procedures.

The Commission maintained its strong focus on measurement and evaluation, to monitor the quality and safety of health care in New Zealand and determine our improvement priorities. In the past year we have made impressive progress in charting the quality and safety environment.

- Our quality and safety markers (QSMs) are a cost-effective measure of the performance of our programmes, and are used by the Ministry of Health as part of its own monitoring of the sector.
- Our quality and safety indicators (QSIs) are a set of measures that compare New Zealand's performance with the international community on measures of safety, patient experience, effectiveness, access/timeliness, efficiency and equity.
- The Atlas of Healthcare Variation is an internationally recognised tool that addresses geographical differences in service provision and outcomes. Variation should be focused on differences between patients, not on differences between providers. The Atlas encourages clinicians to ask if the right services are being provided in the right way.

- We have also made excellent progress in measuring patient experience in hospitals with a survey carried out in every DHB. We have started work on expanding the survey to non-hospital settings.

In 2015 we were very pleased to welcome renowned US health care improvement expert and best-selling author Dr Atul Gawande to Wellington, in partnership with the Auckland Writers Festival. Two highly successful events with Dr Gawande were attended by more than 1400 people. In 2014 during Patient Safety Week we hosted Professor James Bagian, a US expert in human factors and a former astronaut, who featured in workshops attended by around 350 participants. Visitors of this calibre stimulate thought and debate in the sector and amongst the public, and inspire and energise the pursuit of excellence.

The work of our mortality review committees is particularly important in ensuring transparency and identifying opportunities to prevent deaths in the future. The committee reports included recommendations aimed at reducing child and youth deaths involving quad bikes and other off-road vehicles. Mortality review has shown the rate of babies dying from 20 weeks of pregnancy to 28 days old has fallen to the lowest number since reporting began in New Zealand in 2007. The Family Violence Death Review Committee has contributed substantially to submissions supporting improved legislation to address one of our community's most distressing problems – the plight of vulnerable children. We have also continued our work to strengthen reporting by DHBs of adverse events, with better reporting systems being implemented and more reliable data being generated as a result. This helps New Zealand to learn from cases where patients have been harmed and prevent that harm from occurring again.

The board is proud of the Commission's achievements in 2014–15, and the achievements of the health and disability sector as a whole. We think New Zealand is very blessed with the culture that prevails in its health and disability services. We are confident of the commitment of our DHBs and our partner agencies; our clinical leads; local quality champions; colleagues in the community and private sector; and many more dedicated people across the country to the cause of improving quality and safety in our health care. Together, we make more progress every year towards ensuring that all our patients and consumers receive the best and safest care possible and the services they really need.

Prof Alan Merry ONZM FRSNZ
Chair
Health Quality & Safety Commission

Shelley Frost
Deputy Chair
Health Quality & Safety Commission

CHIEF EXECUTIVE'S FOREWORD

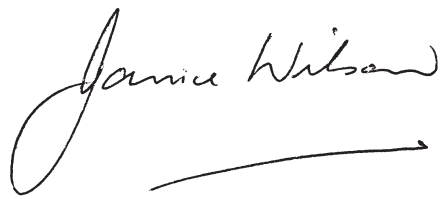
Building capacity and capability for continuous quality improvement is an imperative for the health sector. During 2014–15 the Commission has continued to support development of this with a number of initiatives such as:

- facilitating national and regional forums
- sponsoring specific training programmes
- providing clinical leads with information and tools to better lead programme activities.

The Commission has also looked to its own capability as an organisation. In 2014–15 we successfully implemented a strategic shift from making regular use of external contractors to achieve our programme goals in the sector, to building our own internal capacity and expertise in quality improvement. We have done this to achieve greater flexibility, enabling us to manage change within the organisation, and also because contracted expertise did not build the sustainable networks and skills we seek in the sector. This shift to retaining more capability in-house has been achieved by reprioritising the Commission's existing budget, and reflects our desire to work within our available funding and collaborate with the sector to ensure long-term improvement. We have also employed a senior medical advisor to provide valuable medical leadership and advice, and to ensure the Commission's work is linked to broader networks of clinical and improvement experts.

Our achievements in the past year have been greatly enhanced by the developing expertise we are building internally. Increasingly we are acting as a hub for clinical and consumer leadership, growing important quality improvement skills and bringing together networks of clinicians to spread good practice and encourage the sharing of good ideas, rather than working in isolation.

I would like to thank the Commission's hard-working staff for their energy and commitment to the broader goal of quality and safety improvement. The progress outlined in this report is in large part due to their efforts, along with those of our partners in the sector.



Dr Janice Wilson
Chief Executive
Health Quality & Safety Commission

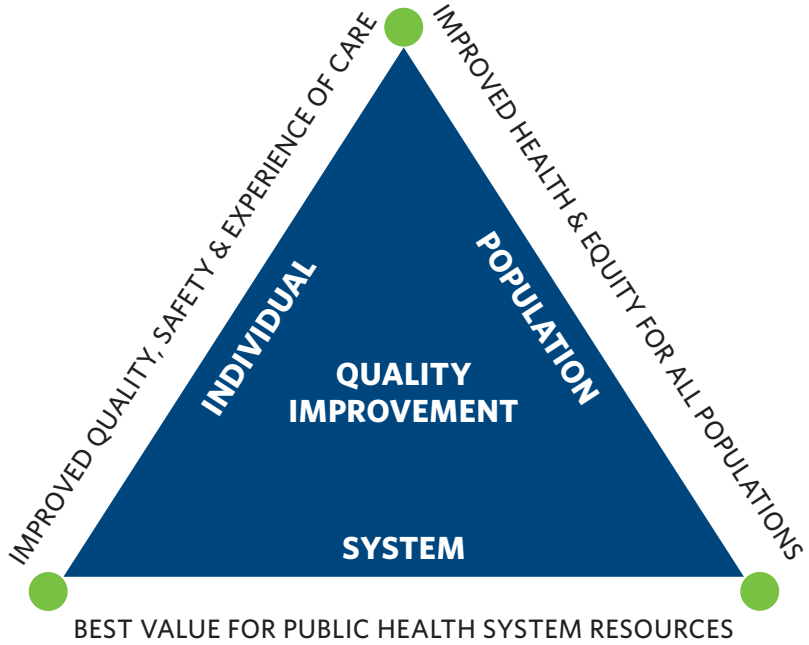
PART ONE

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.[1] 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.

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

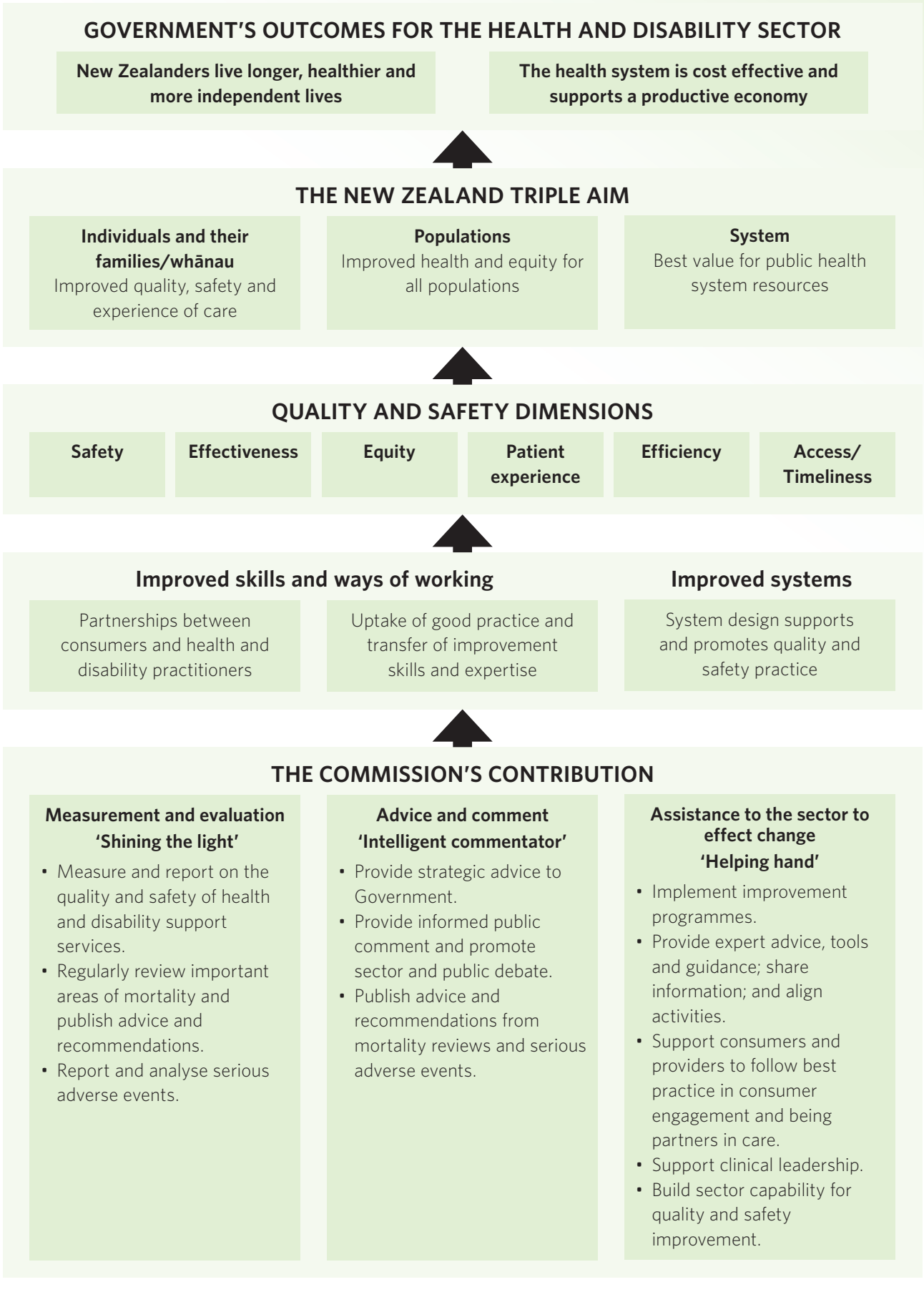


'DOING THE RIGHT THING, AND DOING IT RIGHT, FIRST TIME'

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

2.0 Our contribution to Government priorities

The Commission supports the Government's priorities for the health and disability sector (see diagram below).



THE YEAR IN REVIEW

The Commission's activities in 2014–15 fell into three output classes:

Output class 1: Measurement and evaluation

Output class 2: Advice and comment

Output class 3: Assistance to the sector to effect change

3.0 Output class 1: Measurement and evaluation

International literature shows that measuring health quality and safety and publishing the findings in considered ways and settings brings about 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 help to identify problems and key improvement opportunities, and provide, assess and share examples of good practice. Without good measurement and evaluation we do not know where waste due to poor quality lies or whether or not interventions to reduce waste have worked.

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

3.1 Measurement and evaluation

During 2014–15, 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 New Zealand health care system. QSIs provide the public and sector with 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. The annual QSI report was published in June 2015.

Nationwide patient experience indicators, developed with the sector in 2013–14 and derived from rigorous patient survey methodology, were included in QSI reporting for the first time in 2014–15. These indicators are being used to understand how patients experience the care they receive in hospitals, to make that care more responsive to their needs. The indicators are collected by district health boards (DHBs) via questionnaires completed by patients, carers and families/whānau. Four areas are surveyed: experience of communication, partnership, coordination of care, and having their physical and emotional needs met. Results were consistently good during the year with an average rating of 8/10.

