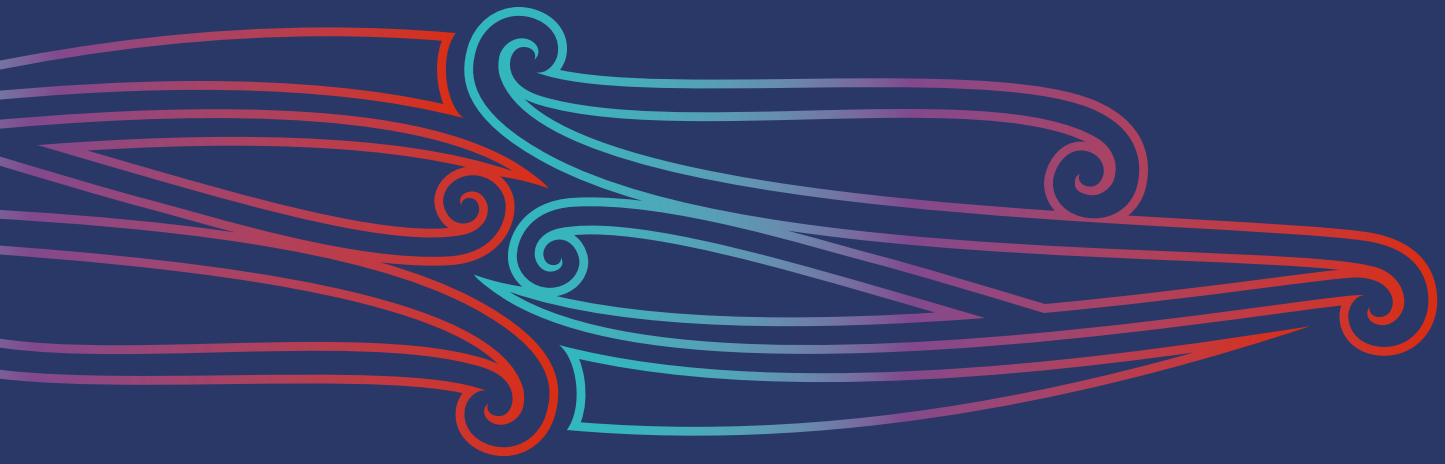
Pūrongo ā-tau 2021/22

ANNUAL REPORT 2021/22

Kupu Taurangi Hauora o Aotearoa | Health Quality & Safety Commission



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Tā mātau matakitenga | Our vision

Hauora kounga mō te katoa

Quality health for all

Tā mātau uaratanga | Our mission

Whakauru | Whakamōhio | Whakaawe | Whakapai Ake

Involve | Inform | Influence | Improve

Ā mātau kaupapa matua pūmau, i ahu mai i Te Tiriti o Waitangi
Our enduring priorities, based on Te Tiriti o Waitangi

Kāwanatanga Partnering and shared decision making	**Tino rangatiratanga** Recognising Māori authority	**Ōritetanga** Equity	**Wairuatanga** Upholding values, belief systems and worldviews

Ā mātau kaupapa rautaki matua | Our strategic priorities

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

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Foreword

Kōrero o mua

We are proud to present the Health Quality & Safety Commission (the Commission) annual report for 2021/22. As we reflect on our work over the last year and look towards the future, we are cognisant of the wider health and disability system landscape.

Over the last year, the entire health workforce has worked tirelessly to manage the COVID-19 Delta and Omicron outbreaks and roll out the COVID-19 immunisation programme – the largest immunisation roll-out in the history of Aotearoa New Zealand. Concurrently, our health system has also been going through a period of significant change. At the time of writing, the Pae Ora (Healthy Futures) Act 2022 has been enacted, disestablishing district health boards (DHBs), establishing Te Whatu Ora – Health New Zealand and Te Aka Whai Ora | Māori Health Authority and a reformed Manatū Hauora – Ministry of Health. Additionally, the new Whaikaha – Ministry of Disabled People has been established to improve outcomes for disabled people, reform the wider disability system and coordinate the government's disability policies.

While the landscape around us has changed and continues to do so at significant pace and scale, the Commission has remained relatively constant and fully committed to our vision of 'Hauora kounga mō te katoa | Quality health for all' and the strategic priorities set out in our *Tauākī Koronga | Statement of Intent 2020–24*.[1] Our strategic priorities align well with the goals underlying system change, and they continue to provide us with useful direction for improving the quality of health care. In fact, the health and disability system is adjusting in ways that will align it more closely with our existing strategic direction. This report outlines what we have achieved, our challenges, our progress against our performance measures and how we have managed our business over the last year.

Our key area of focus over the last year was supporting the health and disability system's response to COVID-19. We did, and continue to do, a significant amount of work to monitor the quality, safety and equity impacts of the COVID-19 pandemic, through our Quality Alerts, the Quality Forum[2] and our annual 'Window on quality', which focused this year on COVID-19. We also produced real-time monitoring reports on the impacts of COVID-19 on different areas of the health and disability sector by gathering intelligence on what was happening on the ground and how COVID-19 was impacting service delivery.

We worked closely with the Health and Disability Review Transition Unit, based within the Department of the Prime Minister and Cabinet, to ensure that quality and safety is embedded into the design of the future health and disability system, briefing both the Minister of Health and the boards of the new agencies on quality functions in the future system. We also developed the code of expectations for health entities' engagement with consumers and whānau and look forward to working with the new health agencies to implement and apply this code to the operational functioning of the health and disability system. Acknowledging the significant changes occurring throughout the health and disability system, the Minister of Health, in his Letter of Expectation, asked the Commission 'whether the current mortality review structures are fit for purpose and delivering the most useful information in the most effective manner'. Over the last year, and as the broader goals of the health system reform became clearer, we took a 'first principles'

[1] Health Quality & Safety Commission. 2020. *Tauākī Koronga: Statement of Intent 2020–24*. Wellington: Health Quality & Safety Commission. URL: hqsc.govt.nz/assets/Core-pages/HQSC-general-resources/StatementOfIntent2020-24.pdf

[2] The Quality Forum is a collaboration of national agencies and organisations working together to share intelligence to learn from each other and to develop common understandings of quality risk areas.

approach to carrying out an independent review of the national mortality review function. We are excited at the opportunity that has arisen to align the mortality review structure with the direction of the broader health and disability system and ensure the structure remains fit for purpose into the future.

We strived to focus our work on achieving equitable health outcomes for all, but particularly for Māori, Pacific peoples and disabled peoples, in an effort to ensure that the changes to the health and disability system will not further impact our communities who require greater resource and attention. We refreshed the membership of our Māori strategic partnership group, Te Rōpū, to reflect the experience and knowledge of selected Māori health communities and leaders across the country. A huge amount of work was undertaken across the advanced care planning programme to meaningfully and effectively enact Te Tiriti o Waitangi (Te Tiriti) principles and support mana motuhake. This includes setting up a co-governance structure made up of a steering group of health experts and our mana-enhancing design partners rōpū (Mana-E) and developing new advanced care planning team mātāpono (values) to reflect our enduring priority to uphold the principles of Te Tiriti.

We also stood up a Pacific team – Tangata o le Moana – to ensure that the voices of Pacific peoples and the nuances between Pacific communities are understood and incorporated within all our work.

Through the COVID-19 lockdowns, we adapted the way we worked, quickly moving to working from home and virtual meetings. Most of our work was relatively unaffected by COVID-19, but some of our more front-line-facing work, such as capability-building programmes, was delayed because of the increasing demands on the health workforce.

We continued to perform well financially. We started the year expecting an end-of-year deficit of $0.120 million and finished the year with a $0.626 million surplus, due to savings made from conducting meetings online rather than travelling for meetings and from work that was delayed or reprioritised due to COVID-19 activities at the frontline. We will be picking up this work and taking it forward over the next year. Travel, committee and publication cost variances were genuine savings in 2021/22, creating $0.400 million of reserves that can increase the scope of our existing work or go toward additional one-off costs or activities associated with the health sector reforms in 2022/23 (or out years).

Our strategic priorities align well with the goals underlying system change, and they continue to provide us with useful direction for improving the quality of health care.

We would like to acknowledge and thank our health workforce for their enormous efforts over the last year. We will continue to support efforts to improve quality, safety and equity for our workforce as we begin to emerge from COVID-19 restrictions and move to fully operationalising the structure of the reformed health and disability system.

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

Dr Dale Bramley
Chair

21 December 2022

Dr Janice Wilson
Chief Executive

21 December 2022

Introduction
Kupu whakataki

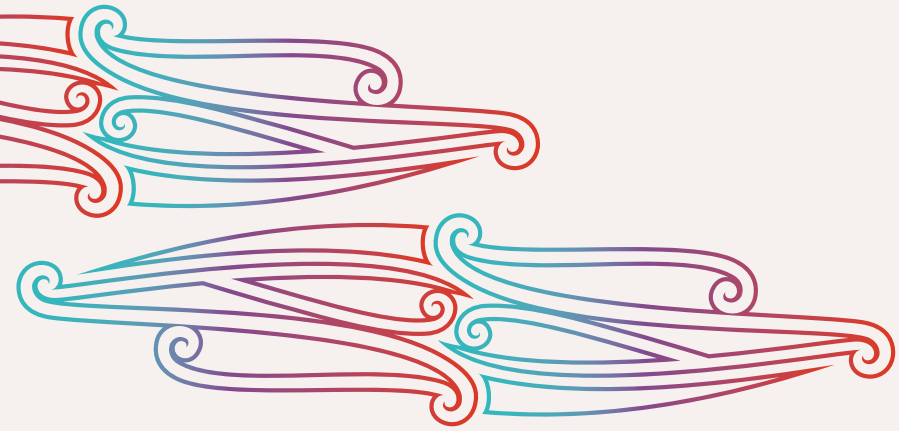
This annual report reflects on our work from 1 July 2021 to 30 June 2022 and our progress against the plans that we set in our Statement of Performance Expectations 2021/22 (SPE).[3]

Over 2021/22, the Health Quality & Safety Commission (the Commission) continued to work to advance our four strategic priorities of:

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

Due to the continuing impact of COVID-19 and the structural changes resulting from the health system reforms, 2021/22 was a challenging year for the health and disability sector. However, it was also one where there was immense opportunity to build up our health system to provide consistent, high-quality health services for everyone, particularly those who have been traditionally underserved. The Commission worked to respond positively to challenges and to maximise the opportunities presented. We worked actively to analyse, understand and disseminate the impacts of COVID-19 on the health and disability system through our annual 'Window on quality', which focused this year on COVID-19, and our real-time monitoring reports.

We provided advice and support to those designing the future health and disability system to ensure quality and safety are embedded into the design of the system. We also worked with those implementing the vision of reform and transforming it into day-to-day practices so they could prepare a quality health and disability system from day 1. We facilitated an independent chair to bring agencies together to meet the Ministerial expectation of delivering a detailed, collaborative model for ensuring the future quality health and disability system by the end of 2022. At the same time, we also took our planned work forward, had some notable successes and achievements and continued our focus on the impacts and outcomes of our work. This introduction briefly covers each of these areas and then presents the structure of this report.



[3] Health Quality & Safety Commission. 2021. *Statement of Performance Expectations | Tauākī o ngā Mahi ka Whāia, 2021/22.* Wellington: Health Quality & Safety Commission. URL: hqsc.govt.nz/assets/Core-pages/About-us/SPE2021-22-web.pdf

We had notable successes and achievements

Results from our impact and outcome reporting for 2021/22

Maintained equity in response rates between **Māori** and **non-Māori** and **non-Pacific** for the patient experience survey

The gap in response rates to the patient experience survey between **Pacific** and **non-Māori non-Pacific** decreased from **5%** to **3%**

An additional **37** **falls** with fractured neck of femur were avoided, bringing our **total to 212 avoided** since 2015

384 disability-adjusted life years (DALYs) were avoided from falls prevention

Patient deterioration rapid responses **increased** to **50%** above baseline

Cardiopulmonary arrests continued to **decrease**

28 further infections following hip and knee surgery were avoided, bringing our total to 120 avoided to date

14 **further infections** following cardiac surgery were avoided, bringing our **total to 95 avoided** to date

108 DALYs were **saved** from postoperative infection prevention

Decreased readmissions (second admissions) for **older people** as a result of an emergency saved a total of **250,000** bed days by June 2021 (up from 98,000 between June 2014 and June 2019)

Highlights

Consumer voice

We received new funding this year to develop the consumer and whānau voice framework, which is a core part of the new health and disability system architecture. Embedding the voices of consumers, whānau and communities in health and disability system planning, evaluation, governance and delivery is critical to achieving a safe and high-quality system.

We completed all deliverables as part of this work.

Ngā pae hiranga | Pathways towards excellence:
We developed a 'hub' for consumer and whānau engagement; a place to share best practice, tools, training and information on consumer, whānau and community engagement. This hub serves as a resource for the health and disability sector.

Consumer health forum Aotearoa:
The consumer health forum Aotearoa promotes and advances the engagement of consumer and whānau voices in the health and disability system. It is an opportunity to link health and disability system entities to diverse consumer groups, at the right level, in the right way. Forum members help set the agenda, which is facilitated by the Commission, and are kept informed about developments and opportunities. Information gathered from the forum will help inform how consumer and whānau voices are built into the health and disability system. Two forums have been held so far, with more than 100 participants attending each. The forum has more than 800 members and is steadily growing.

Code of expectations for consumer and whānau engagement:
We developed a code of expectations to support consumer and whānau engagement in the health and disability sector and to enable consumer and whānau voices to be heard. Consultation on the draft code began in September 2021 and concluded on 31 March 2022. A key focus was engaging with Māori, Pacific peoples and people with disabilities. In total, we received 169 submissions, and the final code we presented to the Minister of Health for sign-off was informed by these multiple perspectives. (The code was tabled in Parliament on 9 August 2022 and officially launched on 25 August 2022.)[4]

The consumer health forum Aotearoa promotes and advances the engagement of consumer and whānau voices in the health and disability system.

[4] For more details on the code, see the webpage Te tikanga mō te mahi tahi a ngā hinonga hauora ki ngā kiritaki me ngā whānau | Code of expectations for health entities' engagement with consumers and whānau on our website at: hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/code-of-expectations-for-health-entities-engagement-with-consumers-and-whanau

COVID-19 real-time monitoring reports

A significant highlight for the year was the completion of eight snapshot real-time monitoring reports on current stressors on the health and disability sector during the Omicron outbreak. We reached out to different areas of the sector each week via our networks to gather intelligence from the workforce.

We also published a summary report of the eight real-time monitoring reports. This report summarised the key themes across all the previous reports and included a consumer/whānau perspective of the impacts of COVID-19 on health services. The report showed that both the health workforce and consumers and whānau experienced negative impacts, both directly and indirectly, from COVID-19, with similar and closely related issues reported across both groups.

We saw **concerns** related to **increasing inequity, staff wellbeing** (paralleled by consumer and whānau reports of increased community stress, anxiety and frustration) and quality raised across both groups**.**

Consumers and **whānau focused** more on the **basics of health care quality** in their response about what is needed in the future. They called for attention to be given to building **positive relationships, joining up communication** (communicating in a variety of accessible ways) and **creating flexible systems** that improve access to services.

In terms of system recovery, workforce groups indicated that workforce- and equity-focused recovery would be important in the short term. **Strategic approaches** to **workforce recovery** and to ensuring **partnerships with Māori, the involvement of Pacific peoples**, community and primary health care in future planning over the longer term, were seen as critical.

New and innovative ways of working were highlighted by **Māori** and **Pacific providers**, including engaging with communities to deliver services in new ways.

These learnings will support future planning of services.

The first point prevalence survey in Aotearoa New Zealand

In May 2022, we released the findings of the first national point prevalence survey (PPS) of healthcare-associated infections (HAIs) in Aotearoa New Zealand. The PPS provides useful insights into HAIs in public hospitals and will help identify quality improvement (QI) opportunities to achieve better health outcomes for patients.[5]

Nearly 6,000 patients were surveyed across 31 hospitals from all district health boards (DHBs). The national point prevalence of HAIs was 6.6 percent, and the HAI rate was 7.7 infections per 100 patients. We are undertaking further detailed analysis to capture equity and the financial costs of HAIs.

We will now work with the health and disability sector, seeking feedback on proposed surveillance or improvement projects that are developed based on findings from the survey.

National stocktake on the management of sepsis in Aotearoa New Zealand

In June 2022, the analytics, consulting and evaluation group Synergia completed a stocktake of sepsis management in Aotearoa New Zealand on behalf of our infection prevention and control (IPC) programme.[6] The stocktake explored the current clinical practices, guidance and protocols used in public hospitals, private surgical hospitals, ambulance services and a selection of emergency and urgent care clinics. It comprised a survey of 119 senior clinical staff and quality and risk managers, 10 interviews and a comparison of organisations' sepsis protocols and guidelines. All DHBs participated in the survey.

The report from this sepsis management stocktake highlighted the variation in the management and monitoring of sepsis and made recommendations for a coordinated national response to sepsis. We will engage with key stakeholders to determine next steps and identify QI opportunities to support the progression of the National Sepsis Action Plan.

Some other achievements from 2021/22

We **trained** more than **900 health and disability professionals** in our seminars, workshops and education and training courses.

We **updated** more than **200 online quality indicators** to help the health and disability sector understand where their quality strengths and challenges lie, and **we developed 'Quality Alerts'** to pinpoint areas of potential concern for the sector to follow up.

We **delivered** at least **20 reports** and **publications, 15 resource guides** and **33 newsletters** highlighting information and resources to help the health and disability sector improve.

[5] Health Quality & Safety Commission. 4 May 2022. *Inaugural point prevalence survey provides useful insights into healthcare-associated infections in public hospitals.* Wellington: Health Quality & Safety Commission. URL: hqsc.govt.nz/news/inaugural-point-prevalence-survey-provides-useful-insights-into-healthcare-associated-infections-in-public-hospitals-across-aotearoa-new-zealand

[6] Williamson F, Gasparini J, Patel D. 2022. *Stocktake of sepsis management in Aotearoa New Zealand.* Wellington: Synergia for Health Quality & Safety Commission. URL: hqsc.govt.nz/resources/resource-library/stocktake-of-sepsis-management-in-aotearoa-new-zealand

Improved service delivery

We worked with five hospitals from three DHBs to test the national paediatric early warning system. The system includes four age-banded paediatric vital signs charts to aid recognition of and response to deteriorating tamariki. These hospital paediatric project teams provided us with valuable insights on how the system operates within their individual environments. Their feedback informed the national implementation approach. We would like to thank the project teams for their significant work during the last year, particularly during COVID-19 restrictions, and for their commitment to this work.

We will begin working with the remaining hospitals across the country from October 2022 to implement the system. Once successfully implemented, this will ensure a common language is used and result in standardised recognition of and response to deteriorating tamariki in hospitals.

We will begin working with the remaining hospitals across the country from October 2022 to implement the system.

Independent review of the national mortality review function

We undertook an independent review of the national mortality review function to provide advice to the Minister of Health on whether the current mortality review structures are fit for purpose and delivering the most useful information in the most effective manner. Our review showed that the mortality review function is highly valued by stakeholders and that the data and advice that has been collected and is currently held, under legislative protection, is highly valued and needs to continue to be protected. Decisions regarding any future changes to the national mortality review function are currently being considered by the Commission. Over the coming financial year, we hope to implement and operationalise the findings of our independent review.

Experience Explorer

We published our Experience Explorer tool. The tool makes patient experience data transparently available to the public and is a step towards a health system centred around the patient and whānau. It allows users to access results from the Commission's national patient experience programme's adult hospital inpatient experience survey and adult primary health care patient experience survey. Experience Explorer is an improved version of our previous public reporting dashboard of results from the patient experience surveys. It presents feedback broken down by DHB, age, gender, ethnic group and disability status, which are important starting points to understand who is experiencing better and poorer quality of care.

Reporting on the health care experience of disabled people during COVID-19

We published our report *The health care experience of disabled people during COVID-19: Summary of findings from the COVID-19 patient experience survey.*[7] The report found the following:

- Disabled people were more likely than non-disabled to report they found barriers accessing care during the lockdown period. (Many disabled people chose not to try and get health care during the first lockdown, with one of the key reasons being not wanting to expose themselves to COVID-19 by being around other people.)
- Disabled respondents reported having worse experiences with their general practitioners and were more likely to say their individual and/or cultural needs were not met.
- Disabled people were more likely to have virtual appointments using telehealth. (While telehealth options flourished during the lockdown period, and some disabled people found it met their health care needs, others did not find this to be the case – telehealth is not the only solution.)

Publication included alternate accessible formats such as sign language. The report was used by some DHBs to guide changes.

[7] Health Quality & Safety Commission. 2021. *The health care experience of disabled people during COVID-19: Summary of findings from the COVID-19 patient experience survey*. Wellington: Health Quality & Safety Commission. URL: hqsc.govt.nz/resources/resource-library/the-health-care-experience-of-disabled-people-during-covid-19-summary-of-findings-from-the-covid-19-patient-experience-survey

Kia whakarite: Be prepared poster and social media campaign

By sharing the real stories of people from a range of demographics across the motu, the Kia whakarite: Be prepared campaign aims to help New Zealanders see that advance care planning is for everyone, not just those with a serious illness or receiving end-of-life care.

We worked with external organisations such as **Federated Farmers of New Zealand**, **Life Flight rescue helicopters** and the **Māori Women's Welfare League.**

We created an initial run of

1,500 poster packs

and distributed

1,145 of them to the sector through pre-orders, and these orders are continuing to grow.

The campaign has also had an excellent social media response, with a paid **Facebook campaign** impression high of

67,262

and an **organic Twitter** impression high of

1,522

This campaign will continue to build into the 2022/23 year.

Older Māori and aged residential care in Aotearoa report

On 2 December, we published new research, which was the first of its kind, to better understand, raise awareness of and start discussion about the quality of care for Māori in aged residential care (ARC).[8] In their report, co-authors Drs Joanna Hikaka and Ngaire Kerse, from the University of Auckland, described how fewer Māori than non-Māori enter ARC, there is a lack of kaupapa Māori aged care services and, for many, ARC is a second choice to staying at home and being cared for by whānau. The report has received nearly 600 views on our website since it was published.

A webinar was held with the authors on 5 May 2022 to discuss the findings with those working in the ARC sector, Māori health workers and social service providers. Approximately 250 participants joined the webinar.

The Perinatal and Maternal Mortality Review Committee

The Perinatal and Maternal Mortality Review Committee (the PMMRC), a statutory committee that reports to the Commission board, worked with the Ministry of Health to address a gap in national-level research-informed vaccine information by providing COVID-19 information to those who are pregnant or breastfeeding. The PMMRC also provided education and support to the previous DHBs and further developed digital functionality to ensure seamless and coordinated reporting of perinatal and maternal mortality.

[8] Hikaka J, Kerse N. 2021. *Older Māori and Aged Residential Care in Aotearoa | Ngā Kaumātua me te Mahi Tauwhiro i Aotearoa.* Wellington: Health Quality & Safety Commission. URL: hqsc.govt.nz/assets/Our-work/Improved-service-delivery/Aged-residential-care/Publications-resources/Older_Maori_and_ARC_report_Dec2021_final.pdf

We took our planned work forward

Table A summarises our progress against the deliverables we set. The deliverables we fully achieved are presented in the green. Those we made progress against but did not fully achieve are presented in purple. Table A shows that we fully achieved three of our seven deliverables and undertook work towards the other four, meeting most of the requirements that we set for ourselves.

Table A: SPE deliverable status

1	Partially achieved	5	Achieved
2	Partially achieved	6	Partially achieved
3	Partially achieved	7	Achieved
4	Achieved		

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

We focused on impacts and outcomes

As well as working to progress our planned work, we also had an eye on our impacts and outcomes and how we were progressing against them. All our work, alongside the work of others, contributes to outcomes, which feed up into and contribute to our vision, which in turn feeds up into and contributes to the government's goals for the health and disability sector and their wellbeing objective 'physical and mental wellbeing – supporting improved health outcomes for all New Zealanders'.[9] We see some promising early signals that suggest our work is on the right track to achieve our longer-term outcome goals.

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

Table B: Progress towards our strategic priorities and longer-term outcomes

Strategic priorities	**What outcomes we hope to see**[10] noted in the 2020/21 annual report	**What we achieved in 2020/21** noted in the 2020/21 annual report **Key achievements (bold)** *What we achieved prior (italics)*	**Future plans**[11] noted in the 2020/21 annual report	**What we achieved in 2021/22**
Improving experience for consumers and whānau	Improved patient and whānau experience as a result of improvements made by providers, which they were supported to make by learning from patient experience surveys (3–5 years)	*Between 2014 and 2019, 20% of questions asked in the hospital patient experience survey showed sustained improvements in reported experience.* In 2020, both inpatient and primary care surveys were refreshed. Since August 2020, baselines for a total of 31 new questions in the hospital survey and 49 new questions in the primary care survey were established. **New baseline established.**	Change from these baselines will be measured. It will take a minimum of two years to identify sustained change from a baseline, with the expectation that we start to see clear patterns of improvement from 2024 onwards.	Continued collection and monitoring of data and creation of a new tool, Experience Explorer. We will evaluate whether improvements have occurred in 2023/24.
	Patient and whānau measures and reporting across our programme areas (qualitative and quantitative) indicating improvement in engagement and experience (3–5 years)	A baseline was established for the consumer QSM. **Baselines established.**	Change from these baselines will be measured. It will take a minimum of two years to identify sustained change from a baseline, with the expectation that we start to see clear patterns of improvement from 2024 onwards.	Continued collection, monitoring and publication of data. We will evaluate whether improvements have occurred in 2023/24.