Quality and safety markers (QSMs) – Each QSM is a targeted set of process and outcome measures designed to track the uptake of interventions supporting the Commission's key priority programmes. The QSMs measure the effect of interventions on the outcomes desired and, through public reporting, stimulate further improvement. Four national QSM progress reports were published during 2014–15. There were significant improvements across most of the process markers and improvements for some outcomes (summarised below, and see sections 8.1, 8.11–8.14 and Appendix 2 for more details).

Progress in 2014–15 in improving health quality and safety to reduce harm and waste:

- The percentage of DHBs complying with best practice for hand hygiene has increased from 61 percent in October 2012 to 80 percent in 2014–15.
- The percentage of operations using best practice relating to use of the World Health Organization (WHO) surgical safety checklist has increased from 71 percent in 2012–13 to 93 percent (January to March 2015).
- The percentage of older patients given a falls risk assessment in DHBs has risen from 77 percent in 2012–13 to 90 percent in 2014–15.
- The number of additional occupied bed-days following in-hospital fractured neck of femurs (hip fractures) decreased from 4124 in 2010–11 to 3204 (April 2014 to March 2015).

The New Zealand Atlas of Healthcare Variation – The Atlas is an interactive web tool that measures variation in the provision and use of specific health services and outcomes by geographic area. It is designed to stimulate improvement through prompting debate and raising questions among clinicians, users and providers of health services about why regional differences in health service use and provision exist.

In 2014–15, four new Atlas domains were published: opioids, falls, infection and antibiotic use following major surgery and cancer.

The *Find My Patient* tool was launched in July 2014. It encourages local-level improvement activities by allowing GPs to securely identify their own patients in Atlas data, specifically those likely to benefit from review. It has been acknowledged internationally.

3.2 Reporting and managing health care incidents

Reportable events

While most patients are treated safely and successfully, 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 analysing the causes of events so we can learn from them and identifying ways to reduce event recurrence throughout the country. By reporting adverse events we promote a culture of openness, transparency and trust. This means improvements can be made and the public can have confidence such events are used to improve services.

Over the year the Commission continued to work with the health sector to increase expertise in learning from adverse events. This work included sharing with providers the crucial lessons learned from reviews of serious adverse events through monthly Open Book reports. These reports alert providers to key review findings and changes implemented to prevent the events happening again.

The Commission published its annual serious adverse events report in October 2014 (see section 8.5 for more details).

3.3 Quality accounts

Quality accounts describe the quality of DHB services and improvement plans. All DHBs now produce and publish quality accounts annually, and engage with their communities to determine quality priorities.

The Commission held its second annual quality accounts workshop for DHBs in April 2015. Some DHBs shared highlights from their accounts, and lessons learned while producing them. The presentations showed the progress made by DHBs and their unique responses to delivering better quality health services and involving consumers at all levels in quality improvement.

3.4 Mortality review committees[2]

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. There are four permanent mortality review committees and one time-limited committee.

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.

The CYMRC published *Child and youth mortality from motorcycle, quad bike and motorised agricultural vehicle use, with a focus on deaths under age 15 years* in December 2014. The report showed that from 2002 to 2012, 33 children were killed in off-road vehicle accidents, nearly half of whom were using the vehicle recreationally.

Following stakeholder consultation, the CYMRC made recommendations to parents and caregivers, and policy recommendations to challenge unacceptable risk factors. The Accident Compensation Corporation (ACC) and WorkSafe New Zealand are working to implement some of those policy recommendations.

The CYMRC also published its *9th Data Report,* which predominantly reports on data from 2008 to 2012. Overall, the number of deaths has reduced, from 699 in 2008 to 600 in 2012. This reduction has, in part, been driven by fewer deaths attributable to sudden unexpected death in infancy in the post-neonatal period (28 days to 1 year) and motor vehicle crashes in young people aged 15–24.

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

As well as updating perinatal and maternal mortality and morbidity rates from previous reports, the 2015 PMMRC report included a special topic – spontaneous preterm birth leading to perinatal related death – and four years of data collection on severe and rare disorders of pregnancy in New Zealand and Australia. The report provided further evidence of the link between smoking, obesity and stillbirth.

Following stakeholder consultation, the PMMRC made wide-ranging recommendations including identifying and addressing modifiable risk; education and training priorities; influenza vaccination; and improving ethnicity data.

The PMMRC also ran a successful workshop in June 2015 focusing on report findings; perinatal loss and talking to families; building capacity in the New Zealand maternity system; and rheumatic heart disease. There were 230 attendees, including the Minister of Health, Hon Dr Jonathan Coleman.

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

In June 2015 the FVDRC published its *Activities Report: July 2014 to June 2015.* The report tracked progress against recommendations made in the FVDRC's *Fourth Annual Report,* which included:

- the Ministry of Social Development's Campaign for Action on Family Violence addressing the danger signs of intimate partner violence
- New Zealand Police progressing effective identification of high-risk victims and serial perpetrators through the police family violence change programme
- a pilot starting in September 2015 responding to the FVDRC recommendation on strengthening the criminal and appellate courts' ability to respond effectively to family violence charges
- delivery of family violence education and training by the judiciary in association with the Institute of Judicial Studies
- Law Commission reviews of changes to the law of self-defence and the introduction of a partial defence, and the creation of a separate crime of non-fatal strangulation.

The FVDRC has written multiple briefing papers, issues papers and discussion documents to inform cross-government work on family violence and sexual violence. Its chair has met with Minister Adams and presented to the Ministerial group for family violence and sexual violence on the FVDRC's recommendations for the development of an integrated family violence response system. Many of the FVDRC's suggestions for change have been specifically noted in *Strengthening New Zealand's Legislative Response to Family Violence: A Public Discussion Document.*

2 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 8.5, fulfils that obligation.

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.

In June 2015, *Perioperative Mortality in New Zealand: Fourth report of the Perioperative Mortality Review Committee* was published. As well as updating perioperative rates from previous reports, the 2015 report presented data on five new areas of clinical importance: coronary artery bypass graft, percutaneous transluminal coronary angioplasty, bariatric surgery, admissions with an American Society of Anesthesiologists (ASA) score of 4 or 5, and severe postoperative sepsis.

Following stakeholder consultation, the POMRC made targeted recommendations to reduce perioperative risk and harm, and improve data collection.

The POMRC also ran a successful workshop in June 2015 focusing on report findings and how to develop local perioperative review. There were 80 attendees including the Associate Minister of Health, Hon Peter Dunne.

The Suicide Mortality Review Committee (SuMRC)

As part of implementing the New Zealand Suicide Prevention Action Plan 2013–2016, the Ministry of Health funded the Commission to trial a suicide mortality review function. The aim was to find out if mortality review methods improve knowledge of contributing factors and patterns of suicidal behaviour, and better identify key intervention points.

The SuMRC has reviewed deaths relating to suicide in three sub-groups: rangatahi (young) Māori, users of mental health and addictions services, and men aged 25–64. Some draft findings about contributing factors and patterns of suicidal behaviour are new, and some reinforce previous research. This work is creating new opportunities to link together previous separate sources of information about suicide, to help agencies cooperate to address the underlying problems. The response from partner agencies to SuMRC's work has been very positive.

The draft SuMRC report was sent out for targeted consultation in May 2015 and will be finalised by October 2015. There was strong stakeholder support for the suicide mortality review function to continue.

4.0 Output class 2: Advice and comment

The specialised knowledge gained through our programmes, measurement and evaluation functions, and local and international networks enables the Commission, alongside the Ministry of Health, to provide expert advice and informed comment on quality and safety matters.

4.1 Strategic advice to Government and government agencies

Several aspects of the Commission's legislative responsibilities, as set out in section 59C(1) of the New Zealand Public Health and Disability Act 2000, include a strategic advice function.

- Advise the Minister of Health on how quality and safety in health and disability services may be improved.
- Advise the Minister on any matters relating to 1) health epidemiology and quality assurance, and 2) mortality.

During the year we provided strategic advice in areas including:

- the refresh of the New Zealand Health Strategy
- mortality (see section 3.4 for details)
- health quality and safety through findings from the Atlas, QSIs and QSMs.

We are a member of the Quality Forum (with the Ministry of Health, ACC and the Health and Disability Commissioner) and the national information sharing forum. We are also increasingly invited to give input to key strategic issues across government agencies.

The Commission helped the Ministry of Health review DHB annual and regional plans, and quality accounts. At a more targeted level, we advised the Ministry of Health and other agencies via working groups and review groups on issues such as:

- consumer engagement and partnership
- collection and use of quality and safety-related data
- improvement education and training
- family violence
- child and youth mortality
- methodologies
- specific programme areas.

4.2 Providing informed public comment and promoting sector and public debate

In 2014–15 work in this area included:

- publishing evidence-based reports and discussion/opinion papers on health quality and safety in peer-reviewed journals, on our website and via other media
- organising successful workshops featuring two renowned international speakers: Prof James Bagian (November 2014) and Dr Atul Gawande (May 2015)
- publishing four mortality review committee reports and working across agencies to encourage implementation of recommendations.

Further details are in sections 8.6 and 8.7.

5.0 Output class 3: Assistance to the sector to effect change

5.1 Background

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

- building the capability of providers and consumers to work as partners in care
- building leadership capability, including clinical leadership
- building quality and safety capability in the sector
- increasing the uptake of evidence-based practice through translating evidence into easy-to-use tools and resources for frontline staff.

5.2 Developing consumer and family/whānau engagement and partnership

There is growing evidence of the importance of partnerships between patients, families/whānau and carers and the health service organisations and professionals who provide services for them. The potential benefits include better outcomes and experience of care, lower costs per case and increased workforce satisfaction. Working with providers and consumers to increase consumer engagement is one of our key strategic priorities.

Consumer network story – Gary Sutcliffe

Kia ora.

My name is Gary Sutcliffe. I retired from the Commission's consumer network in June 2015. Being a founding member of this group is a privilege and I have enjoyed the opportunities to connect and work with many people during this time.

I am a 66-year-old Aucklander with two adult children and five granddaughters, and my wife and I have been married for 41 years. My family is important to my work in the health sector and I have developed into the role of being a consumer representative in a number of varied settings. After 18 years as a banker and almost 20 years in the sports industry I joined the mental health sector in 2004 in a consumer development leadership role with Framework Trust in Auckland. Over the past 11+ years, I have worked with three Auckland-based non-governmental organisations, managed the Auckland regional consumer network and during 2005–06 was seconded to the Counties Manukau Health mental health development team in a peer support role. Since October 2013 I have been working in primary health with East Tamaki Healthcare as a peer support specialist.

The main changes and improvements I have seen in the health sector – and to some extent been part of – have been an increased emphasis on co-design with services working alongside consumers and family/whānau in developing innovative changes and improvements to service delivery. The Commission has also supported a number of consumers to attend health conferences during this time through sponsorship, including the Australasian Long-Term Conditions Conference and APAC Forum.

I have seen a considerable shift in the attitude and willingness of health providers and government agencies to connect with the consumer voice and seek feedback and input on service improvement and critical policy work. During my three years on the consumer network, I have been impressed by Ministry of Health personnel we have met and of their connectedness with the network. I know that the Commission has worked very hard to ensure the consumer network is a valued and effective consumer voice. I was delighted to be on the interview panel selecting new members for the consumer network in September – and was pleased to see another seven people join the group. I am sure their individual and collective contributions will build significantly on the base we set up in 2012.