[9] For more detail on how outcomes contribute, please see Appendix 1: Our outcomes framework, clarified in our 2021/22 SPE.

[10] These outcomes were clarified in our 2021/22 SPE.

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

Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake	Improved Māori patient experience survey results (%) from baselines (3–5 years)	Baseline measures established for Māori respondents for the 31 and 49 questions in our two patient experience surveys. **Baselines established.**	Change from these baselines will be measured. It will take a minimum of two years to identify sustained change from a baseline, with the expectation that we start to see clear patterns of improvement from 2024 onwards.	Continued collection, monitoring and publication of data. We will evaluate whether improvements have occurred in 2023/24.
	Qualitative and quantitative measures and reporting across programme areas that show improved health equity for Māori (3–5 years)	*Reduction in inequity for surgical site infections following hip and knee replacements from a rate twice as high as non-Māori, non-Pacific to statistically identical between 2014 and 2016.*	Reporting by ethnicity on all QSM outcomes will continue. We expect to see maintenance of equity, where this exists, and achievement of equity in new programmes.	Continued collection of data and monitoring of outcomes. Results remain low and equitable.
	Improved Māori health outcome measures (5–10 years)	**Baselines established.**	Progress on all measures in the Māori health equity report will be tracked – and baselines for 2018/20 are available.	Continued collection, monitoring and publication of data.
Achieving health equity	Maintained or improved patient experience survey representativeness, particularly for groups experiencing health inequity (3–5 years)	A series of technical fixes, including provision of free data and coupling of text and email invitations, led to increased survey response rates. • **The Māori primary care survey response rate increased from 11% to 20% (equal with non-Māori, non-Pacific) between August 2020 and May 2021.** • **The Pacific primary care survey response rate increased from 9% to 15% between August 2020 and May 2021.**	Continued maintenance and improvement of Māori and Pacific survey response rates will be monitored.	Due to the challenges of the Omicron period, survey responses fell for all ethnic groups. However, Māori response rates remained identical to those for non-Māori, non-Pacific (16% for both groups), and the gap between Pacific and non-Māori, non-Pacific fell from 5% to 3%.
	Reductions in unwarranted health care variation measures across population groups (3–5 years)	All Atlas measures are broken down by ethnicity, of which there are well over 100. *There are numerous examples of significant increases in equity, including asthma-inhaled corticosteroid dispensing, gout hospital admissions, non-steroidal anti-inflammatory drug use with no urate-lowering therapy and maternity low birth-rate babies. However, interpretation is complex because many factors contribute to unwarranted variation.*	We will continue to monitor all Atlas measures.	Continued collection of data. The direct effects of the COVID-19 period on access to health care are substantial, so no further publication of 2020 data has been undertaken.
	Greater health equity in our system and programme measures (3–5 years)	*Reduction in inequity for surgical site infections following hip and knee replacements from a rate twice as high as non-Māori, non-Pacific to statistically identical between 2014 and 2016, and the reduction has been maintained.*	Reporting by ethnicity on all QSM outcomes will monitor maintenance of equity, where this exists, and achievement of equity in new programmes.	Continued collection of data and monitoring of outcomes. Results remain low and equitable.

Strengthening systems for high-quality services	Reduced mortality over time in mortality review cohort groups (long term, intergenerational)	*There was a steep reduction in child and youth deaths between 2011 and 2014 – equivalent to around 100 deaths per year.*	Key group mortality rates will continue to be monitored, with a specific focus on deaths likely to be preventable.	
	Improved quality and safety measures within our programme areas (2–5 years or longer)	*Since their inception, the following improvements in outcomes and processes associated with the Commission's quality and safety programmes have been identified:* • *Falls – 25% reduction in falls with a fractured neck of femur, equating to 175 avoided fractured necks of femur.* • *The patient deterioration programme has resulted in a 40% increase in rapid response team escalations and a statistically significant decrease in hospital cardiopulmonary arrests, avoiding around 200 to date.* • *Safe surgery – 673 post-operative DVTs/PEs avoided.* • *IPC – 17% reduction in post-operative infections for hips and knees, equating to 92 avoided infections; 18% reduction in post-operative infections for cardiac surgery, equating to 81 avoided infections.* • *The Commission supported 18 improvement projects in primary care, and 14 of 18 showed measurable improvement.*	For all past, continuing and future quality improvement programmes, we will measure key outcomes to quantify avoided harms.	In the period to March 2022, we achieved the following results. • A further 37 falls with fractured neck of femur were avoided, making 212 since 2015. • Patient deterioration rapid response team escalations further increased to around 50% above baseline, while the decrease in in-hospital cardiopulmonary arrests is now around 240; an additional 28 infections following hip and knee surgery were avoided, so the total avoided infections stands at 120; for cardiac surgery, there are now 95 avoided infections.
	Reduced number of DALYs lost due to complications and poor outcomes within our programme areas (2–5 years)	*Based on published estimates of the DALYs lost associated with specific health care-related harms, we can estimate the following DALYs avoided to date:* • *Falls – 175 fractured necks of femur avoided = 287 DALYs avoided.* • *Safe surgery – 673 post-operative DVT/PEs avoided = 397 DALYs avoided.* • *IPC –173 post-operative infections avoided = 87 DALYs avoided.*	For all past, continuing and future quality improvement programmes, we will measure key outcomes to quantify avoided harms and seek estimated DALY losses associated with these.	Updated DALY estimates now stand at: • falls – 348 DALYs avoided • post-operative infections – 108 DALYs avoided.
	Reduced bed-days within our programme areas (2–5 years or longer)	*Re-admission (second admission) of older people as a result of an emergency reduced, resulting in 98,000 fewer bed-days between June 2014 and June 2019.*[12]	Historically, we have focused on bed-days, but we now have measures and indicators that are more useful (such as DALYs and direct measures of harm and/or cost). However, we will continue to measure bed-days when these are relevant.	At June 2021, reduction in bed-days associated with re-admission (second admission) of older people as a result of an emergency stood at 250,000 bed-days.

DALY = disability-adjusted life year; DVT = deep vein thrombosis; IPC = infection prevention and control; PE = pulmonary embolism; QSM = quality and safety marker.

[12] Health Quality & Safety Commission. 2021. *Open4Results – June 2019*. Wellington: Health Quality & Safety Commission. URL: hqsc.govt.nz/resources/resource-library/open4results-june-2019/

How this report is organised

Te raupapa o te pūrongo nei

In the Commission's 2021/22 SPE, we describe deliverables through a single output class: supporting and facilitating improvement. This output class covers our functions of:

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

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

Part 1: Our performance statement | Wāhanga 1: Tā mātou mahi
covers the standards of delivery performance we achieved compared with the forecast standards in our 2021/22 SPE.

Part 2: Other work that strengthens our performance | Wāhanga 2: He mahi anō hei whakakaha i tā mātou mahi
covers broader organisation performance information, showing how we strengthen and develop our organisation's performance, as well as the work that we do beyond our SPE.

Part 3: Our financial statements | Wāhanga 3: Pūrongo pūtea
cover the actual revenue we earned over the 2021/22 year and output expenses incurred, compared with the expected revenues and proposed output expenses included in our SPE.

Part 4: Statement of responsibility | Wāhanga 4: He kupu haepapa
completes our annual report.

The final part of this annual report comprises Audit New Zealand's audit report on our work.

Part 1: Our performance statement

Wāhanga 1: Tā mātou mahi

This part of our annual report details our performance against the work and deliverables we planned in our SPE.

We report on each of our seven planned deliverables in seven tables, respectively. The table row labelled 'Plan' shows the work that we agreed to deliver in our 2021/22 SPE. The row labelled 'Report', identifies how we progressed with delivering to our plan. We also use a simple colour coding system to readily identify our performance. All of our deliverables align to more than one of our strategic priorities, with most aligning to all four.

Strategic priorities	SPE deliverable						
	1	2	3	4	5	6	7
Improving the health services experience for consumers and whānau	✓	✓	✓	✓	✓	✓	✓
Embedding and enacting Te Tiriti o Waitangi, supporting mana motuhake	✓		✓	✓	✓		✓
Achieving health equity	✓	✓	✓	✓	✓	✓	✓
Strengthening systems for high-quality services	✓	✓	✓	✓	✓	✓	✓

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

Work plan and report table 1: Undertake patient experience surveys (primary health care, inpatient) and analyse and publish results (SPE 1)

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

1	Deliverable	Timeliness	Quantity	Quality	Impact
Plan	Undertake patient experience surveys (primary health care, inpatient) and analyse and publish results.	Update patient experience portals four times by 30 June 2022.	Analyse and report survey results across at least four different cohort groups (all, Māori, Pacific peoples, disabled people).	Facilitate a patient experience survey governance group meeting at least three times a year to provide governance and oversight and to monitor patterns of response and advise on actions to increase representativeness, as required.	Provide evidence, from DHB annual plans, that 100% of DHBs are drawing on the patient experience survey results to improve quality.
Report	The survey continues to grow, with the number of general practices participating in the primary health care patient experience survey increasing. In May 2022, a total of 959 practice facilities participated; this is an increase from 880 in August 2020. The survey programme invites patients to provide feedback four times a year, and –over the 2021/22 year – feedback was received from more than 130,000 respondents across both the primary health care and hospital inpatient experience surveys. Patient experience survey data is provided to participating health providers (DHBs, primary health organisations and general practices) through a secure online portal. Each quarter, survey data is uploaded to this portal following completion of fieldwork and data quality checks.	In 2021/22, primary health care patient experience survey data was published on 7 July 2021, 13 September 2021, 20 January 2022 and 30 March 2022, and hospital inpatient experience survey data was published on 30 September 2021, 12 January 2022, 14 April 2022 and 16 June 2022.	Survey results are viewable on the portal by different cohort groups, including national (all Aotearoa New Zealand), Māori, Pacific peoples and disabled people.	The governance group met twice this financial year. A governance group meeting was scheduled for 14 February 2022. However, the COVID-19 resurgence created time pressures on group members, so the group agreed to be updated by email rather than meet in person.	Regional-/district-level annual plans for 2022/23 are not being updated due to the health system transition. However, all regions/districts are contining to survey both inpatient and primary health care providers. DHBs had to include actions on the patient experience survey in their system-level measures plans for 2021/22.
Result	This component is ***fully achieved***	This component is ***fully achieved***	This component is ***fully achieved***	This component is ***partially achieved***	This component is ***partially achieved***

Our work plan for deliverable 1 was ***partially achieved***, as the increasing demands of COVID-19 on the health workforce meant that it was not possible to hold a third governance group meeting. Additionally, the health system reforms meant that district and regional annual plans were not updated, as the system was about to change. However, all other components of this measure were met in the set time frames, with patient experience surveys published over the course of the financial year.

Work plan and report table 2: Pilot the te ao Māori improvement framework and implementation guide (SPE 2)

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

2	Deliverable	Timeliness	Quantity	Quality	Impact
Plan	Pilot te ao Māori improvement framework and implementation guide.	The pilot will be completed by 1 January 2022.	At least three mainstream providers will be involved in the pilot to inform the approach to be used in the next phase.	An advisory group of Māori providers, experts and leaders, including Ministry of Health staff, working to implement Whakamaua: Māori Health Action Plan will review pilot feedback and recommend changes to be made, if required, by 30 May 2022.	Surveys of (1) pilot participants and (2) advisory group members undertaken by 30 June 2022 will show that 70% agree that the framework will effectively support Whakamaua. Once implemented, the framework will positively influence the experience of Māori whānau in health services and lead to improved health outcomes for Māori.
Report	We piloted a te ao Māori improvement framework and implementation guide in the 2021/22 year. The next phase of this piece of work will be reported against in next year's annual report.	Although this timeframe was not met, all activities were successfully completed by the end of the financial year.	We engaged three mainstream health service providers to pilot the framework: Mary Potter Hospice (the Hospice), Wellington; Turanga Health, Gisborne; and Te Whare Maire, Wairoa Hawke's Bay. Each provider completed the pilot process and provided useful feedback.	In May 2022, two expert advisory groups and members of the Māori directorate at the Ministry of Health participated in a wānanga. Each group was provided with a presentation of the framework and its implementation plan. Feedback from both advisory groups confirmed that the framework was easy to understand and the four central principles that were included in the framework made sense. The groups also stated that it was good to see how these pathways would contribute towards achieving equity.	Feedback was gathered through wānanga. While the te ao Māori framework is included as a key deliverable in Whakamaua, overall, Ministry of Health staff said development of the framework was in line with what they have developed, and they could see how its implementation would work towards achieving the outcomes of Whakamaua.
Result	This component is ***fully achieved***	This component is ***partially achieved***	This component is ***fully achieved***	This component is ***fully achieved***	This component is ***fully achieved***

Our work plan for deliverable 2 was ***partially achieved***, as COVID-19 events made it impossible to meet the initial timeframe of pilot competition by 1 January 2022, with providers kept busy responding to the pandemic and delivering care within the constraints of significant COVID-19 restrictions. However, all activities were successfully completed by the end of the financial year.

Ahuahu Kaunuku (our Māori health outcomes team) describes the work done for this measure.

We engaged three health service providers to pilot the framework: Mary Potter Hospice (the Hospice), Wellington; Turanga Health, Gisborne; and Te Whare Maire, Wairoa, Hawke's Bay. Each provider completed the pilot process and provided useful feedback.

The Hospice's feedback demonstrated the usefulness and simplicity of the framework, which made it 'easy' to implement. Of all the principles in the framework, wairuatanga (spirituality) was the one concept consistently considered and achieved in the delivery of Mauri Mate, the Māori palliative care framework, developed for the hospices of Aotearoa.

Turanga Health's feedback focused heavily on the challenges of the framework as a primary health organisation working from a kaupapa Māori basis and the framework's relevance to their service delivery. Turanga Health felt the framework does not consider organisations that may be at different levels of implementing te ao Māori across their service delivery arm. They also claimed that whānau should be informing service design.

The Partners in Care team used the framework in developing their co-design project, and the system safety and capability team implemented the framework across their Improvers programme curriculum and Human factors and ergonomics storyboard design.

Te Whare Maire is an organisation delivering health and wellbeing services using the Whānau Ora approach. Their feedback echoed that of the Hospice in that it was positive, and they conveyed that the framework and the implementation plan were clearly written and useable. They also suggested that the changes in their rohe needed to occur at the governance level. They stated that they had experienced no challenges or issues with the framework or its implementation plan, they thought it would not be difficult for the DHB to implement in their rohe and they raised a concern that the framework would likely not be implemented or even acknowledged by the audiences that need it the most.

Several teams across the Commission also implemented the framework within their programmes of work. The Partners in Care team used the framework in developing their co-design project, and the system safety and capability team implemented the framework across their Improvers programme curriculum and Human factors and ergonomics storyboard design.

In May 2022, Ahuahu Kaunuku completed wānanga with two expert advisory groups. We also presented and held a wānanga with members of the Māori directorate of the Ministry of Health. Each group received a presentation of the framework and its implementation plan. Feedback from both advisory groups confirmed that the framework was easy to understand and that the four central principles included in the framework made sense. The groups also stated that it was good to see how these pathways would contribute towards achieving equity.

While the te ao Māori framework is included as a key deliverable in Whakamaua, overall, Ministry of Health staff said development of the framework was in line with what they have developed, and they could see how its implementation would work towards achieving the outcomes of Whakamaua. Information and feedback collected from the pilot process was provided to each rōpū for consideration and comment. Feedback from the pilot and the advisory groups was used to inform and improve the framework's implementation plan.

An external expert advisor and an expert from the Ministry of Health reviewed the implementation plan and pilot. We considered their feedback and, where their comments added value, made changes to the plan.

The framework has not yet been implemented across the country as the pilot process was only recently completed and not all necessary updates to the plan have been undertaken. A communications plan is currently underway with the support of the Commission's communications team. Ahuahu Kaunuku is in the process of developing a socialisation and national implementation package to occur in the next financial year. This has been written into the 2022/23 SPE and is a deliverable that will be reported against in the next annual report.

Work plan and report table 3: Quality Forum and Quality Alerts (SPE 3)

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

3	Deliverable	Timeliness/ Quantity	Quality	Impact
Plan	Quality Forum and Quality Alerts	Four updated Quality Alerts will be delivered by 30 June 2022. Four Quality Forums will be facilitated by 30 June 2022.	Feedback will be sought from DHBs after each Quality Alert and changes needed will be made twice in the year. Quality Forums will be attended by representatives from the Ministry of Health, Accident Compensation Corporation (ACC), DHBs, Health and Disability Commissioner (HDC) and other appropriate stakeholders. Information will be shared between participants to assist understanding of quality concerns in the health system and to inform Quality Alerts. Feedback will be sought after each Quality Forum and the method adjusted in response.	A qualitative evaluation of the Quality Alert and Quality Forum will assess effectiveness by May 2022. • Quality Alerts: The evaluation will show that these are useful for improving knowledge and are likely to support improvement. • Quality Forums: The evaluation will show that forums have improved information sharing, learning and understanding of quality concerns and are likely to become a coordination point for appropriate intervention. Evaluation will show that the Commission has responded to feedback provided since 1 July 2021.
Report	Quality Forums were held, and Quality Alerts were sent out to the health and disability sector over the financial year. These were key mechanisms to enable us to monitor and analyse the quality and safety of health services during a period of significant change in the health system.	Quality Forums were held on 20 July 2021, 30 September 2021, 26 January 2022 and 26 April 2022. Quality Alerts were sent out on 15 October 2021, 17 December 2021, 30 March 2022 and 30 June 2022.	DHBs sent feedback to us following each Quality Alert, and this was used to make changes or improve. Quality Forums were attended by representatives from the various agencies. Members attended from the Ministry of Health, ACC, HDC, primary health care services, DHBs, Consumer Council and the Commission – attendance was mostly maintained despite the pandemic response. During the year, membership was extended to include Te Tumu Whakarae of both the Health and Disability Review Transition Unit and the interim Health New Zealand. DHBs can view Quality Alerts for other DHBs through the front page of the Quality Alerts platform. A collaborative approach was taken, with agencies contributing to agenda setting and prioritisation. We sought feedback formally via an online survey and interviews with participating agencies to inform the evaluation. An anonymous online survey was administered using SurveyMonkey following meetings in November 2021 (for the July and September forums) and January 2022 (for the January forum). Face-to-face interviews were held in March 2022 as part of the evaluation. No feedback was sought after the last forum on 26 April 2022: it was too soon after the face-to-face evaluation meetings, we did not want to overload participants in the middle of a COVID surge and sufficient content was gathered in March.	The evaluation was completed in May 2022, meeting expectations. The evaluation confirmed that the Quality Forum improved information sharing and understanding and is likely to become a coordination point in the future. We sought feedback from and collaborated with participating agencies on the development and ongoing improvement of the Quality Forum. We completed the evaluation interviews of the Quality Alerts before 30 May. These evaluations had mixed feedback, but general messages were that the evaluations had a positive impact. The evaluations showed that the Commission has responded to feedback provided since 1 July 2021.
Result	This component is ***fully achieved***	This component is ***fully achieved***	This component is ***partially achieved***	This component is ***partially achieved***

Our work plan for deliverable 3 was ***partially achieved.*** COVID-19 meant we were cognisant of the time constraints of attendees and did not want to overload them with unnecessary meetings for which we already had content. However, Quality Alerts and Quality Forums were completed four times by the end of the financial year.

Work plan and report table 4: Mortality review (SPE 4)

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

4	Deliverable	Timeliness/ Quantity	Quality	Impact
Plan	Mortality review	Two mortality review committees will publish at least one report each by 30 June 2022.	The mortality review committees will consult with key internal and external stakeholders on their reports and recommendations. Two external subject matter experts will review all published reports and provide feedback to the committees and secretariat in writing. Reviewers will agree that recommendations, if implemented, are likely to impact on mortality and morbidity.	The committees will report on the progress of their recommendations every 6 months, using the Mortality Review Committee[13] monitoring tool. Monitoring will show evidence of follow-up and details of the implementation of recommendations.
Report	The Family Violence Death Review Committee (FVDRC) seventh report, *A duty to care*,[14] called on government agencies to fulfil their relational obligations to care for those experiencing family violence. Before the report's release, the chair of the committee, Dr Fiona Cram, presented the report to the Ministers of the Joint Venture for the Prevention of Family and Sexual Violence. The Ministers, representing 10 government agencies, actively engaged with the contents of the report. Hon Marama Davidson, Minister for the Prevention of Family and Sexual Violence, highlighted how the report supported the direction of Te Aorerekura: National Strategy to Eliminate Family Violence and Sexual Violence[15] and challenged public servants to go further in their service to the community in the area of protecting those experiencing family and sexual violence. The Child and Youth Mortality Review Committee (CYMRC) delivered its 15th data report and infographic, highlighting the higher rate of mortality among Māori and Pacific pēpi, tamariki and rangatahi compared with babies, children and young people in other ethnic groups and the urgent need to do more to reduce child and youth mortality. Alongside the Commission, the CYMRC has also supported the transition of the previous DHBs assuming the responsibility for funding and supporting local child and youth mortality review coordinators and delivering local mortality reviews as a local child and youth QI initiative.	The CYMRC 15th data report was published in quarter 1 (22 September 2021), and the FVDRC seventh report was published in quarter 4 (7 June 2022).	Internal (within the Commission) and external stakeholders were consulted in the process of developing these reports and recommendations. Subject matter experts reviewed the reports and provided feedback to both the committees and the secretariat in writing.	We are progressing work on monitoring progress on recommendations to see if and how the recommendations have been implemented.
Result	This component is ***fully achieved***	This component is ***fully achieved***	This component is ***fully achieved***	This component is ***fully achieved***

[13] Please note that, under the Impact column in the published SPE for 2021/22, it states it is the 'Medical Research Council monitoring tool'. This was an error and should read 'Mortality review committees monitoring tool'.

[14] Health Quality & Safety Commission. 2022. *Seventh report: A duty to care | Pūrongo tuawhitu: Me manaaki te tangata.* Wellington: Health Quality & Safety Commission. URL: hqsc.govt.nz/assets/Our-work/Mortality-review-committee/FVDRC/Publications-resources/Seventh-report-transcripts/FVDRC-seventh-report-web.pdf

[15] For more details on this strategy, see the webpage Te Aorerekura: National Strategy to Eliminate Family Violence and Sexual Violence on the Ministry of Health website at: health.govt.nz/our-work/preventative-health-wellness/family-violence-and-sexual-violence/te-aorerekura-national-strategy-eliminate-family-violence-and-sexual-violence

Work plan and report table 5: Analyse and report on the impacts of COVID-19 on the quality of health and disability services (SPE 5)

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

5	Deliverable	Timeliness	Quantity	Quality	Impact
Plan	Analyse and report on the impacts of COVID-19 on the quality of health and disability services.	The analysis and report will be completed and the report published by 31 December 2021.	The report will include analysis of indicators of access, availability, quality and experience of care, together with early outcomes where these are available, with appropriate sub-population analysis used to explore effect on equity.	Experts from relevant population groups will be engaged to provide oversight and advice for developing the report.	Providers will be surveyed by 30 March 2022. At least 70% of those who respond to the survey, and have read the report, will agree that the report provided useful intelligence regarding the impact of COVID-19 on the quality of health and disability services.
Report	We analysed and reported on the impacts of our response to COVID-19 on selected aspects of the functioning of the country's health and disability system so we can learn from that experience and shape resilient system responses in the future. A second part of this 'Window on quality', which will be reported on in the next annual report, will explore other critical aspects not already covered, as data emerges from the health and disability system, revealing the effects of the Delta outbreak of COVID-19 on other services.	The report *A Window On Quality 2021: COVID-19 and impacts on our broader health system – Part 1 | He tirohanga kounga 2021: me ngā pānga ki te pūnaha hauora whānui – Wāhanga 1 March 2020 to August 2021* was published on the Commission's website on 20 December 2021.[16]	The report includes analysis of the various indicators. Quality encompasses access, experience and outcome (as per the Institute of Medicine's six domains of quality). Sub-population analysis, particularly for Māori and Pacific peoples, is included throughout the report to explore effect on equity.	A range of experts were engaged with through the development of this report.	Providers were surveyed, and 100% of those who responded indicated that the report provided useful intelligence regarding the impact of COVID-19 on the quality of health and disability services. We note that the response rate was low due to COVID-19.
Result	This component is ***fully achieved***	This component is ***fully achieved***	This component is ***fully achieved***	This component is ***fully achieved***	This component is ***fully achieved***

[16] For more information, see www.hqsc.govt.nz/resources/resource-library/a-window-on-quality-2021-covid-19-and-impacts-on-our-broader-health-system-part-1-he-tirohanga-kounga-2021-me-nga-panga-ki-te-punaha-hauora-whanui-wahanga-1