The Commission is 'walking the talk' with its commitment to partnering with consumers by supporting this network and all consumers engaged in the various work programmes. I commend the consumer network and the Commission for their leadership and look forward to following future and further developments.

Consumer representation continues to be mandatory in all Commission work programmes. We have an active consumer network to support and guide us.

The Partners in Care framework is the basis of our work to improve health literacy, improve consumer participation and develop leadership capability for providers and consumers.

During 2014–15 we:

- produced a guide for DHBs on consumer participation and engagement
- held a Patient Safety Week (November 2014)
- supported a third eight-month Partners in Care co-design education programme, for six teams of consumers and health care personnel
- produced a facilitators' guide for training consumer representatives
- produced Māori responsiveness videos.

Our guide, *Engaging with Consumers,* published in June 2015, is a practical tool for DHBs and the health and disability support services they fund. It covers consumer engagement in the design and delivery of services, and the development of policy and governance procedures. The guide provides evidence about consumer engagement, shares the successes and learnings of New Zealand providers about how they engage with consumers, and promotes good practice throughout the sector.

Patient Safety Week had three complementary focuses:

- Workshops in Auckland, Wellington and Dunedin with Prof James Bagian, human factors specialist.
- Launch of *Let's PLAN for better care* (a health literacy initiative to help consumers prepare well for their visit to the GP or other primary health professional) and a training resource for consumer representatives.
- Promotions in secondary care.

There was high demand for all resources and activities. All four James Bagian workshops were fully subscribed, and feedback was very positive. There was strong media interest in the workshops, with coverage by major media outlets.

5.3 Building and supporting sector capability

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) and has been a focus for building capability, particularly in our national improvement programmes.

Activities during 2014–15 included:

- providing ongoing education and training for quality improvement practitioners and advisors
- building capability for successful implementation of improvements as part of our national improvement programmes, including the *Open for better care* campaign
- providing web-based learning packages, videos, interactive PDFs, tools and links to learning resources produced by the Commission and by other agencies
- with the Ministries of Health, Justice, Social Development and Education, developing a generic learning programme for frontline workers on quality improvement knowledge, methods and tools
- implementing an expert advisory group to help plan and develop programmes to build capability in quality improvement and patient safety
- hosting several improvement-related workshops, symposiums and meetings
- supporting and building a network of improvement science experts and practitioners, including hosting a web-based repository and communication space, which now has 100 members
- regular meetings with Health Workforce New Zealand to discuss our work programmes.

5.4 Building and supporting clinical leadership and governance

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

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. We continue to hold regular meetings of the clinical leads to support their work in leading change. We also provide them with professional development and educational opportunities in quality improvement and help them develop a network across programmes.

The Commission continued to develop and expand a package of materials to inform those in governance roles, particularly in DHBs, about aspects of quality and safety in health and disability services relevant to clinical leadership and governance. Providing ongoing education and training in quality improvement, and patient safety for DHB boards (and others in governance positions) continued to be focus areas for us during the year.

5.5 The *Open for better care* national patient safety campaign

The Commission leads and coordinates *Open for better care,* the national patient safety campaign. The campaign aims '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 focuses on one topic at a time. Each topic identifies simple changes in practice that can make a difference to patient safety. We provide tools, interventions, collaborations, promotions, resources and workforce development opportunities to help people do the right thing. Reducing perioperative harm and reducing harm from high-risk medicines were completed in 2014–15, and the second falls topic – with a focus on community settings – began.

A highlight of the campaign was Patient Safety Week, held in the first week of November 2014. There was good participation from DHBs; all undertook at least some of the activities, and many had a strong patient safety focus for the whole week. There was also strong buy-in from private providers.

The *Open for better care* brand and approach is now well recognised across the sector.

Victoria University of Wellington and the University of Otago (Wellington) research centres jointly evaluated the campaign. A draft report was received in June 2015 and is being considered, with a final report expected over the coming months.

More information about the campaign topics is in section 8.15.

5.6 Reducing harm from falls

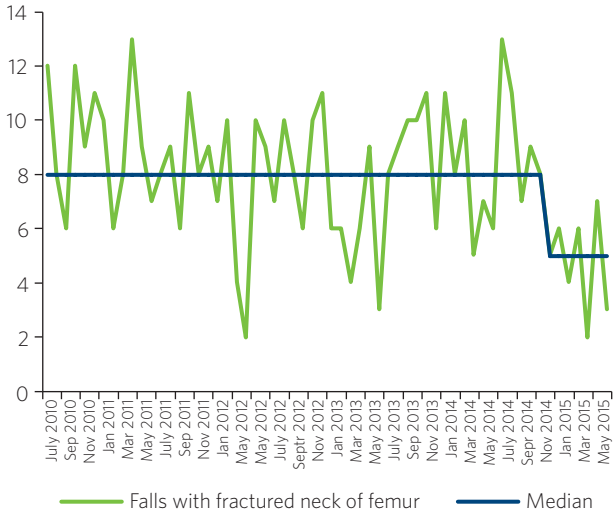
The reducing harm from falls programme is a national, multi-agency programme led by the Commission to reduce harm from falling, and the costs of treatment, rehabilitation and care.

In 2014–15, the falls programme provided resources, tools and information for the sector (including aged residential care, primary care and community settings) to build capability and inform evidence-based best practice. These included the 'Stay Independent' falls prevention toolkit for clinicians in primary care and the community, which encourages early conversations with consumers.

The third annual 'April Falls' quiz was popular, with a record 2600 responses (up from 1516 the previous year), including 69 percent first-time participants. A resource was produced to support use of the quiz for learning and teaching, and a quiz summary was made available to each DHB. Attitudes and knowledge were surveyed and showed improvement. Agreement that falls are preventable remained high at around 97 percent. There was an increase in the percentage of respondents who consider that risk assessments for people aged 75+ 'almost always' take place in their workplace – from 68 percent in 2014 to 78 percent in 2015.

The falls Atlas domain was released along with a workbook to help health professionals talk to consumers about fractures and better understand the falls and fracture harm across their region. For results of the reducing harm from falls programme see section 8.11 and Appendix 2.

Run chart showing in-hospital falls with a fractured neck of femur



5.7 Medication safety programme

The medication safety programme aims to reduce the number of New Zealanders harmed by medication errors and adverse drug events, to ensure 'the right patient gets the right medicine, in the right dose, at the right time, by the right route, correctly recorded'.

Reducing harm from high-risk medicines

The key deliverable for 2014–15 was a nationally coordinated programme to reduce harm from high-risk medicines; in particular, opioids in secondary care, including morphine, methadone and oxycodone. Opioids have benefits, but their use can result in adverse events and harm to patients.

We successfully hosted a national medication safety forum with over 250 participants and national and international guest speakers. This was the platform to launch our *Open for better care* campaign topic, which ran from October 2014 to March 2015. The topic included 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. A series of webinars were also held to build capability across medication safety networks.

The safe use of opioids national collaborative also started in October 2014 and will run until May 2016. There were national and regional learning sessions and supporting local DHB action periods where agreed interventions were tested. The first national learning session was held in February 2015, with a keynote address from Associate Minister of Health, Hon Peter Dunne. The second was held in June 2015 with Dr John Krueger from the Institute for Healthcare Improvement, who covered measurement, theory and change ideas.

We issued four *Medication Safety Watch* bulletins during the year. These provided 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 each bulletin. We also issued two alerts to health care providers on metoprolol and transdermal patches.

Hospital eMedicines Management (eMM)

The eMM programme is a partnership between the Commission and the National Health Board/National Health IT Board. It focuses on electronic prescribing and administration (ePA) and electronic medicines reconciliation (eMR), a system for hospitals that streamlines the process by which a patient's medicine information is accurately transferred from admission, at points of transfer and on discharge.

There is a national programme to roll out eMR and ePA throughout the country. By 30 June 2015 five DHBs had implemented ePA and four had implemented eMR, with a further two actively progressing their plans for eMR implementation.

Aged residential care (ARC) medication chart

A standardised, electronically generated ARC medication chart and process, piloted at six ARC facilities during 2012–13, continued to be used in five of the pilot sites. The evaluation of the pilot suggested some refinements to the chart process and a further test. Resources and training materials were developed during the year, in preparation for the second phase of testing in early 2016.

5.8 Infection prevention and control programme

The infection prevention and control programme aims to significantly improve patient outcomes by preventing and controlling healthcare associated infections in the health and disability sector.

In 2014–15, the infection prevention and control programme focused primarily on reducing surgical site infections (SSIs) and improving compliance with the WHO five moments for hand hygiene.

Surgical site infection improvement programme

SSIs are the second most common healthcare associated infections. They are costly to treat, associated with increased mortality and can have a significant impact on quality of life.

In collaboration with DHBs, the surgical site infection improvement (SSII) programme implemented an evidence-based bundle of improvement interventions for reducing SSIs for hip and knee arthroplasty and cardiac surgery. Underpinning these interventions is a nationally consistent approach for collecting and reporting high quality data for these surgeries.

All four regions were visited twice by the SSII programme team during the past year to build local capability for quality improvement through data analysis. An online knowledge repository of surveillance training materials and implementation manuals was established.

For results of the SSII programme see section 8.12 and Appendix 2.

Hand hygiene

In July 2014 the hand hygiene programme published a communication toolkit for DHBs, which included ideas and guidance to promote hand hygiene and help health care workers to improve their practice. The use of the 'frontline ownership' approach has been particularly effective in supporting local improvement activities, and contributed to significantly increased performance rates.

Process improvements: Compliance reached the national target of 80 percent in June 2015, up from 73 percent in June 2014.

For results of the hand hygiene programme see Appendix 2.

5.9 Reducing perioperative harm (improving surgical safety)

Potentially preventable complications arise in 10–15 percent of all New Zealand surgical procedures.

In 2014–15 the Commission worked with Waikato and Lakes DHBs and Southern Cross Auckland on a proof of concept project, testing approaches to improve teamwork and communication in operating theatres. Resources and tools were developed and published online for the roll-out of these approaches to DHBs in 2015–16.

Also, during the first quarter, the *Open for better care* campaign focused on raising awareness of the teamwork and communication approach to improving patient safety in operating theatres. Resources were developed and provided to the sector as part of the campaign, including posters, evidence summaries and an improvement toolkit. This includes work led by Auckland DHB to use the WHO surgical safety checklist more effectively.

For results of the reducing perioperative harm programme see section 8.13 and Appendix 2.

> *'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

5.10 Addressing clinical deterioration and reducing pressure injuries

During the year, we investigated two potential new programme areas where the sector has asked the Commission to consider a national approach: clinical deterioration and pressure injuries.

In consultation with an expert sector group, we developed an investment case to address 'the clinically deteriorating patient'.

We also produced a report scoping a case for a national quality improvement programme to reduce pressure injuries. Before a decision on investment is made, further work is required on the baseline for pressure injury prevalence.

6.0 Maintaining and developing organisational capability

6.1 Governance

The Commission is governed by a board of eight members appointed by the Minister of Health.

Three board committees supported the board's work in 2014–15.

The Finance and Audit Committee (which includes an independent member, Andrew Boyd from HealthShare) provided assurance and assistance on the Commission's:

- risk, control and compliance framework, and external accountability responsibilities
- financial statements and adequacy of internal control systems.