Work plan and report table 6: Quality improvement science capability building in the health and disability sector (SPE 6)

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

6	Deliverable	Timeliness	Quantity	Quality	Impact
Plan	Quality improvement science capability building in the health and disability sector.	Define and develop curriculum content for two courses (Frontline QI and expert/advisor QI) that will meet the quality improvement needs of staff, in partnership with Māori, by 1 January 2022. Deliver the Frontline QI course by 30 June 2022. Deliver the expert/advisor QI course by 30 June 2022.	Frontline staff (60) will attend the frontline staff QI training. Health sector staff (25) will attend the expert/advisor QI training.	Advice will be sought from independent experts in QI science on the QI needs of staff in services to inform curriculum development. They will agree that the course curriculum meets the needs of staff. High levels of interest and course enrolments will show that the courses are of interest and relevant to staff in services.	Surveys and interviews of participants will show that • 70% have increased knowledge of improvement science • 70% feel that they will be able to apply the knowledge in their work.
Report	Despite the many challenges the health and disability system faced over the last year, we are proud that we assisted with QI science capability building in the health and disability sector.	**We defined and developed curriculum content for the following courses.** • *Frontline QI courses:* Improving together: Improvers primary health care; Improving together: Improvers mental health and addictions; Improving together: Improvers general. • *Expert/advisor QI course:* Improving together: Advisors. • Te Tihi (an alliance of nine iwi, hapū and Māori organisations who work collectively to deliver whānau-centred services based on the Te Ara Whānau Ora process) were actively involved in developing course content for the Improving together: Improvers primary health care course. • Quality and risk systems manager Hauora Tairāwhiti was contracted to provide a te ao Māori world view for the Improving together: Advisors curriculum. • A QI expert was contracted for their education and QI expertise to support the development of the Improving together: Advisors programme. *Improving together: Improvers programmes:* Improvers primary care: 6 September 2021–16 December 2021; Improvers mental health and addictions: 22 February 2022–7 June 2022; Improvers general: 8 March 2022–28 June 2022. Expert/advisor QI course: The original dates for the programme were 23 August 2021–12 May 2022. These dates were changed in response to the escalating COVID-19 demands on participants. The updated dates were 11 August 2021–13 July 2022.	Frontline QI courses A total of 67 attendees have completed all course requirements across the three courses. Expert/advisor QI course: 23 participants have completed this course.	The Commission engaged an Improving together: Frontline improvers advisory group (FLAG) in 2021. The FLAG comprised health care providers, consumers and representatives from stakeholder organisations. The aim of FLAG was to advise on the development of the core curriculum for use in a range of health care settings and adapt this curriculum for use in the wider primary health care sector. The development of the curriculum followed an iterative, consensus-based approach. Feedback and suggestions regarding the current version of the curriculum were gathered as part of the regular FLAG meetings, with a regular agenda item, and amendments were made as required. Actions for the group specifically included reviewing the current curriculum on Teams. Extensive feedback was also collated offline. Individual feedback was also provided.	For Frontline QI courses, 98% of participants had increased their knowledge of QI science, and 74% felt confident to apply the knowledge they had gained to their work. For the three Frontline QI courses, the number of participants who completed the pre-course assessment was 101. Of the 101 participants, 73 were eligible for the post-survey assessment. Ultimately, 67 participants successfully completed the course, with an overall response rate of 68%. These participants were surveyed using SurveyMonkey. Advisors: 100% reported increased QI knowledge and skills, and 95% felt confident to apply the knowledge they had gained to their work. For the Expert/Advisor QI course, 27 participants completed the pre-course assessment. In total, 23 students completed the course, all of whom completed the post-course assessment. These participants were sent an Excel spreadsheet to complete and return.
Result	This component is ***fully achieved***	This component is ***partially achieved***	This component is ***partially achieved***	This component is ***fully achieved***	This component is ***fully achieved***

All programmes were successfully delivered. Our work plan for deliverable 6 was ***partially achieved,*** as the impact of COVID-19 increasing demands on the health workforce resulted in lower than initially planned numbers of participants and delays in course completion. However, the team worked to ensure that all other aspects of this deliverable were successfully met.

Work plan and report table 7: Quality improvement programmes

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

7	Deliverable	Timeliness/ Quantity	Quality	Impact
Plan	Quality improvement programmes	At least two quality improvement planned intervention responses[17] / programmes will be progressed by 30 June 2022, in partnership with influencers.	Quality improvement intervention responses/programmes will all have a measurement plan to measure and monitor change, using quality improvement science approaches. Each planned response and measurement plan will be reviewed by relevant experts.	Influencers will be surveyed by 30 June 2022 and • 70% will indicate increased knowledge of quality improvement science within the area of focus and • 70% will indicate that they consider the intervention likely to lead to improvement.
Report	QI programmes were carried out over the last year.	**Programme 1:** Optimising the use of antibiotics for urinary tract infections in ARC. This programme was carried out over late 2020 to 2022. **Programme 2:** The national rehabilitation major trauma collaborative was undertaken between March 2021 and June 2022. Eleven teams from across New Zealand participated in this collaborative.	**Programme 1:** A measurement plan with an extensive list of measures was created by each group. The measurement plans were reviewed by the ARC leadership group, the ARC quality leads group and the urinary tract infection steering group and project team, including project leads from the ARC sector. **Programme 2:** The Institute for Healthcare Improvement Breakthrough Series Collaborative model was the QI methodology used. Using the QI methodology and co-design, all teams developed robust quantitative and qualitative data collection plans to understand the key issues within their services. Project teams gathered data using a range of methods, including clinical documentation audits and patient experience surveys to measure change in their systems. Experts from the Commission's QI team reviewed their measurements. The collaborative project was supported by an expert advisory group of 17 people, including four consumers and experts from across the trauma, rehabilitation and research sectors.	**Programme 1:** Staff surveyed influencers from 7 to 28 April 2022 who worked on the project aimed to improve optimising the use of antibiotics for urinary tract infections in ARC. There was a total of 12 responses (representing individuals and teams) to the survey across the ARC pilot facilities. 100% of the respondents either 'agreed' or 'strongly agreed' that this initiative increased their knowledge in QI science. 100% of respondents either agreed or strongly agreed that the interventions tested have resulted in improvements in their facilities. **Programme 2:** The survey was sent out on 7 July 2022: 100% indicated increased knowledge of QI science within their area of focus, and 90% indicated they considered the intervention likely to lead to improvement.
Result	This component is ***fully achieved***	This component is ***fully achieved***	This component is ***fully achieved***	This component is ***fully achieved***

[17] Responses are interventions that are appropriate for addressing the particular quality concern raised. These may be a mix of multi-year, multi-intervention programmes; smaller projects; or individual, focused interventions. Each intervention will be designed to address the quality challenge within the context that requires improvement.

Part 2: Other work that strengthens our performance

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

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

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

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

Governance – our board

We are governed by a board of 10 members who are appointed by the Minister of Health and led by Dr Dale Bramley. The most up-to-date information about our board can be found on our website.[18]

The board is supported in its governance decision-making by some key advisory groups. These are described in more detail below.

Te Rōpū, Māori advisory group

Te Rōpū, as an active Māori strategic partner, advises our board and chief executive on strategic issues and priorities and provides operational advice where required. This advice helps us identify, and provides direction around, key quality and safety issues for Māori consumers and their whānau, hapū and iwi Māori.

Te Rōpū consists of Māori health sector leaders who are networked, known, respected and knowledgeable about issues and priorities for whānau, hapū and iwi Māori to advance Māori health and to challenge the system to achieve health equity. They proactively identify where and when a Māori world view or approach can be used in the design and implementation of QI initiatives.

We would like to pay particular tribute to outgoing Te Rōpū members Dr Sue Crengle, Dr Denise Wilson and Hingatu Thompson. These members have provided invaluable service, insight and direction over the many years they have been involved. Ngā mihi nui ki a koutou mō ō koutou mahi.

We also welcome four new members to Te Rōpū: Dr Matire Harwood, Bernadette Jones, Chas McCarthy and Denis Grennell. We look forward to working with our new members. Nau mai haere mai ki tā tātou mahi.

Consumer advisory group

Our board established the consumer advisory group to advise from a consumer and whānau perspective and provide a consumer view on health quality and safety. The consumer advisory group has eight members, representing a range of communities, including Māori, Pacific peoples, disability, and mental health and addictions. Our website includes the most recent information on membership of this group.[19]

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

Audit committee

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

In 2021/22, the audit committee work programme largely focused on reviewing risks arising from data management and use, along with active involvement and input into our measurement of non-financial performance reporting.

[18] See the webpage Ngā kanohi o te Poari | Board members on our website at: hqsc.govt.nz/about-us/our-people/board-members

[19] See the webpage Te kāhui mahi ngātahi | Our consumer advisory group on our website at: hqsc.govt.nz/consumer-hub/partners-in-care/our-consumer-advisory-group

Monitoring and reporting

In 2021/22, we continued providing regular briefings on our work and quality issues and quarterly update reports on performance against our SPE to the Minister with delegated responsibility for the Commission. We kept the Minister and Ministry of Health informed of any potentially contentious events or issues in a timely manner.

Over the year to 30 June 2022, we provided the Minister of Health and Ministry of Health with information to allow monitoring of our performance, including the following.:

Quarterly statements of financial performance, financial position and contingent liabilities

Quarterly reports on progress against our performance measures

Quarterly reports on emerging quality and safety risks as part of the no surprises expectation

An annual report in accordance with the Crown Entities Act 2004 and Public Finance Act 1989[20]

Strengthening and developing our organisation

In 2021/22, we continued our important work to strengthen our organisation so that we can more effectively facilitate and contribute to 'quality health for all'.

Embedding Te Tiriti o Waitangi in everything we do

We continued our work to embed Te Tiriti in all that we do, further building on our Statement of Intent (SOI) commitment to embed 'Te Tiriti o Waitangi strongly in our strategy and SOI, supporting mana motuhake and making te ao Māori perspectives and world views central to our work'.[21]

Over this period, we continued to strengthen and grow our Māori health outcomes team, Ahuahu Kaunuku. This team supports our organisation by providing Te Tiriti leadership, expertise and advice on key pieces of work, with a specific focus on:

- ensuring quality and safety improvement for whānau Māori
- developing partnerships with iwi, hapū and Māori communities and organisations to support improvement initiatives
- influencing and supporting other teams by providing a Māori world view and mātauranga Māori to strengthen teams' programmes of work to influence systems design and practices.

We confirmed a work programme, Te Whāinga Amorangi, to support our contribution (as a Crown entity) to embody the government's good-faith and collaborative approach to Māori–Crown relationships by building the staff and organisational capability.

This was supported by our internal champions group (Te Tira Whakarite), who focus on the implementation of our Te Whāinga Amorangi plan. Additionally, Te Tira Whakarite continued to actively support a culture of collegiality in discussing the challenges, opportunities and solutions for enacting Te Tiriti articles across all our work and what that means in practice.

Ahuahu Kaunuku also coordinates ongoing capability building in te reo, waiata and tikanga Māori for all our staff. We recently developed our own karakia to be used at the opening and closing of hui.

In developing our organisation's code of expectations for consumer and whānau engagement in the health sector, Ahuahu Kaunuku consulted with Māori, whānau, hapū and marae to privilege whānau voice through a series of wānanga to better understand the experience of Māori in engaging with health and disability services. This resulted in the development of case studies and kōrero to support the code's implementation.

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[20] Section 50D(3b) of the New Zealand Public Health and Disability Act 2000 requires the Commission to, at least yearly, report to the Minister of Health on the progress of mortality review committees. We must also include each report in our next year's annual report, which provides our report against our SPE. To this end, we publish the reports of the PMMRC and the Perioperative Mortality Review Committee (POMRC), see:

- PMMRC. 2021. *Fourteenth Annual Report of the Perinatal and Maternal Mortality Review Committee | Te Pūrongo ā-Tau Tekau mā Whā o te Komiti Arotake Mate Pēpi, Mate Whaea Hoki: Reporting mortality and morbidity 2018 | Te tuku pūrongo mō te mate me te whakamate 2018.* Wellington: Health Quality & Safety Commission. URL: hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/4210
- POMRC. 2021. *Equity in outcomes following major trauma among hospitalised patients: Ninth report of the Perioperative Mortality Review Committee.* Wellington: Health Quality & Safety Commission. URL: hqsc.govt.nz/our-programmes/mrc/pomrc/publications-and-resources/publication/4274

[21] Health Quality & Safety Commission. 2020. *Tauākī Koronga: Statement of Intent 2020–24.* Wellington: Health Quality & Safety Commission, page 13. URL: hqsc.govt.nz/assets/Core-pages/HQSC-general-resources/StatementOfIntent2020-24.pdf

Partnering and engaging

As a partnership-focused organisation, we collaborate with and support others to work towards quality health for all. This means working across the health and disability system with our partners and stakeholders, including iwi, hapū, whānau Māori, Pacific peoples, clinicians, government agencies, academics, non-governmental organisations, the health and disability sector workforce and professional health bodies. In 2021/22, we continued to build partnerships and work with others to influence improvement.

Environmental sustainability

In December 2020, the government announced a climate change emergency and the establishment of the Carbon Neutral Government Programme to accelerate emissions reductions in the public sector and be carbon neutral by 2025. The programme set a target of a 21 percent reduction in gross carbon emissions intensity by 2025.

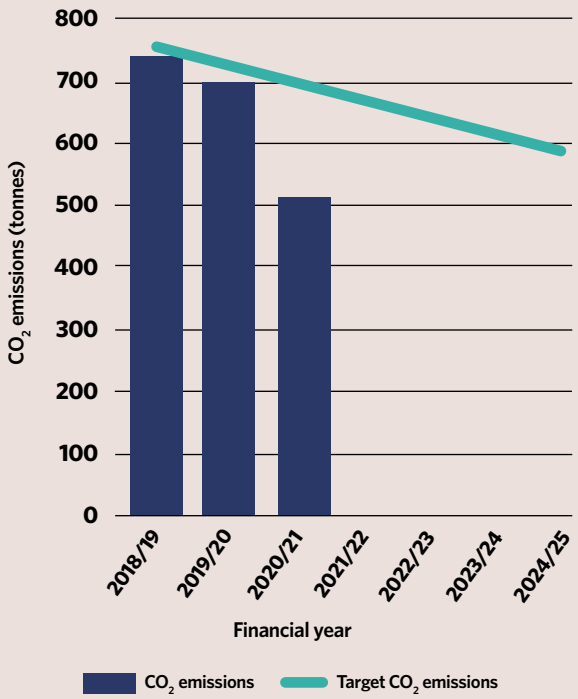
The Commission is committed to fully reducing our carbon footprint and becoming carbon neutral by 2025 and contracted Toitū Envirocare to audit our annual carbon emissions report. We were recently Toitū CarbonReduce Organisation certified for the base year of 2018/19.

Through Toitū Envirocare's carbon reduce programme, we record our annual greenhouse gas emissions and develop targets for reducing those emissions. Our baseline figure is 736 tonnes for 2018/19. An approximate 3.5 percent reduction per year will enable us to meet our overall 21 percent gross carbon emissions reduction by 30 June 2025 (see Figure A).

An approximate 3.5 percent reduction per year will enable us to meet our overall 21 percent gross carbon emissions reduction by 30 June 2025.

We have seen a significant reduction in carbon emissions since our base year, mainly due to reduced travel associated with COVID-19 restrictions but also due to changes to more sustainable electricity providers, reduced paper use and more sophisticated reporting of freight costs and waste management. Although travel restrictions have now been lifted nationally, we remain committed to ensuring our travel emissions continue to be sustainable as travel is our biggest greenhouse gas emissions producer.

Figure A: Target 21 percent carbon emission reduction



Accessibility

We are a signatory of the government Accessibility Charter, which is a commitment to providing accessible information and online tools to all disabled people. Signing the charter indicates we are committed to working progressively over a five-year period to making information that is intended for the public accessible so everyone can interact with us in a way that meets their individual needs and promotes their independence and dignity.

We progressed our work relating to accessibility in various ways over the past 12 months. Some of the highlights include launching a new website, which was designed in accordance with the New Zealand Web Accessibility Standard, changing our practices so that all videos we produce contain captions and transcripts and providing publications for consumers in alternate formats, such as Braille and Easy Read.

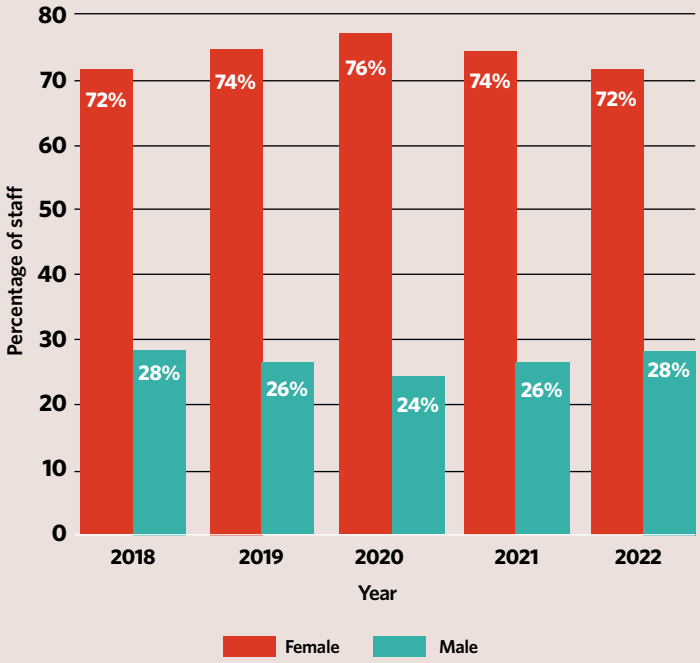
Developing and strengthening our organisation through our people

Our people are our greatest asset. We provide equal employment opportunities and ensure our policies, practices and processes are fair and equitable for all job applicants and employees.

We recognise the Crown's obligations under Te Tiriti and the aspirations of Māori, other ethnic or minority groups and people with disabilities. We recognise the importance of human resources, infrastructure and leadership in improving working conditions and providing better health services for all New Zealanders, but with a particular focus on whānau Māori and Pacific peoples.

We support our staff by providing annual professional development opportunities, and – during 2021/22 – staff continued to take up offers of secondment, additional duties and internal promotions.

Figure B: Gender



As of 30 June 2022:

we had

109 staff members

(up from 85 in 2020/21), with 99 full-time equivalents (FTEs). One of these FTEs was on secondment for most of the year, and three were on maternity leave

81 were full time

(up from 71 in 2020/21)

28 were part time

(24 in 2020/21)

45%

had more than two years of service with the Commission (compared with 60 percent in 2020/21)

25%

of staff were fixed term, up from 17 percent in 2021

around

6%

of staff identified that they live with a disability. (Wherever possible, we ensure our workplace environment is suitable for our people with disabilities.)

around

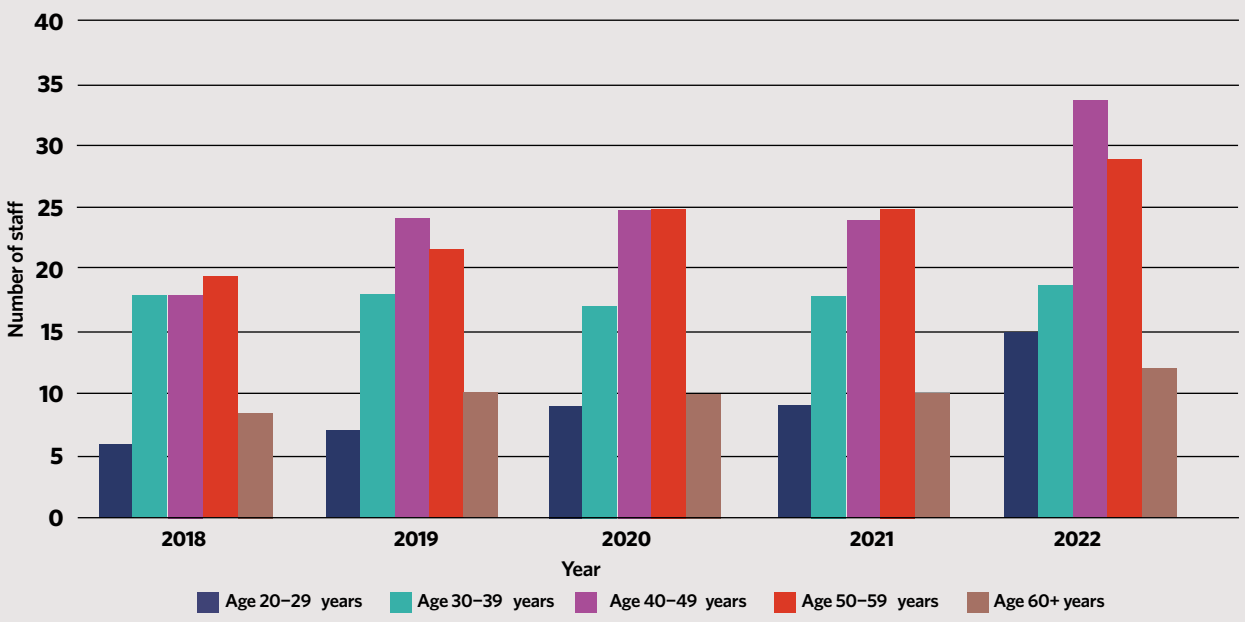
72% are female

28% are male

(as shown in Figure B), which is relatively similar to our numbers over previous years.

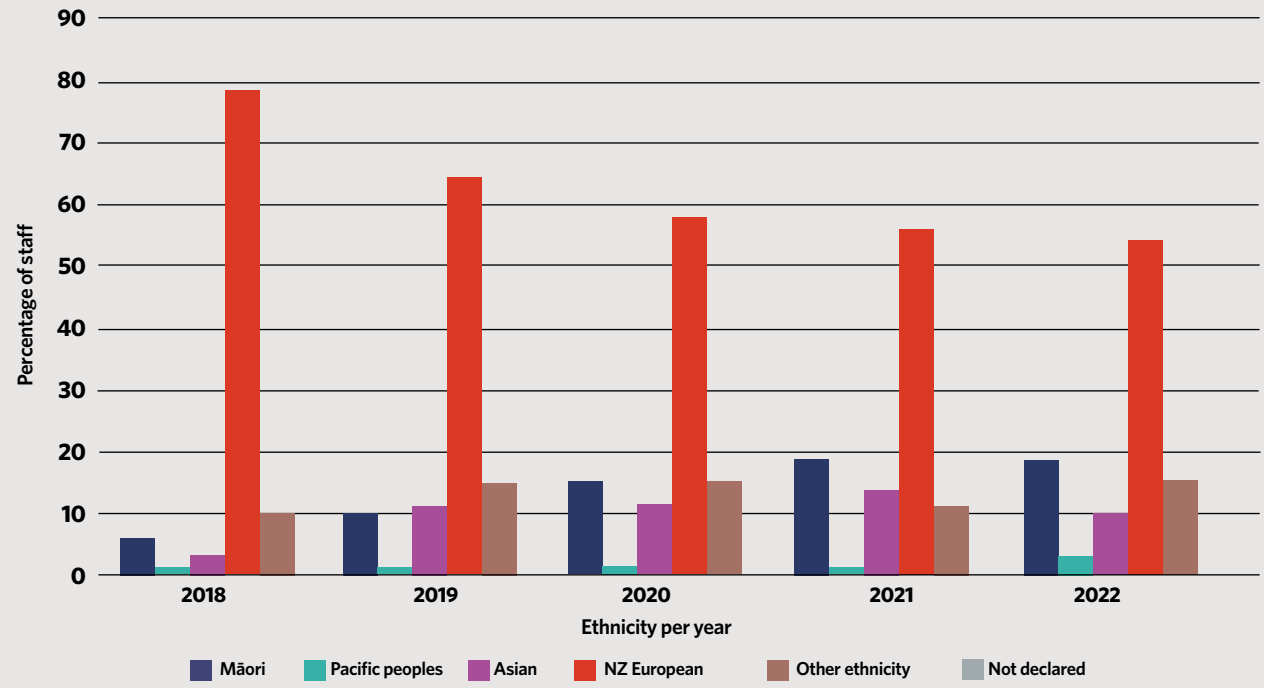
We have a relatively consistent distribution of age groups among our staff (as shown in Figure C). In the 2021/22 year, the number of staff in the 20–29 years age group was nearly double that in that age group for the previous three years.

Figure C: Age



Over the past five years, we increased our Māori workforce from 6 percent in 2018 to 19 percent since 2021 (Figure D).

Figure D: Ethnicity



Equal employment opportunities and the Rainbow Tick

We have an equality and diversity policy in place and are committed to providing equal employment for all groups of people. We were proud to receive the Rainbow Tick in June 2019 and were recertified in June 2022.

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

In 2022/23, we will have a specific focus on proactively supporting and increasing our disabled workforce.

Remuneration

We have shown pay restraint during the past three years in response to the COVID-19 pandemic and as advised by Te Kawa Mataaho Public Service Commission.