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

Te Roopū Māori advised the board and Chief Executive on strategic issues, priorities and frameworks from a Māori world view and identified key quality and safety issues for Māori consumers and organisations.

Full board and committee membership is listed in Appendix 1.

The Minister of Health's 2014–15 Letter of Expectations specified that 'entities need to be constantly looking for ways to improve how they do their business and deliver value for taxpayers' investment in them. The Performance Improvement Framework (PIF) was designed with this expectation in mind.' The Minister asked Crown entities to use either the PIF methodology or some other methodology for continuous performance improvement.

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 board instigated a PIF self-review process during 2014–15. The process, and in particular the process for developing a four-year excellence horizon, provided a useful format for the board to consider 'the contribution that New Zealand needs from the Commission' and our future strategic priorities. The review is not complete, but findings from the interviews carried out to date by external advisors were very positive, showing a high degree of trust and respect for the Commission across the sector. Findings from the PIF process are expected to help the Commission clarify its future strategy and vision, and also ensure it has the organisational management capability to make any changes needed.

6.2 Staff

In 2014–15, 40–47 staff carried out the Commission's work. This was in addition to our sector-based clinical leads for each programme area, lead agencies for some programmes and a number of expert committees.

6.3 Good employer obligations

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 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 and pursue education and training opportunities. In 2014–15, these opportunities included:

- online seminars on the history of quality improvement and patient safety, frameworks, system profound knowledge, Lean, and the Institute for Healthcare Improvement model for improvement and co-design
- a face-to-face meeting with Dr John Krueger, covering aim statements, driver diagrams, theory of change and plan–do–study–act cycles
- cultural competencies.

Some staff undertook a Machinery of Government course and visited Questions for Oral Answer in Parliament.

Several staff developed their management skills by acting in more senior positions as vacancies arose, or when senior staff were 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, which include:

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

Our policy is to support flexible work arrangements for employees who have carer responsibilities under the provisions of Part 69AA of the Employment Relations Act 2000, and also who require flexible work opportunities for other reasons such as further study and career development.

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

Support and culture

Weekly all-staff meetings are held in Wellington (with Auckland staff videoconferencing in). At these meetings, staff talk about their work and current issues, recognise staff and team successes and, from time to time, hear from external speakers. All staff are expected to attend.

The Commission has a very active health, safety and wellness committee, which manages areas such as workplace hazards and other safety issues. This committee regularly arranges activities to promote a healthy and joined-up workplace. We also fund an employment assistance programme, a professional counselling service to help staff and/or their families/whānau with work or personal issues.

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

6.4 Equal employment opportunities (EEO)

Workplace profile as at 30 June 2015

As at 30 June 2015 there were 45.3 full-time equivalent staff members (with a head count of 38 full-time and 9 part-time). Forty-seven percent have served for more than two years.

EEO policy

We have a specific policy on equality and diversity. This includes a firm commitment to EEO principles and ensures 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 work. Understanding, appreciating and realising the benefits of individual differences enhances the quality of our work environment and better reflects the diverse 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 staff recruitment and management are made aware of our EEO policy requirements. We actively seek and target diversity when recruiting.

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.

All Commission internal policies were reviewed and updated in 2014–15 in consultation with staff.

6.5 External relationships

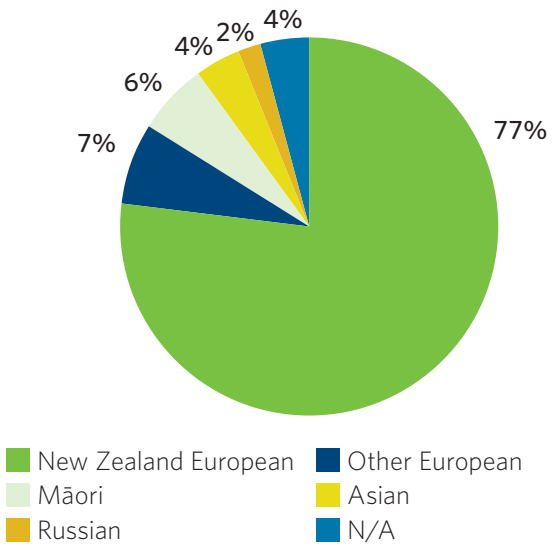
Engagement with the Minister and Ministry of Health

In 2014–15 we provided monthly update reports to the Associate Minister of Health with delegated responsibility for the Commission and provided quarterly update reports on performance against the Statement of Performance Expectations. We met with the Associate Minister regularly, and kept both the Associate Minister and Ministry of Health informed in a timely manner of any potentially contentious events or issues.

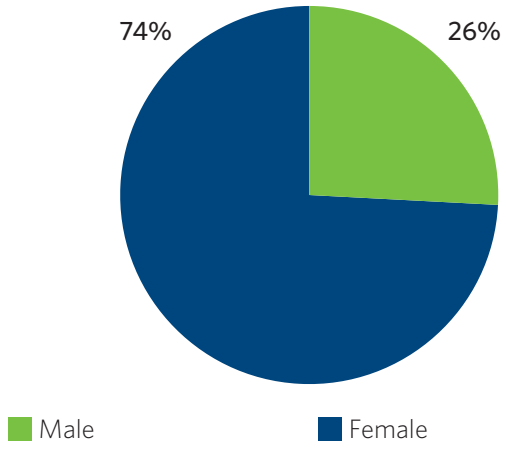
Collaboration and partnerships with stakeholders

New Zealand is a small country and partners are vital to a small agency like the Commission. We tap into the considerable expertise in the sector and overseas, and identify and learn from existing innovative quality and safety practices. Of particular importance are our partnerships with DHBs, the Ministry of Health, the Health and Disability Commissioner, ACC, professional colleges and associations, clinical leads, 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.

Breakdown of staff by ethnicity



Breakdown of staff by gender



We have developed partnerships for work in priority areas where our investment will be supplemented by investment by other agencies, such as our work on reducing harm from falls, neonatal encephalopathy and pressure injuries, where ACC provided additional resources.

In 2014–15, we engaged with the Ministry of Health routinely in joint strategic planning and over joint work programmes, including high-level involvement in the revision of the Health Strategy. In addition, the Commission, the Ministry of Health, the Health and Disability Commissioner and ACC are part of a Quality Forum to support collaboration and joint planning. The four agencies work collaboratively, sharing and using the different information received by each agency to good effect.

We worked with the Ministries of Social Development, Education and Health on developing the Improving Together website, an online introduction to quality improvement that focuses on small-scale, rapid cycle changes to accelerate the improvement of services and processes across the social sector.

Communication with stakeholders and the public

In 2014–15 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 2014–15, hits on our website increased to 78,311 unique visits and 526,992 page views compared with 63,864 unique visits and 437,956 page views in 2013–14.

Significant communications effort was focused on supporting the *Open for better* care campaign during the year.

6.6 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. In 2014–15, we built on the recommendations of the 2013–14 audit review by Audit New Zealand. This was overseen by our Finance and Audit Committee.

The audit results for 2014–15 are in section 12.0.

Improving internal efficiency

The Commission uses 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 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 and companies, and by the Office of the Auditor-General.

Payroll functions and payments to committee members have been outsourced to a third-party specialist payroll provider which can provide services more economically than we 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 programme has a clear focus on its value proposition, both human and economic. There is now a clear life-cycle for programmes 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 augment our relatively small investment capability.

In 2013–14 we contracted the Victoria University of Wellington and the University of Otago (Wellington) research centres to evaluate the *Open for better care* campaign, the overall impact of the Commission's work and the improvement advisor development programme. A draft was provided to the Commission in June 2015 and is expected to be completed over the coming months.

Meeting our legal responsibilities

We ensure we meet our good employer requirements as set out in the Public Finance Act 1989, the Public Records Act 2005, the State Sector Act 1988, the Crown Entities Act 2004 and other applicable Crown entity legislation.

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.

Risk management

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

6.7 Permission to act despite being interested in a matter

For 2014–15, there were no instances where permission was given to act despite being interested in a matter.

PART TWO

7.0 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 3.4 and 8.9.

8.0 Report against the Statement of Performance Expectations

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 2014–15 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 Performance Expectations 2014–15
- 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 Performance Expectations 2014–15.

OUTPUT CLASS 1: INFORMATION, ANALYSIS AND ADVICE

8.1 Progress reports to the Ministry of Health and DHBs against QSM markers for patient falls, healthcare associated infections and surgical harm – achieved

Measure	2014–15 performance
Deliverable dates: Reports due September 2014, December 2014, March 2015 and June 2015	
Four QSM reports published	Four national progress reports were published, on 30 September 2014, 15 December 2014, 31 March 2015 and 30 June 2015. For results see 8.11 to 8.14 and Appendix 2.
Reports and data are subject to expert clinical and technical peer review	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.
Process improvement in the sector and reduction in harm and cost are discussed in an annual report which draws together information from a number of these reports (8.1, 8.2, 8.3, 8.4, 8.5)	The Commission's 'state of the nation' report, *A Window on Quality,* to be published shortly, will discuss process improvements and reduction in harm and cost. It was completed by 30 June 2015.

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

2013–14 performance: Two QSM reports published and baseline markers established for SSI markers

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

Measure	2014–15 performance
Deliverable date: 30 June 2015	
At least one report published	The national QSIs report annual update was published on the Commission's website on 25 June 2015 with new data.
Report and data are subject to expert clinical and technical peer review	A QSI expert advisory group provided expert clinical and technical peer review of all indicators at their development. International comparisons are added from peer reviewed publications.
Process improvement in the sector and reduction in harm and cost are discussed in an annual report which draws together information from a number of these reports (8.1, 8.2, 8.3, 8.4, 8.5)	The Commission's 'state of the nation' report, *A Window on Quality,* to be published shortly, will discuss process improvements and reduction in harm and cost. It was completed by 30 June 2015.

2011–12 performance: First indicators report published
2012–13 performance: Indicators report and update published
2013–14 performance: Indicators report updated

8.3 New Atlas domains – achieved

Measure	2014–15 performance
Deliverable date: 30 June 2015	
At least four domains published	Four new domains were published: • Opioids, published to align with the *Open for better care* topic on reducing harm from high-risk medicines (19 December 2014) • Falls, published to align with the start of the Commission's annual 'April Falls' month initiative (1 April 2015) • Infection and antibiotic use following major surgery (30 June 2015) • Cancer (7 July 2015).
Reports and data are subject to expert clinical and technical peer review	An 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.
Process improvement in the sector and reduction in harm and cost are discussed in an annual report which draws together information from a number of these reports (8.1, 8.2, 8.3, 8.4, 8.5)	The Commission's 'state of the nation' report, *A Window on Quality,* to be published shortly, will discuss process improvements and reduction in harm and cost. It was completed by 30 June 2015.

2011–12 performance: First Atlas domain published
2012–13 performance: Seven Atlas domains published
2013–14 performance: Six Atlas domains published

8.4 Delivery of patient experience indicators – achieved

Measure	2014–15 performance
Deliverable dates: October 2014, January 2015, April 2015	
Reports published quarterly from October 2014	Three quarterly inpatient experience survey reports were published: • 4 November 2014 • 12 February 2015 • 30 April 2015. Results have been positive and broadly consistent across the four surveys to date, with weighted averages of 8.4 to 8.7 out of 10 over the four categories measured.
Reports and data are subject to expert clinical and technical peer review	The patient experience tool was developed after extensive consultation and testing with the sector and service users, and following rigorous analysis of international trends in measuring patient experience.
Process improvement in the sector and reduction in harm and cost are discussed in an annual report which draws together information from a number of these reports (8.1, 8.2, 8.3, 8.4, 8.5)	The Commission's 'state of the nation' report, *A Window on Quality,* to be published shortly, will discuss process improvements and reduction in harm and cost. It was completed by 30 June 2015.

New performance measure for 2014–15

8.5 Reportable events – achieved

Measure	2014–15 performance
Deliverable date: 30 December 2014	
At least one report published	Report was published: • *Making health and disability services safer: Serious adverse events reported to the Health Quality & Safety Commission, 1 July 2013 to 30 June 2014,* was published 30 October 2014. The report details 454 serious adverse events in 2013–14, a 4 percent increase in events, with 454 serious adverse events reported, up from 437 in 2012–13. This slight increase is likely to reflect the health sector's increasing commitment to improved reporting of cases, with a growing range of providers reporting their serious adverse events, including private surgical hospitals, aged residential care facilities, disability services, the National Screening Unit and hospices. Two hundred and forty-eight events were patients experiencing serious harm from falls. Clinical management events were the second most frequently reported, with 158 in total. The report also details examples of actions taken by the Commission to improve patient safety, such as the global trigger tool programme, the trial Suicide Mortality Review Committee, and medication safety alerts.
Reports and data are subject to expert clinical and technical peer review	The adverse events learning programme expert advisory group provides expert clinical and technical peer review of all reports and data.
Process improvement in the sector and reduction in harm and cost are discussed in an annual report which draws together information from a number of these reports (8.1, 8.2, 8.3, 8.4, 8.5)	The serious adverse events annual report discussed process improvements and reduction in harm.

2011–12 performance: One report published

2012–13 performance: One report published

2013–14 performance: Two reports published

OUTPUT CLASS 2: ADVICE AND COMMENT

8.6 Articles in peer-reviewed journals – achieved

Measure	2014–15 performance
Deliverable date: 30 June 2015	
At least two articles published	Four articles were published: • *New Zealand Medical Journal,* 'The Health Quality and Safety Commission: making good health care better' (30 January 2015) • *New Zealand Medical Journal,* 'Measurement of New Zealand health care' (1 May 2015) • *New Zealand Medical Journal,* 'A new surgical site infection improvement programme for New Zealand: early progress' (15 May 2015) • *ANZ Journal of Surgery,* 'Briefings and debriefings in one surgeon's practice' (issue 85, May 2015).
A survey of key audiences is undertaken to analyse the usefulness of the article/paper and the application of key learnings to practice	A survey will be undertaken on the above articles by 31 December 2015.

New performance measure for 2014–15

8.7 Opinion papers – achieved

Measure	2014–15 performance
Deliverable date: 30 June 2015	
At least two opinion papers disseminated	Two articles were published: • Central line bacteraemia article, *North & South* magazine, March 2015 • 'In the end' (on Dr Atul Gawande and end-of-life care), *Metro* magazine, May 2015.
A survey of key audiences is undertaken to analyse the usefulness of the article/paper and the application of key learnings to practice	A survey will be undertaken on the above articles by 31 December 2015.

New performance measure for 2014–15

8.8 Workshops featuring international speakers – achieved

Measure	2014–15 performance
Deliverable date: 30 June 2015	
At least two international speakers	Visits by two international speakers were held: • Prof James Bagian, a US expert in human factors and a former astronaut, was the focus of quality and safety events during Patient Safety Week 2014 (3–7 November) in Auckland, Wellington and Dunedin. Around 300 attendees participated in the three workshops. Prof Bagian was also interviewed widely for TV, radio and print media. • Dr Atul Gawande, a renowned US quality and safety expert, visited Wellington 18–19 May 2015 in a visit arranged in partnership with the Auckland Writers Festival and part-sponsored by PricewaterhouseCoopers. Around 1400 people attended the two events, and Dr Gawande met both the Minister of Health and Hon Peter Dunne.
An evaluation of speaking engagements is undertaken to inform future choice of speakers and the most effective way to conduct speaking engagements. This will include analysis of stakeholders represented and the key learnings they take from the sessions	Evaluations were carried out seeking email feedback on Prof Bagian and Dr Gawande's visits, and returned very positive results.
A survey undertaken no later than three months after each speaking engagement to analyse application of key learnings to practice	Surveys were undertaken for both the Bagian and Gawande events, showing very positive results: • Prof Bagian's presentations and facilitation received the highest scores for the sessions in Patient Safety Week, ranging from 4.13 to 4.32 out of 5 for his keynote address. • Dr Atul Gawande's talks received a weighted average of 4.49 and 4.61 out of 5 with the majority rating these sessions extremely useful. Sixty-four percent of survey respondents noted changes they would make to their practice as a result of the day, with 70 individual respondents giving permission for Commission staff to contact them and discuss the practice change.

New performance measure for 2014–15

8.9 Mortality review committee reports – achieved

Child and youth mortality review

Measure	2014–15 performance
Deliverable date: 31 December 2014	
At least one report published	Published *Child and youth mortality from motorcycle, quad bike and motorised agricultural vehicle use, with a focus on deaths under age 15 years,* 17 December 2014. The report showed that, from 2002 to 2012, 33 children were killed in off-road vehicle accidents, nearly half of whom were using the vehicle recreationally. It made a series of recommendations to parents and caregivers, and a range of policy recommendations to challenge unacceptable risk factors.
Any advice or recommendations made in the reports will be consulted on with parties that may be involved in their implementation	All parties involved in potential implementation of recommendations were consulted.
An annual analysis will be undertaken by each committee of implementation of previous recommendations	Analysis was completed and follow-up will be considered by the CYMRC in upcoming meetings.

2011–12 performance: Two reports published
2012–13 performance: One report published
2013–14 performance: Two reports published

Perinatal and maternal mortality review

Measure	2014–15 performance
Deliverable date: 30 June 2015	
At least one report published	Published *Ninth Annual Report of the Perinatal and Maternal Mortality Review Committee,* 23 June 2015. The report showed that the rate of babies dying from 20 weeks of pregnancy to 28 days old (the perinatal mortality rate) has fallen to the lowest number since reporting began in New Zealand in 2007. There was one death for every 100 babies born in New Zealand in 2013. Although the overall reduction in perinatal mortality is not statistically significant, the measured reduction is encouraging.
Any advice or recommendations made in the reports will be consulted on with parties that may be involved in their implementation	Appropriate consultation occurred.
An annual analysis will be undertaken by each committee of implementation of previous recommendations	Analysis was completed and formed a part of the published annual report.

2011–12 performance: Two reports published
2012–13 performance: One report published
2013–14 performance: One report published

Family violence death review

Measure	2014–15 performance
Deliverable date: 30 June 2015	
At least one report published	Published *Family Violence Death Review Committee Activities Report,* 30 June 2015. It contains a summary of progress made on recommendations made in the committee's past two annual reports, and a list of committee activities since its last report.
Any advice or recommendations made in the reports will be consulted on with parties that may be involved in their implementation	The activities report does not contain substantive recommendations.
An annual analysis will be undertaken by each committee of implementation of previous recommendations	The analysis of the implementation of previous committee recommendations was the main focus of the activities report.

2011–12 performance: One report published
2012–13 performance: One report published
2013–14 performance: One report published

Perioperative mortality review

Measure	2014–15 performance
Deliverable date: 30 June 2015	
At least one report published	Published *Fourth report of the Perioperative Mortality Review Committee,* 15 June 2015. The report presents the committee's findings on the epidemiology of perioperative mortality for 2008–12 in five new clinically important areas. It also extends analyses from clinical areas included in previous reports to cover the time period for 2008–12.
Any advice or recommendations made in the reports will be consulted on with parties that may be involved in their implementation	Appropriate consultation occurred.
An annual analysis will be undertaken by each committee of implementation of previous recommendations	Analysis was completed and formed a part of the published annual report.

2011–12 performance: One report published
2012–13 performance: One report published
2013–14 performance: Two reports published

8.10 Annual mortality review conferences – achieved

Measure	2014–15 performance
Deliverable date: 30 June 2015	
At least two mortality review conferences held	Two conferences were held: • POMRC conference, Auckland, 15 June 2015 (80 attendees including Hon Peter Dunne) • PMMRC conference, Wellington, 23 June 2015 (230 attendees including Hon Dr Jonathan Coleman).
The conferences are approved for credit towards relevant professional college and society continuing professional development programmes	The conferences were approved for accreditation.
A survey is undertaken no later than three months after each conference to analyse application of key learnings to practice	POMRC: Immediate post-conference survey will be joined by three-month survey to be completed shortly. PMMRC: Surveys will be undertaken.

New performance measure 2014–15

OUTPUT CLASS 3: ASSISTANCE TO THE SECTOR TO EFFECT CHANGE

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

Measure	2014–15 performance
Deliverable date: 30 June 2015	
The programme includes: • resources, tools and information for the sector (including aged residential care and community settings) • annual 'April Falls' focus • building capability	• The 'Stay Independent' falls prevention toolkit for primary care and consumers was released and promoted to end users in community and primary care. A primary care clinical lead has been appointed to help implementation. • The 'April Falls' quiz, which is the main promotional tool for raising sector awareness, was launched on 1 April 2015 at the start of the April Falls month. It proved popular, with a record 2600 responses including 69 percent first-time participants. A resource was produced to assist using the quiz as a learning and teaching exercise. • Falls clinical lead Sandy Blake's programme of DHB and aged care facility engagement visits continued. These help to spread good practice and build capability throughout the sector. We also continued engagement with the Ministry of Health and ACC in the cross-sector steering group for an integrated work programme for older people.
A clinical leader and an expert advisory group inform the programme	Sandy Blake, director of nursing, patient safety and quality, Whanganui DHB, is the clinical lead. The falls expert advisory group meets quarterly. The clinical lead and expert advisory group consider all aspects of the programme and provide expert advice.
Annual measurement of changes in attitude and knowledge in the sector is undertaken	The April Falls quiz measures attitudes and knowledge, which will form part of the planned reporting.
The QSM reports include quarterly measurement of uptake of good practice and outcomes including reduction in harm and cost	QSM reports were published quarterly. They include measurement of uptake of good practice through process measures and the results through outcome measures. • Nationally, falls risk assessments of older patients remain static at 90 percent. Ninety percent of patients assessed as at risk of falling receive an individualised care plan. • The number of in-hospital falls with a fractured neck of femur is 81 cases in 2015 (rolling year ended) compared with 95 cases in 2012. Over the period 2010–12 and applying the age/gender/admission type-specific rates to 2014–15 admissions, we would have expected 106 falls in the year. The reduction of 25 falls causing a fractured neck of femur has avoided $1.2 million of cost, and is shown to be a statistically significant shift downwards since December 2014. For further detail see Appendix 2.