Staff who were employed in their current role before 31 December 2020, are permanent or on a fixed-term employment agreement of more than 12 months and are in a band lower than 17 were eligible for consideration for an increase as a result of this year's remuneration review process. The increase in salary for those eligible was around 1–2 percent, and the total cost implications were less than $0.045 million.

Gender pay equity

Median pay rates were similar between the genders for the 2021/22 year; however, the average salary gender pay gap was 4 percent for the year. Compared with median salaries for the 2020/21 year, there is no gap for 2022. This is down from 7 percent in the 2020/21 year. We are unable to calculate a 'motherhood penalty' total because we do not collect this level of personal detail from staff.

Flexibility and work design

We support flexible work arrangements for employees who have carer responsibilities[22] and for other reasons such as study and career development. Flexible work arrangements may include:

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

Our information technology and modern communication technologies also help staff work more flexibly; during the COVID-19 lockdowns, staff were able to work remotely. We continue to support a hybrid approach to working from the office or elsewhere.

Staff wellness and wellbeing

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

[22] Meeting the provision of Part 6AA of the Employment Relations Act 2000.

Over the 2021/22 year, we built on our existing wellness and wellbeing work by adding in more supports for our staff, particularly around COVID-19 and its impacts. In particular, we:

- supported staff to work more flexibly, better enabling staff to meet business requirements in ways that worked for them
- provided access to free gym membership for all Wellington-based staff; 80 staff members took up the initial gym membership offer, and 31 of those did so in the 2021/22 year
- organised an external mental wellness check-in survey for staff, which was run by our health, safety and wellness committee
- offered resilience workshops to all staff
- offered trauma and life cover insurance to all eligible staff, based on age range

Health and safety

We have a primary duty of care to ensure the health and safety of our staff, contractors and visitors.

To meet this duty of care, we take collective responsibility for proactively promoting and encouraging safe and healthy work practices. Managers, staff, contractors, facilities contractors and the health, safety and wellness committee all have a role in supporting health, safety and wellbeing within the Commission.

Our board is updated regularly on all matters relating to health and safety within our organisation via our chief executive. Managers maintain a watching brief and are proactive in addressing and minimising any potential situations where stress or fatigue could develop. The managers and staff can take part in risk and hazard identification sessions and regularly review work and systems to minimise any risks.

Staff who experience a workplace injury or illness receive appropriate rehabilitative care. Staff can also take part in any external health and safety audits. In all cases, we encourage staff to take part in wellness activities while receiving ongoing education about health and safety. All health, safety and wellness committee representatives are required to receive training relevant to their health and safety duties.

Third-party-funded work

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

Mental health and addiction improvement

We continued to work with DHB teams on projects agreed through national sector leadership related to mental health and addiction improvements. We continued to focus on the Zero seclusion: safety and dignity for all project, with significant engagement from the health and disability sector in our new Maximising physical health project, and conducted a scoping activity related to medication safety, prescribing and the medicines management process in mental health.

Major trauma quality improvement programme

We continued to provide intelligence and improvement support to the National Trauma Network. After releasing the Māori experiences of major trauma rehabilitation report,[23] we are now collaborating with ACC to ensure the increased cultural safety of acute trauma services and improved experiences and outcomes for Māori. Work is also progressing well on developing guidance for assessing and managing traumatic brain injuries.

The national rehabilitation collaboration has concluded, and we are working to publish a series of case studies that can inform and inspire the spread of improved models of care. Increased use of data, including patient-reported outcome measures and ACC contract data, continued to provide insights into opportunities for optimising care and rehabilitation for all patients with major trauma and their whānau. The major haemorrhage work continued to progress and embed the guidance and self-audit processes into business-as-usual operations for trauma teams.

Advance care planning

The advance care planning programme continued to support providers, Te Whatu Ora – Health New Zealand districts, non-governmental organisations, communities and whānau to think and talk about what matters most to the people the health and disability system serves. During 2021/22, the programme worked with its mana-enhancing design partners rōpū (Mana-E) to develop a five-year strategy and roadmap of actions, with a focus on increasing access and acceptability of advance care planning for whānau Māori. This was endorsed by the DHB chief executives in November 2021, together with funding to the end of June 2024, and will ensure continuity of the programme during the health system reforms.

Healthcare-associated infections

We have been working with DHBs to ensure that IPC remains central to their work programmes in the changing environment associated with COVID-19. Work and funding related to the surgical site infection improvement and hand hygiene programme are ongoing. Outyear work programmes are under development, based on the findings of the recent national PPS, with a national PPS report published in early May 2022.

Australian and New Zealand Intensive Care Society – clinical register

We continued to maintain the Australian and New Zealand Intensive Care Society's clinical register for New Zealand intensive care units. The funding for this register is now part of our baseline funding and does not need to be invoiced quarterly.

Patient experience surveys

In 2021/22, we ran the primary and secondary health care patient experience surveys on behalf of the Ministry of Health (to change to Te Whatu Ora – Health New Zealand in the 2022/23 year). Further details on the patient experience surveys are reported under SPE 1.

Consumer voice

We received new funding in the 2021/22 year to develop the consumer and whānau voice framework. We completed all deliverables as part of this work programme – developing a code of expectations for how health entities will engage with consumers and whānau, developing a consumer health forum infrastructure and strengthening our role as a centre of excellence for consumer and whānau engagement. Our Partners in Care team led this work over the last year. Funding has been confirmed for the ongoing development of the consumer and whānau voice framework.

[23] Health Quality & Safety Commission. 2022. *Ngā whānau Māori wheako ki te tauwhiro pāmamae me te whakaoranga | Whānau Māori experiences of major trauma care and rehabilitation.* Wellington: Health Quality & Safety Commission. URL: hqsc.govt.nz/resources/resource-library/whanau-maori-trauma-care-rehabilitation

Part 3: Our financial statements

Wāhanga 3: Pūrongo pūtea

Managing our finances

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

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

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

Compliance

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

Risk management

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

Risk management is a standing agenda item at each board meeting. Our audit committee provides independent assurance and help to the board on our financial statements and the adequacy of systems of internal controls. The 2021/22 year saw us focus on reviewing data use and data storage risks.

Financial statements

Revenue/expenses for output class for the year ended 30 June 2022	Output class: supporting and facilitating improvement		Total	
	$000s		$000s	
	Actual	Budget	Actual	Budget
Revenue				
Crown revenue	15,343	15,653	15,343	15,653
Interest revenue	33	3	33	3
Other revenue	5,380	4,488	5,380	4,488
Total revenue	**20,756**	**20,144**	**20,756**	**20,144**
Expenditure				
Operational and internal programme costs	14,817	14,239	14,817	14,239
External programme cost	5,313	6,025	5,313	6,025
Total expenditure	**20,130**	**20,264**	**20,130**	**20,264**
Surplus/(deficit)	626	(120)	626	(120)

Statement of comprehensive revenue and expenses for the year ended 30 June 2022

Actual 2021 $000		Notes	Actual 2022 $000	Budget 2022 $000
	Revenue			
14,283	Revenue from Crown	2	15,343	15,653
3	Interest revenue		33	3
4,597	Other revenue	3	5,380	4,488
18,883	**Total revenue**		**20,756**	**20,144**
	Expenditure			
10,476	Personnel costs	4	11,814	11,297
154	Depreciation and amortisation	12, 13	199	183
2,811	Other expenses	6	2,804	2,759
3,440	External quality and safety programmes		3,796	4,382
1,566	External mortality programmes		1,517	1,643
18,447	**Total expenditure**		**20,130**	**20,264**
436	**Surplus/(deficit)**		**626**	**(120)**
0	Other comprehensive revenue		0	0
436	**Total comprehensive revenue**		**626**	**(120)**

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

Statement of financial position as of 30 June 2022

Actual 2021 $000		Notes	Actual 2022 $000	Budget 2022 $000
	Assets			
	Current assets			
3,047	Cash and cash equivalents	7	3,663	2,373
199	Goods and services tax receivable		77	336
431	Debtors and other receivables	8	527	281
121	Prepayments		133	42
3,798	**Total current assets**		**4,400**	**3,032**
	Non-current assets			
159	Property, plant and equipment	12	508	327
0	Intangible assets	13	0	0
159	**Total non-current assets**		**508**	**327**
3,957	**Total assets**		**4,908**	**3,359**
	Liabilities			
	Current liabilities			
873	Creditors and other payables	14	1,042	1,143
708	Employee entitlements	16	851	568
168	Revenue in advance		180	0
1,749	**Total current liabilities**		**2,073**	**1,711**
	Non-current liabilities			
99	Employee entitlements	16	100	0
99	**Total non-current liabilities**		**100**	**0**
1,848	**Total liabilities**		**2,173**	**1,711**
2,109	**Net assets**		**2,735**	**1,648**
	Equity	**17**		
500	Contributed capital		500	500
1,609	Accumulated surplus		2,235	1,148
2,109	**Total equity**		**2,735**	**1,648**

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

Statement of changes in equity for the year ended 30 June 2022

Actual 2021 $000		Notes	Actual 2022 $000	Budget 2022 $000
1,673	Balance at 1 July		2,109	1,768
436	Total comprehensive revenue and expenses for the year Surplus/(deficit)		626	(120)
	Owner transactions			
0	Capital contribution		0	0
2,109	**Balance at 30 June**	**17**	**2,735**	**1,648**

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

Statement of cash flows for the year ended 30 June 2022

Actual 2021 $000		Notes	Actual 2022 $000	Budget 2022 $000
	Cash flows from operating activities			
14,403	Receipts from Crown		15,343	15,653
4,427	Other revenue		5,296	4,418
3	Interest received		33	3
(8,189)	Payments to suppliers		(7,960)	(8,745)
(9,999)	Payments to employees		(11,670)	(11,283)
(78)	Goods and services tax (net)		122	(32)
558	Net cash flow from operating activities	18	1,164	14
	Cash flows from investing activities			
(93)	Purchase of property, plant and equipment		(548)	(411)
0	Purchase of intangible assets		0	0
(93)	Net cash flow from investing activities		(548)	(411)
	Capital flows from financing activities			
0	Capital contribution		0	0
0	Net cash flows from financing activities		0	0
465	**Net (decrease)/increase in cash and cash equivalents**		**616**	**(397)**
2,582	Cash and cash equivalents at the beginning of the year		3,047	2,770
3,047	**Cash and cash equivalents at the end of the year**	**7**	**3,663**	**2,373**

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

Notes to the financial statements

Note 1: Statement of accounting policies

Reporting entity

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

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

The financial statements for the Commission are for the year ended 30 June 2022 and were approved by the board on 21 December 2022.

Basis of preparation

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

Standards issued not yet effective and not early adopted

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

PBE IPSAS 41 financial instruments

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

PBE FRS 48 service performance reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. The Commission has determined the main impact of the new standard is that additional information will need to be disclosed on those judgements that have the most significant effect on the selection, measurement, aggregation and presentation of service performance information.

Statement of compliance

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

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

Measurement base

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

Budget figures

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

Functional and presentation currency

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

Changes in accounting policies

There have been no changes in accounting policies.

Critical accounting estimates and assumptions

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

There are no estimates and assumptions for 2021/22 that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant accounting policies

Revenue

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

Revenue from the Crown

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

Other revenue

Other revenue is recognised as revenue when it becomes receivable unless there is an obligation in substance to return the funds if conditions of the other revenue are not met. If there is such an obligation, the other revenue is initially recorded as other revenue received in advance and recognised as revenue when conditions of the other revenue are satisfied.

Interest

Interest income is recognised using the effective interest method.

Foreign currency transactions

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

Operating leases

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

Cash and cash equivalents

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

Debtors and other receivables

Debtors and other receivables are measured at face value less any provision for impairment. No provisions for impairment are in place in the 2021/22 year.

Short-term receivables are recorded at the amount due, less an allowance for credit losses. The Commission applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables. In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess shared credit risk characteristics.

They have been grouped based on the days past due. Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation or a failure to make contractual payments for a period of greater than 90 days past due.

Bank deposits

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

Inventories

Inventories held for sale are measured at the lower of cost (calculated using the first-in, first-out basis) and net realisable value. No inventories were held for sale in the 2021/22 year.

Property, plant and equipment

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

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

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

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

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

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

Impairment of property, plant and equipment

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

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

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

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

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

Depreciation

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

Building fit-out (over the term of building lease)	
10 years	10 percent SL
Leasehold improvements	
10 years	10 percent SL
Computers	
3 years	33 percent SL
Office equipment	
5 years	20 percent SL
Furniture and fittings	
5 years	20 percent SL

Intangibles

Software acquisition

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

Amortisation

Amortisation begins when the asset is available for use and stops at the date the asset is 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:

Acquired computer software	
3 years	33 percent SL

Impairment of property, plant and equipment and intangible assets

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

Non-cash-generating assets

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

Goods and services tax

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Creditors and other payables

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

Employee entitlements

Salary and wages are recognised as employees provide services.