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

2013–14 performance: Advice on risk assessment and individualised care plans and resulting increased use

8.12 A nationally coordinated programme to reduce SSIs – achieved

Measure	2014–15 performance
Deliverable date: 30 June 2015	
The programme includes: • provision of best practice guidelines for prevention of SSIs • use of data to inform quality improvement activity and for monitoring, analysis and reporting	• An online knowledge repository has been established as an authoritative source of surveillance training materials and implementation manuals for the SSII programme. • Regional network meetings organised in the Midland, Central and South Island regions to illustrate how to use SSI data for local improvement initiatives. All four regions are visited twice a year, to build local capability for quality improvement through data analysis.
A clinical leader and an expert advisory group inform the programme	The clinical lead, Dr Arthur Morris, and an external steering group and clinical leadership group inform the SSII programme. An expert faculty has also been formed to provide clinical input and advice to the SSII programme.
The QSM reports include quarterly measurement of uptake of good practice and outcomes including reduction in harm and cost	QSM reports were published quarterly. They include measurement of uptake of good practice through process measures and the results through outcome measures. The Commission uses 90-day outcome measures for orthopaedic surgery, so this data runs one quarter behind to allow monitoring to occur. Process improvements: Results are encouraging, with increases in: • antibiotics given at the right time (<60 minutes prior to knife to skin) – an average of 95 percent of cases in October to December 2014 compared with 85 percent in July 2013 (target is 100 percent) • the right antibiotic (cefazolin) and right dose (2g) – an average of 90 percent of cases in March 2015 compared with 55 percent in July 2013 (target is 95 percent (to allow for a different antibiotic to be used in cases of allergy to cefazolin)) • the right skin preparation – 98 percent of cases compared with 91 percent in July 2013 (target is 100 percent). Outcomes: Overall the orthopaedic SSI rate has been stable at 1.3/100 procedures; however, individual DHBs have seen a reduction in the rate. At this stage it is too early to see an improvement in the national outcome measure because it was not until December 2014 that a full year of data from all DHBs had been reported on.

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

2013–14 performance: Best practice guidelines provided, national SSI IT system implemented, baselines established for tracking progress

8.13 A nationally coordinated programme to reduce perioperative harm – achieved

Measure	2014–15 performance
Deliverable date: 30 June 2015	
The programme includes: • implementation of improvement strategies and activities focused on: – use of the surgical safety checklist – briefing and debriefing • provision of resources on the Commission website	• A proof of concept process tested evidence-based interventions and international approaches to the process of implementing surgical team briefings, the WHO surgical safety checklist, and debriefings, with public and private hospital teams. Subsequently we delivered resources and tools for the launch of the first cohort of the perioperative harm teamwork and communications intervention roll-out to seven DHBs, to implement the interventions within their operating theatres. • The proof of concept was posted on the Commission website on 20 March 2015, and all of the available resources are available on the Commission website for reference. Second and third cohort DHBs are being encouraged to examine and learn from the material before their own implementation phase.
A clinical leader and an expert advisory group inform the programme	The perioperative harm expert advisory group is led by Ian Civil (medical clinical lead) and Miranda Pope (nursing clinical lead).
The QSM reports include quarterly measurement of uptake of good practice and outcomes including reduction in harm and cost	QSM reports were published quarterly. They include measurement of uptake of good practice through process measures and the results through outcome measures. Process improvements: The recorded use of all three parts of the surgical safety checklist remained at over 90 percent for the period January to March 2015. This is an increase of over 20 percent from the same period in 2013 (the baseline). Fourteen DHBs achieved the threshold level. However, the paper-based method of data collection for this measure may be contributing to an overly compliance-focused use of the checklist, rather than enhancing teamwork and communication amongst the surgical team as it is intended to do. DHBs have been asked to refocus on teamwork and communication in their annual plans. Outcomes: Compared with the 2012 baseline year, we estimate there have been 73 fewer postoperative cases of deep vein thrombosis (DVT) and pulmonary embolism (PE) resulting in 2576 fewer bed-days and a $2 million reduction in cost. However, there were 202 more perioperative sepsis cases than would have been expected using 2012 rates, resulting in 1998 more bed-days and more than $1.5 million in extra cost. Overall, additional bed-days and costs across the two measures have reduced.

2012–13 performance:	Baseline data collected on percentage of operations where the surgical checklist was used properly
2013–14 performance:	QSM reports published showing 95 percent use of surgical checklist (target 90 percent), but increased rates of infection due to more complex cases

8.14 Phase one of a nationally coordinated programme to reduce harm from high-risk medicines – achieved

Measure	2014–15 performance
Deliverable date: 30 June 2015	
Programme implementation includes: • capability building • provision of resources and tools • medication safety networks to strengthen regional and secondary care collaboration	• The *Open for better care* high-risk medicines topic ran from October 2014 to March 2015, highlighting programme work, activities and resources in the areas of the case for change, identifying medication errors and harm, partnering with patients and families, preventing and mitigating medication errors and harm, and the safe use of opioids. • The safe use of opioids national collaborative was also launched in October 2014 and will run to May 2016 (approximately 18 months). It provides national learning sessions and supports local DHB action periods during which agreed interventions are tested. Four regional 'learning session zero' events were held in October and November 2014 to start the collaborative learning process. • A *Let's PLAN for better care* pharmacy week was held in February 2015 to encourage people to learn more about their medicines by talking to their pharmacist, or by taking away useful information.
QSMs are established for the programme and baseline data collected against which uptake of good practice and outcomes, including reduction in harm and cost, can be measured	Process and structural measures were agreed following consultation with the sector. The Commission introduced a QSM to measure medicine reconciliation in each DHB as eMR is implemented locally through 2014 and 2015. Four DHBs have implemented the eMR system and two of them provided measurements reported by the system. Six of the other 16 DHBs have a timeframe for eMR implementation.
A clinical leader and expert advisory group inform the programme	Dr John Barnard is the medication safety programme clinical lead. The medication safety expert advisory group meets regularly to inform the programme.

2013–14 performance: Agreed set of interventions for high-risk medicines finalised and QSM for eMR developed

8.15 A national patient safety campaign – *Open for better care* – achieved

Measure	2014–15 performance
Deliverable date: 30 June 2015	
Topics four and five of the campaign are launched	• *Open for better care* topic four, high-risk medicines, was launched at the medication safety forum at Westpac Stadium in Wellington, 16 October 2014. Topic initiatives included launch materials such as factsheets and posters, a series of 'one step' tools to improve clinical practice in high-risk medicines, and Patient Safety Week in November 2014, which focused on the visit of Prof James Bagian. • *Open for better care* topic five, falls, began with the April Falls 2015 promotion and will conclude in September 2015. It focused on knowing and learning from DHB regional falls data. Posters were developed with specific falls data for each DHB region (for people aged 50 or older). A workbook was designed to assist DHBs to understand the implications of their regional falls implications. The April Falls quiz acted as both a survey of current falls expertise and a development tool. • More information about the campaign topics is found in sections 8.14 (high-risk medicines) and 8.11 (falls).
Evaluation of the first three campaign topics is undertaken, including analysis of their success in brand recognition and visibility, increasing engagement and motivation and uptake of evidence-based practice	Victoria University of Wellington and the University of Otago (Wellington) research centres jointly evaluated the national *Open for better care* campaign.[3] A draft report was received in June and is being considered, with a final report expected over the coming months.

2013–14 performance: Two campaigns topic undertaken

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

8.16 National guidance to assist DHBs to engage with consumers at governance, policy and service delivery levels – achieved

Measure	2014–15 performance
Deliverable date: 30 June 2015	
All DHBs receive national guidance Seminars are held to introduce guidance to DHBs	The national guide for promoting consumer engagement in DHBs was released on 30 June 2015. It covers consumer engagement in the design and delivery of services, and the development of policy and governance procedures. The guide: • provides information about consumer engagement – both nationally and internationally • shares the successes and lessons of New Zealand providers about how they engage with consumers • promotes networking throughout the health and disability sector. Regional workshops including consumer representatives were run in 11 towns and cities in April and May 2015 to introduce the contents of the new guide and seek any final feedback before it was launched.
Consumers and all DHBs are consulted on the content of the guidance	Detailed consultation with consumers and DHBs occurred before the guidance was published.
A survey will be undertaken no later than three months after the seminars to analyse application of key learnings to practice	It has been decided to give DHBs longer to implement the guidance before an appraisal is conducted. The survey is now planned for late 2015 or early 2016.

2011–12 performance:	Published register of consumer organisations, groups and individuals undertaking advisory and/or representative roles in the health and disability sector
2012–13 performance:	Implemented 2012–13 Partners in Care action plan, including actions relating to health literacy, consumer register, resources for consumers, consumer narratives and co-design
2013–14 performance:	Produced resources for providers working with consumers, consumers working with providers, and Partners in Care training

9.0 Revenue/Expenses for output classes

	Output class 1 Measurement and evaluation		Output class 2 Advice and comment		Output class 3 Assistance to the sector to effect change		Total	
	Actual $000	Budget $000	Actual $000	Budget $000	Actual $000	Budget $000	Actual $000	Budget $000
Revenue								
Crown revenue	6,862	6,632	577	577	6,017	6,017	13,456	13,226
Interest revenue	48	32	6	4	51	34	105	70
Other revenue	192	0	211	0	499	0	902	0
Total revenue	**7,102**	**6,664**	**794**	**581**	**6,567**	**6,051**	**14,463**	**13,296**
Expenditure								
Operational and internal programme cost	4,069	3,314	694	531	3,670	2,884	8,433	6,729
External programme cost	3,084	3,350	231	50	2,752	3,352	6,067	6,752
Total expenditure	**7,153**	**6,664**	**925**	**581**	**6,422**	**6,236**	**14,500**	**13,481**
Surplus/(deficit)	(51)	0	(131)	0	145	(185)	(37)	(185)

10.0 Financial statements

10.1 Statement of comprehensive revenue and expenses for the year ended 30 June 2015

Actual 2014 $000		Notes	Actual 2015 $000	Budget 2015 $000
	Revenue			
13,166	Revenue from Crown	2	13,456	13,226
100	Interest revenue		105	70
368	Other revenue	3	902	0
13,635	**Total revenue**		**14,463**	**13,296**
	Expenditure			
4,148	Personnel costs	4	5,680	4,642
143	Depreciation and amortisation	12,13	106	149
3,004	Other expenses	6	2,647	1,938
4,566	External quality and safety programmes		4,028	4,132
2,239	External mortality programmes		2,039	2,620
14,100	Total expenditure		**14,500**	**13,481**
(466)	**Surplus/(deficit)**		**(37)**	**(185)**
0	Other comprehensive revenue		0	0
(466)	**Total comprehensive revenue**		**(37)**	**(185)**

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

10.2 Statement of financial position as at 30 June 2015

Actual 2014 $000		Notes	Actual 2015 $000	Budget 2015 $000
	Assets			
	Current assets			
2,151	Cash and cash equivalents	7	2,170	2,347
381	GST receivable		262	331
125	Debtors and other receivables	8	306	60
158	Prepayments		68	50
2,816	**Total current assets**		**2,806**	**2,788**
	Non-current assets			
99	Property, plant and equipment	12	202	220
24	Intangible assets	13	15	70
123	**Total non-current assets**		**217**	**290**
2,938	**Total assets**		**3,023**	**3,078**
	Liabilities			
	Current liabilities			
1,341	Creditors and other payables	14	1,476	1,379
287	Employee entitlements	16	273	205
1,628	**Total current liabilities**		**1,749**	**1,584**
1,628	**Total liabilities**		**1,749**	**1,584**
1,311	**Net assets**		**1,274**	**1,494**
	Equity			
1,777	General funds July		1,311	1,679
0	Contributed capital	17	0	0
(466)	Surplus/(deficit)		(37)	(185)
1,311	**Total equity**		**1,274**	**1,494**

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

10.3 Statement of changes in equity for the year ended 30 June 2015

Actual 2014 $000		Notes	Actual 2015 $000	Budget 2015 $000
1,777	Balance at 1 July		1,311	1,679
	Comprehensive revenue and expenses for the year			
(466)	Surplus/(deficit)		(37)	(185)
	Owner transactions			
0	Capital contribution		0	0
1,311	**Balance at 30 June**	**17**	**1,274**	**1,494**

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

10.4 Statement of cash flows for the year ended 30 June 2015

Actual 2014 $000		Notes	Actual 2015 $000	Budget 2015 $000
	Cash flows from operating activities			
13,166	Receipts from Crown		13,456	13,226
495	Other revenue		721	0
100	Interest received		105	70
(9,955)	Payments to suppliers		(8,486)	(8,724)
(4,142)	Payments to employees		(5,695)	(4,590)
140	Goods and services tax (net)		119	23
(196)	Net cash flow from operating activities	18	220	5
	Cash flows from investing activities			
44	Purchase of property, plant and equipment		(185)	(249)
0	Purchase of intangible assets		(16)	0
44	Net cash flow from investing activities		(201)	(249)
	Capital flows from financing activities			
0	Capital contribution		0	0
0	Net cash flows from financing activities	17	0	0
(152)	**Net (decrease)/increase in cash and cash equivalents**		**19**	**(244)**
2,303	Cash and cash equivalents at the beginning of the year		2,151	2,591
2,151	**Cash and cash equivalents at the end of the year**	7	**2,170**	**2,347**

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

10.5 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. The Commission does not operate to make a financial return. Accordingly, the Commission has designated itself as a public benefit entity for financial reporting purposes.

The financial statements for the Commission are for the year ended 30 June 2015, and were approved by the Board on 30 October 2015.

BASIS OF PREPARATION

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

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 Tier 2 public benefit entity (PBE) accounting standards and comply with PBE accounting standards. The Commission meets the criteria for Tier 2 PBE as it is not publicly accountable and has expenses ≤$30 million.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There are no material adjustments arising on transition to the new PBE accounting standards.

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.

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

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. The Commission has applied these standards in preparing the 30 June 2015 financial statements.

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. The Commission considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement. The fair value of revenue from the Crown Revenue has been determined to be equivalent to the amounts due in the funding arrangements.

Grants received

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

Interest

Interest income is recognised using the effective interest method.

Foreign currency transactions

Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into NZ$ (the functional currency) using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses

resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

Operating leases

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

Cash and cash equivalents

Cash and cash equivalents 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 2014–15.

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 2014–15.

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 surplus or deficit 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 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

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

Non-cash generating assets

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

Goods and services tax

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Creditors and other payables

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

Employee entitlements

Short-term employee entitlements

Employee benefits 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 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 $0.902 million ($0.260 million 2013–14) was received from

- the National Health IT Board's contribution to the eMM programme
- DHBs' contributions to the patient experience survey
- expansion of the Medication Error Reporting Programme
- James Bagian and Atul Gawande workshops
- perioperative and perinatal mortality review annual conferences.

Note 4: Personnel costs

	Actual 2014 $000	Actual 2015 $000
Salaries and wages	3,924	5,286
Recruitment	22	101
Temporary personnel	11	50
Membership, professional fees and staff	63	76
Training and development		
Defined contribution plan employer contributions	129	120
Increase/(decrease) in employee entitlements	(1)	47
Total personnel costs	**4,148**	**5,680**

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 2014 $000	Actual 2015 $000
Audit fees to Audit NZ for financial audit	29	30
Staff travel and accommodation	317	394
Printing/Communications	253	203
Consultants and contractors	1,002	627
Board costs/Mortality committees	510	618
Outsourced corporate services and overhead	667	766
Onerous contracts	126	0
Loss on property, plant and equipment	87	0
Other expenses	13	9
Total other expenses	**3,004**	**2,647**

Note 7: Cash and equivalents

	Actual 2014 $000	Actual 2015 $000
Cash at bank and on hand	2,151	2,170
Total cash and cash equivalents	**2,151**	**2,170**

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 2014 $000	Actual 2015 $000
Debtors and other receivables	125	306
Less: provision for impairment	0	0
Total debtors and other receivables	**125**	**306**

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 2014–15.

Note 11: Non-current assets held for sale

The Commission has no current or non-current assets held for sale in 2014–15.

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 2013	152	144	123	419
Additions	26	13	0	39
Disposals	0	0	(87)	(87)
Balance at 30 June 2014/1 July 2014	178	157	36	371
Additions	113	74	0	187
Disposals	(102)	(4)	(36)	(142)
Balance at 30 June 2015	189	227	0	416
Accumulated depreciation and impairment losses				
Balance at 1 July 2013	95	60	18	173
Depreciation expense	49	32	17	98
Balance at 30 June 2014/1 July 2014	144	92	35	271
Depreciation expense	48	34	0	82
Elimination on disposal	(101)	(3)	(35)	(139)
Balance at 30 June 2015	91	123	0	214
Carrying amounts				
At 1 July 2013	57	84	105	246
At 30 June and 1 July 2014	34	64	1	99
At 30 June 2015	98	104	0	202

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 2013	128
Additions	4
Balance at 30 June 2014/1 July 2014	132
Additions	15
Balance at 30 June 2015	147
Accumulated amortisation and impairment losses	
Balance at 1 July 2013	63
Amortisation expenses	45
Balance at 30 June 2014/1 July 2014	108
Amortisation expenses	24
Balance at 30 June 2015	132
Carrying amounts	
At 1 July 2013	64
At 30 June and 1 July 2014	24
At 30 June 2015	15

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 2014 $000	Actual 2015 $000
Creditors	510	794
Accrued expenses	705	682
Other payables	126	0
Total creditors and other payables	**1,341**	**1,476**

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

Note 15: Borrowings (NZ IAS 1.77)

The Commission does not have any borrowings.

Note 16: Employee entitlements

	Actual 2014 $000	Actual 2015 $000
Current portion		
Accrued salaries and wages	142	30
Annual leave	145	234
Total current portion	287	264
Non-current portion	0	9
Total employee entitlements	**287**	**273**

No provisions for sick leave or retirement leave have been made in 2014–15.

Provisions for long service leave have been made in 2014–15.

Note 17: Equity

	Actual 2014 $000	Actual 2015 $000
General funds		
Balance at 1 July	1,777	1,311
Surplus/(deficit) for the year	(466)	(37)
Capital contributions	0	0
Balance at 30 June	**1,311**	**1,274**

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 2014 $000	Actual 2015 $000
Net surplus/(deficit)	(466)	(37)
Add/(less) movements in statement of financial position items		
Debtors and other receivables	267	(62)
Creditors and other payables	(150)	136
Depreciation	143	106
Prepayments	5	91
Employee entitlements	5	(14)
Net movements in working capital		
Net cash flow from operating activities	(196)	220

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 2014 $000	Actual 2015 $000
Not later than one year	320	192
Later than one year and not later than five years	30	0
Later than five years	0	0
Total non-cancellable operating leases	**350**	**192**

At balance date the Commission leases a property (from 1 March 2014) at Levels 1 and 8, 17–21 Whitmore Street, Wellington. The lease expires in March 2016. Subsequent to balance date the Commission signed for a further three-year period to March 2019. The three-year value of the lease is $0.657 million.

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 sub-lease 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.

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

KEY MANAGEMENT PERSONNEL

Salaries and other short-term employee benefits to key management personnel[4] totalled $1.07 million ($1.04 million 2013–14).

4 Key management personnel, comprising four full-time employee equivalents, for 2014–15 include the Chief Executive, General Manager, Director of Measurement and Evaluation, and Chief Financial Officer (2013–14: four full-time employees). Board members have been reported separately.

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 2014–15 year was:

	Actual 2014 $000	Actual 2015 $000
Prof Alan Merry* (Chair)	29	29
Shelley Frost* (Deputy Chair)	18	18
Dr David Galler*	15	15
Geraint Martin*	7	0
Anthea Penny	11	0
Dame Alison Paterson	15	15
Dr Dale Bramley*	15	15
Robert Henderson*	7	17
Heather Shotter	5	15
Gwendoline Tepania-Palmer	5	15
Total board member remuneration	**127**	**139**

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.

Note 23: Employee remuneration

Total remuneration paid or payable:

	Employees 2014	Employees 2015
$100,000–$109,999	4	6
$110,000–$119,999	2	4
$120,000–$129,999	1	0
$130,000–$139,999	2	2
$140,000–$149,999	1	3
$150,000–$159,999	1	1
$160,000–$169,999	2	1
$190,000–$199,999	1	0
$200,000–$209,999	0	2
$220,000–$229,999	1	1
$230,000–$239,999	1	0
$250,000–$259,999	0	1
$380,000–$389,999	1	1
Total employees	**17**	**22**

During the year ended 30 June 2015 no employees received compensation and other benefits in relation to cessation.

Note 24: Events after the balance date

After balance date the Commission signed for a further three-year period to March 2019 at Levels 1 and 8, 17–21 Whitmore Street, Wellington. The three-year value of the lease is $0.657 million.

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 2014–15 Statement of Performance Expectations are as follows.

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSES

The year-end result for the year to 30 June 2015 is a $0.037 million deficit against a planned Statement of Performance Expectations deficit of $0.185 million.

Although the year-end results show a surplus variance to plan of around $0.148 million, the majority of this relates to the receipt of an additional $0.230 million by the Commission for the expansion of the Medication Error Reporting Programme through the New Zealand Pharmacovigilance Centre, of which only $0.090 million has been expended to date with the remaining $0.140 million to be expended over the following two-year period.

Additional overhead and occupancy costs are associated with the additional floor in the Whitmore Street offices, insurance, IT support and software licensing for the additional staff employed during 2014–15.

STATEMENT OF FINANCIAL POSITION

Cash and cash equivalents at the beginning of the year were lower than budgeted due to the final results for 2013–14 being different to what was forecast at the time. Debtors are higher than budgeted due to invoices being raised in quarter four for the additional unbudgeted revenue streams including eMM, the Medication Error Reporting Programme and the primary care experience survey.

Intangible assets are lower than planned as operating software renewal has been extended out by 12 months.

STATEMENT OF CHANGES IN CASHFLOW

Due to the receipt of an additional $1 million in revenue during the period, both revenue received and 'payment to suppliers and employees' are higher than budgeted figures.

Cash and cash equivalents at the beginning of the year were lower than budgeted due to the final results for 2013–14 being different to forecast totals.

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.

Note 29: Adjustments arising on transition to the new PBE accounting standards

There have been no reclassifications on the face of the financial statements in adopting the new PBE accounting standards. Nor have there been any recognition and measurement adjustments associated with non-exchange revenue.

Note 30: Responsibilities under the Public Finance Act

To comply with our responsibilities under the Public Finance Act the activities funded through the Crown Vote Health and how performance is measured against the forecast information contained in the Estimates of Appropriation 2014–15 and of those as amended by the Supplementary Estimates.

MONITORING AND PROTECTING HEALTH AND DISABILITY CONSUMER INTERESTS (M36)

This appropriation is intended to achieve the following: Provision of services to monitor and protect health consumer interests by the Health and Disability Commissioner, District Mental Health Inspectors and Review Tribunals, and the Mental Health Commission.

The Commission also received Crown funding of $0.26 million from the Vote Health – National Mental Health Services (M36) appropriation and a further $0.22 million from the Vote Health – Primary Health Care Strategy (M36) appropriation.

Output class financials	Actual 2014–15	Budget 2014–15	Location of end-of-year performance information
Crown Funding (Vote Health – Monitoring and Protecting Health and Disability Consumer Interests (M36))	12,976,000	12,976,000	The end-of-year performance information for this appropriation are those reported in the statement of performance.

11.0 Statement of responsibility

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

The board of the Health Quality & Safety Commission are responsible for any end-of-year performance information provided under section 19A of the Public Finance Act 1989.

We have 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 performance fairly reflect the financial position and operations of the Health Quality & Safety Commission for the year ended 30 June 2015.

Signed on behalf of the board:

Prof Alan Merry ONZM FRSNZ
Chair
30 October 2015

Shelley Frost
Deputy Chair
30 October 2015

12.0 Auditor's report

Independent Auditor's Report

To the readers of Health Quality and Safety Commission's financial statements and performance information for the year ended 30 June 2015

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 the performance information, including the performance information for an appropriation, of the Commission on her behalf.

Opinion on the financial statements and the performance information

We have audited:

- the financial statements of the Commission on pages 43 to 58, that comprise the statement of financial position as at 30 June 2015, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Commission on pages 10 to 19, 27 to 42, and 65 to 69.

In our opinion:

- The financial statements of the Commission:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2015;
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with the Public Benefit Entity Accounting Standards.
- The performance information:
  - presents fairly, in all material respects, the Commission's performance for the year ended 30 June 2015, including:
    - for each class of reportable outputs:
      - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
      - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriation;
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 30 October 2015. 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 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 the 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 the 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 the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the 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 performance information 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 performance information within the Commission's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

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

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 performance information that:

- comply with generally accepted accounting practice in New Zealand and Public Benefit Entity Accounting Standards;
- present fairly the Commission's financial position, financial performance and cash flows; and
- present fairly the Commission's performance.

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

The Board is responsible for such internal control as it determines is necessary to enable the preparation of financial statements and 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 the performance information, whether in printed or electronic form.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

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 Dale Bramley (*Ngā Puhi*)

Dr David Galler

Robert Henderson

Dame Alison Paterson

Heather Shotter

Gwendoline Tepania-Palmer (*Te Aupōuri, Ngāti Kahu, Ngāti Pāoa Tainui*)

Board committees

Finance and Audit Committee:

Alison Paterson (Chair)

Andrew Boyd

Dr Dale Bramley

Prof Alan Merry

Heather Shotter

Communication and Engagement Committee:

Heather Shotter (Chair)

Shelley Frost

Dr David Galler

Gwen Tepania-Palmer

Roopū Māori members:

Tuwhakairiora (Tu) Williams (Chair) (*Ngāti Porou, Whakatōhea, Ngaitai*)

Dr Peter Jansen (*Ngāti Raukawa*)

Dr George Laking (*Te Whakatōhea*)

Marama Parore (*Ngāti Whātua, Ngāti Kahu, Ngāpuhi*)

Leanne Te Karu (*Muaūpoko/Whanganui*)

Prof Denise Wilson (*Ngāti Tahinga (Tainui)*)

Consumer network members:

Martine Abel

James Ahipene (*Ngāti Tūwharetoa*)

Kula Alapaki

Vicki Culling

Alison Franklin

Te Rina Ruru (*Ngāti Kahu ki Whāingaroa/Te-Aitanga-a-Māhaki*)

Gary Sutcliffe

Ivan Yeo

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	Suicide Mortality Review Committee
Dr Sue Belgrave (Chair)	Dr Leona Wilson (Chair)	Dr Felicity Dumble (Chair)	Assoc Prof Julia Tolmie (Chair)	Prof Robert Kydd (Chair)
Alison Eddy (Deputy Chair)	Dr Catherine Ferguson (Deputy Chair)	Dr Stuart Dalziel (Deputy Chair)	Prof Denise Wilson (Deputy Chair) (*Ngāti Tahinga (Tainui)*)	Dr Sarah Fortune (Deputy Chair)
Gail McIver	Dr Philip Hider	Dr Paula King (*Ngāpuhi, Ngāti Whātua, Te Rarawa*)	Prof Dawn Elder (Deputy Chair)	Prof Roger Mulder
Linda Penlington	Dr Digby Ngan Kee	Dr Terryann Clark (*Ngāpuhi*)	Miranda Ritchie	Dr Jemaima Tiatia-Seath
Dr Max Berry	Dr Jonathan Koea (*Te Ātiawa*)	Dr Janine Ryland (co-opted)	Paul von Dadelszen	Maria Baker (*Ngāpuhi, Te Rarawa*)
Dr Rose Elder	Rosaleen Robertson	Gillian Buchanan (co-opted)	Pamela Jensen	Dr Deborah Peterson
Dr Sue Crengle	Teena Robinson	Jacqui Moynihan (co-opted)	Dr Fiona Cram (*Ngāti Pahauwera*)	Dr John Crawshaw (ex officio)
			Prof Jane Koziol-McLain	Prof Sunny Collings (advisor)

Clinical leads

Dr John Barnard	Medication safety programme
Sandy Blake	Reducing harm from falls programme
Prof Ian Civil	Reducing perioperative harm programme
Gillian Robb	Global trigger tool programme
Dr Sally Roberts	Infection prevention and control programme
Dr David Sage	Reportable events

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Auditor

Audit New Zealand on behalf of the Auditor-General

Appendix 2: Measuring progress against the QSMs

The QSMs 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	Actual 2013–14	Target 2014–15	Actual 2014–15	Expected outcomes over the next four years	Data source
	Process measures						
Percentage observed compliance with all 'five moments for hand hygiene'	**62.1%** **(October 2012)**	70.5% (June 2013)	73%	80%	80% with 12 out of 20 DHBs meeting the target	Maintain at least 80% compliance	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)	95%	73%	90% (July to December 2014)	Maintain at least 90% compliance	*Target CLAB Zero* programme
	Outcome measures						
Rate of healthcare associated *Staphylococcus aureus* bacteraemia[5] per 1000 inpatient days	0.14	**0.11**	0.12	Maintenance of rate between 0.07 infections and 0.11 per 1000 bed-days	0.12 (July 2014 to March 2015)	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[6 7 8]	Hand Hygiene New Zealand programme
Rate of central line associated bacteraemia (CLAB) per 1000 line days	**3.5**[9]	0.49	0.52	<1	0.42 (July to December 2014)	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)	1.3 (March 2013 to March 2014)	Not specified	1.2 (March 2014 to March 2015)	Literature suggests a reduction of 25–27% should be possible[10 11]	ICNet

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

6 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.

7 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.

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

9 *Target CLAB Zero* final report.

10 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.

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

Table 2: Reducing perioperative harm

Marker	Actual 2010–11	Actual 2011–12	Actual 2012–13	Actual 2013–14[12]	Target 2014–15	Actual 2014–15	Expected outcomes over the next four years	Data source
	Process measures							
Percentage of operations where all three parts of the WHO surgical safety checklist are used			**71.2%**	95% (April to June 2014)	90%	93% (January to March 2015)	Target is 90%	Chart reviews[13]
	Outcome measures							
Postoperative sepsis rate[14] per 1000 surgical episodes	8.37[15]	8.9	**10.77**	12.3[16]	Reduction of around 30% over three years	13.3 (July 2014 to March 2015)	Literature suggests a reduction of around 30% should be possible.[17] 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. 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[18]	4.08	**3.66**	5.89		6.6 (July 2014 to December 2014)		NMDS
Postoperative DVT/PE rate per 1000 surgical episodes	3.94[19]	3.97	**3.81**	4.18[20]		4.1 (July 2014 to March 2015)		NMDS

12 The estimates based on the NMDS use actual data for a calendar year. Validated NMDS data for the full year is not available until at least three months after the end of the period.

13 Based on chart reviews – we are working towards observer-based data in future.

14 Calculated as the number of surgical admissions where postoperative sepsis and postoperative DVT/PE were 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.

15 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.

16 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 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.

18 *Ibid.*

19 *Ibid.*

20 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	Actual 2013–14	Target 2014–15	Actual 2014–15	Expected outcomes over the next four years	Data source
	Process measures							
Percentage of older patients given a falls risk assessment			**77%**	90%	90%	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%**	90%	90%	90%		DHB audits of patient aged 75+
	Outcome measures							
In-hospital fractured neck of femur (FNOF)	111	91	**97**	92	Reduction of falls with FNOF of 10–30% over three years	88 (April 2014 to March 2015)	Reduction of falls with FNOF to 75–95 falls would be consistent with literature which suggests a reduction of 10–30% is possible.[21]	NMDS
Additional occupied bed-days (OBDs) following in-hospital FNOF	4124	3944	**2677**	513[22]	Measurement of associated reduction in additional OBDs and cost	3204 (April 2014 to March 2015)		NMDS
Cost of additional OBDs associated with FNOF			**$2.06 million**	$0.4 million		$2.4 million		NMDS/ Cost data from New Zealand Institute of Economic Research (NZIER)[23]

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

22 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.

23 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 SSIs

Marker	Actual July to September 2013	Actual January to March 2014	Target 2014–15	Actual 2014–15	Expected outcome over the next four years (target)	Data source
	Process measures					
Antibiotic given at right time	**85%**	92%	No annual target identified	94%	100%	ICNet
Right antibiotic and right dose (2g cefazolin)	**55%**	78%[24] (see Note 1)		90%	95%[25]	
Right skin preparation	**91%**	98%[26]		98%	100%	

Marker	Actual July to September 2013	Actual January to March 2014	Target 2014–15	Actual July to September 2014	Actual January to March 2015	Expected outcome over the next four years (target)	Data source
	Outcome measures						
Number of surgical site infections	30	24	No annual target identified	32	25	Literature suggests a reduction of 25–27% should be possible	ICNet
Infections per 1000 hip and knee operations	13	10		13	10		
Sum of estimated incident cost ($)	$0.53 million	$0.425 million		$0.57 million	$0.44 million		

22 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.

23 De Raad, *op. cit*.

24 Fourteen DHBs have reached the 95 percent threshold compared with only three at 2013 baseline.

25 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 percent.

26 The 100 percent target was met by 13 DHBs. Six more DHBs are achieving 99 percent.

Table 5: Reducing medication errors

Marker	Baseline 30 June 2015	Expected outcome over the next four years (target)	Data source
	Structural measure		
eMR implemented anywhere in the DHB	**5 DHBs**	All DHBs	DHB eMR system
Number and percentage of relevant wards with eMR implemented	**Ranging between 50% and 91% for the four DHBs reporting**	All relevant wards	DHB eMR system
	Process measures		
Percentage of relevant patients aged 65 and over (55% for Māori and Pacific patients) where eMR was undertaken within 72 hours of admission	**Ranging between 49% and 58% for the two DHBs reporting**	Not specified	DHB eMR system
Number and percentage of relevant patients aged 65 and over (55% for Māori and Pacific patients) where eMR was undertaken within 24 hours of admission	**Ranging between 19% and 51% for the two DHBs reporting**	Not specified	DHB eMR system
Percentage of patients aged 65 and over (55% for Māori and Pacific patients) discharged where eMR was included as part of the discharge summary	**Ranging between 55% and 65% for the two DHBs reporting**	Not specified	DHB eMR system

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