Short-term employee entitlements

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

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

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

Long-term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the year in which the employee provides the related service, such as retirement and long service leave, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to employees, based on years of service, years to entitlement, the likelihood that employees will reach the point of entitlement and contractual entitlement information
- the present value of the estimated future cash flows.

Presentation of employee entitlements

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

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, no unfulfilled conditions or contingencies are attached to government funding.

Crown revenue for the 2021/22 year was $0.310 million less than originally budgeted (and the associated expenditure of this) for suicide mortality review. $0.180 million for suicide mortality review has been treated as revenue in advance.

Note 3: Other revenue

- Total other revenue received was $5.380 million (2021: $4.597 million), consisting of:
- $1.500 million (2021: $1.500 million) from DHBs for the mental health and addiction quality improvement programme
- $0.895 million (2021: $0.000 million) from the Department of the Prime Minister and Cabinet for the consumer and whānau voice framework
- $0.868 million (2021: $0.830 million) from DHBs for the advance care planning programme
- $1.224 million (2021: $1.228 million) from DHBs for infection prevention and control
- $0.036 million (2021: $0.106 million) from additional workshop and event revenue
- $0.800 million (2021: $0.795 million) from ACC for the National Trauma Network
- $0.021 million (2021: $0.014 million) from adverse events training workshops
- $0.025 million (2021: $0.000 million) from PHARMAC towards communicating about medicines to consumers
- $0.008 million (2021: $0.008 million) from ACC and PHARMAC for Patient Safety Week
- $0.000 million (2021: $0.101 million) from the Council of Medical Colleges for the Choosing Wisely campaign
- $0.000 million (2021: $0.000 million) from DHBs for the patient experience surveys question set
- $0.000 million (2021: $0.000 million) from ACC and PHARMAC towards behavioural insights measurement
- $0.013 million (2021: $0.015 million) other revenue.

Note 4: Personnel costs

	Actual 2021 $000	Actual 2022 $000
Salaries and wages	9,789	10,759
Recruitment	140	143
Temporary personnel	216	460
Membership, professional fees and staff training and development	150	161
Defined contribution plan employer contributions	215	243
Increase/(decrease) in employee entitlements	(34)	48
Total personnel costs	**10,476**	**11,814**

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 because its net assets are below the capital charge threshold.

Note 6: Other expenses

	Actual 2021 $000	Actual 2022 $000
Audit fees to Audit New Zealand for financial audit	37	50
Staff travel and accommodation	209	134
Printing and communications	182	148
Consultants and contractors	524	471
Board costs	189	190
Mortality review committees	215	206
Lease rental	526	598
Outsourced corporate services and overheads	925	1,003
Other expenses	4	4
Total other expenses	**2,811**	**2,804**

Note 7: Cash and cash equivalents

	Actual 2021 $000	Actual 2022 $000
Cash at bank and on hand	3,047	3,663
Total cash and cash equivalents	**3,047**	**3,663**

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

While cash and cash equivalents at 30 June 2022 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

Note 8: Debtors and other receivables

	Actual 2021 $000	Actual 2022 $000
Debtors and other receivables	431	527
Less: provision for impairment	0	0
Total debtors and other receivables	**431**	**527**

Fair value

The carrying value of receivables approximates their fair value.

Impairment

The impairment of short-term receivables is now determined by applying an expected credit loss model. All receivables greater than 30 days in age are considered to be past due.

Note 9: Investments

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

Note 10: Inventories

The Commission had no inventories for sale in 2021/22.

Note 11: Non-current assets held for sale

The Commission had no current or non-current assets held for sale in 2021/22.

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 2020	371	405	85	861
Additions	89	4	0	93
Disposals	0	0	0	0
Balance at 30 June 2021/1 July 2021	460	409	85	954
Additions	525	23	0	548
Disposals	(282)	(121)	(13)	(416)
Balance at 30 June 2022	703	311	72	1,086
Accumulated depreciation and impairment losses				
Balance at 1 July 2020	260	324	57	641
Depreciation expense	107	33	14	154
Elimination on disposal	0	0	0	0
Balance at 30 June 2021/1 July 2021	367	357	71	795
Depreciation expense	171	21	7	199
Elimination on disposal	(282)	(121)	(13)	(416)
Balance at 30 June 2022	256	257	65	578
Carrying amounts				
At 1 July 2020	111	81	28	220
At 30 June and 1 July 2021	93	52	14	159
At 30 June 2022	447	54	7	508

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

Note 13: Intangible assets

The Commission has no intangible assets.

Note 14: Creditors and other payables

	Actual 2021 $000	Actual 2022 $000
Creditors	604	558
Accrued expenses	261	474
Other payables	8	10
Total creditors and other payables	**873**	**1,042**

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

Note 15: Borrowings

The Commission does not have any borrowings.

Note 16: Employee entitlements

	Actual 2021 $000	Actual 2022 $000
Current portion		
Accrued salaries and wages	195	283
Annual leave and long-service leave	513	568
Total current portion	708	851
Non-current portion long-service leave	99	100
Total employee entitlements	**807**	**951**

No provision for sick leave or retirement leave was made in 2021/22 as these have been assessed as immaterial. Provision for long-service leave was made in 2021/22.

Note 17: Equity

	Actual 2021 $000	Actual 2022 $000
Contributed capital		
Balance at 1 July	500	500
Capital contributions	0	0
Repayment of capital	0	0
Balance at 30 June	500	500
Accumulate surplus/(deficit)		
Balance at 1 July	1,173	1,609
Surplus/(deficit) for the year	436	626
Balance at 30 June	1,609	2,235
Total equity	**2,109**	**2,735**

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

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

	Actual 2021 $000	Actual 2022 $000
Net operating surplus	436	626
Non-cash items		
Depreciation	154	199
Add movements in working capital items		
(Increase)/decrease in receivables	(167)	(96)
(Increase)/decrease in prepayments	(14)	(12)
Increase/(decrease) in GST receivables	(78)	122
(Decrease)/increase in payables and accruals	105	169
Increase/(decrease) in employee entitlements	5	144
Increase in revenue in advance	117	12
Net working capital movements	**(32)**	**339**
Net cash flow from operating activities	**558**	**1,164**

Note 19: Capital commitments and operating leases

Capital commitments

There were no capital commitments at balance date (2021: nil).

Operating leases as lessee

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

	Actual 2021 $000	Actual 2022 $000
Not later than one year	465	502
Later than one year and not later than five years	321	783
Later than five years	0	0
Total non-cancellable operating leases	**786**	**1,285**

At balance date, the Commission leased a property (from 1 March 2014) at levels 8 and 9, 17 Whitmore Street, Wellington. The lease has been extended by two years and expires in March 2025. The value of the lease to March 2025 is $1.177 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 10 staff. The sublease expiry date is December 2023.

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

Note 20: Contingencies

Contingent liabilities

The Commission has no contingent liabilities (2021: $nil).

Contingent assets

The Commission has no contingent assets (2021: $nil).

Note 21: Related party transactions

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

The Commission is a wholly owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the Commission would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (eg, 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[24] totalled $1.257 million, four FTE (2021: $1.34 million, five FTE).

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

The total value of remuneration paid or payable to each board member (or their employing organisation*) during the full 2021/22 year was as follows.

	Actual 2021 $000	Actual 2022 $000
Dr Dale Bramley* (chair)	29	29
Mr Andrew Connolly	11	6
Dr Jennifer Parr	15	15
Philomena Antonio	15	15
Dr Collin Tukuitonga	15	15
Professor Peter Crampton*	15	15
Raewyn Lamb (deputy chair)	0	18
Shenagh Gleisner	14	15
Dr Tristram Ingham	15	15
Dr Wil Harrison	15	7
Total board member remuneration	**144**	**150**

* The member was paid by their employing organisation.

Fees were in accordance with the Cabinet's Fees Framework.

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

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

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

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

[24] Key management personnel for 2021/22 included the chief executive, director of health quality intelligence, medical director and chief financial officer. Board members are reported separately.

Note 23: Employee remuneration

Total remuneration paid or payable in the 2021/22 year was as follows.

	Employees 2021	Employees 2022
$100,000–$109,999	2	4
$110,000–$119,999	5	6
$120,000–$129,999	8	7
$130,000–$139,999	7	4
$140,000–$149,999	2	1
$150,000–$159,999	2	2
$160,000–$169,999	3	6
$170,000–$179,999	0	1
$180,000–$189,999	3	2
$190,000–$199,999	0	1
$200,000–$209,999	0	0
$210,000–$219,999	0	0
$220,000–$229,999	0	2
$230,000–$239,999	3	0
$240,000–$249,999	1	1
$250,000–$259,999	0	0
$260,000–$269,999	0	0
$270,000–$279,999	1	1
$280,000–$289,000	0	0
$290,000–$299,999	0	0
$300,000–$309,000	0	0
$310,000–$319,999	0	1
$390,000–$399,999	1	0
$400,000–$409,999	0	0
$410,000–$419,999	0	0
$420,000–$429,999	0	1
Total employees	**38**	**40**

During the 2021/22 year, no employees received compensation or other benefits in relation to cessation.

Note 24: Events after the balance date

There were no material events after the balance date.

Note 25: Financial instruments

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

Note 26: Capital management

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

The Commission is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowing, acquisition of securities, issues of 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 2021/22 SPE follow.

Statement of comprehensive revenue and expenses

The financial results show a year-end surplus of $0.626 million compared with a budgeted deficit of $0.120 million. The year-end surplus variance is mainly associated with significant travel savings ($0.150 million), reduced board and committee meeting costs ($0.070 million), fewer printed publications ($0.101 million) and some delays in non-SPE-related programme expenditure associated with COVID-19 restrictions that impacted on the capacity of the health and disability sector to work with the Commission (net impact of $0.500 million).

These COVID-19 restrictions impacted on the ability to engage face to face with frontline health workers, especially in the areas of QI capability training and within areas such as mental health, HAIs and advance care planning that the Commission will continue to progress and deliver in 2022/23.

Travel, committee and publication cost variances identified above were genuine savings in 2021/22, creating $0.400 million of reserves that can increase the scope of existing work or go toward additional one-off costs or activity associated with the health sector reforms in 2022/23 (or out years).

Overall revenue for the financial year was $0.612 million above budgeted levels: $0.895 million for the consumer and whānau voice framework and $0.030 million additional interest revenue were offset by $0.310 million less revenue than originally budgeted (and the associated expenditure of this) for suicide mortality review. Netting off the additional revenue was additional staff expenditure of $0.527 million, $0.184 million of additional contractor costs and $0.148 million of additional operating costs due to increased activity.

Statement of financial position

Cash and cash equivalents were higher than budgeted due to expenditure on both staffing and programmes being less than budgeted.

Property, plant and equipment was over budget as the Commission had planned to replace its laptop fleet in 2020/21; however, because of manufacturing delays due to COVID-19, this now shows in the 2021/22 financial statements.

Employee entitlements are $0.383 million higher than budgeted mainly due to a higher level of accrued annual leave while staff deferred taking holidays due to the COVID-19 lockdowns.

Equity levels at the end of June 2022 are $2.735 million (2021: $2.109 million).

Statement of changes in cashflow

Because the Commission had an underspend in 2021/22, 'payments to suppliers' and 'payments to employees' were both lower than budgeted figures.

The Commission had planned to replace its laptop fleet in 2020/21, but because of manufacturing delays due to COVID-19, this now shows in the 2021/22 financial statements and is why 'cashflows from investing activity' are $0.137 million higher than budgeted for 2022.

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 to do so. The Commission did not acquire any such shares and currently does not plan to do so.

Note 29: Responsibilities under the Public Finance Act

To comply with responsibilities under the Public Finance Act 1989, the Commission reports here the activities funded through the Crown Vote Health and how performance is measured against the forecast information contained in the Estimates of Appropriations 2021/22 and of those as amended by the Supplementary Estimates.

Monitoring and protecting health and disability consumer interests (M36)

This appropriation is intended to achieve: Provision of services to monitor and protect health consumer interests by the HDC, district mental health inspectors and review tribunals and Te Hiringa Mahara | Mental Health and Wellbeing Commission.

Output class financials	Actual 2021/22 $000	Budget 2021/22 $000	Location of end-of-year performance information
Crown Funding (Vote Health – Monitoring and Protecting Health and Disability Consumer Interests (M36))	14,376	14,376	The end-of-year performance information for this appropriation is reported in the 'Our performance statement' section (page 17).

The Commission also received Crown funding of:

- $0.895 million from Vote Prime Minister and Cabinet – Departmental Output Expenses Appropriation – Health and Disability System Reform – Department of the Prime Minister and Cabinet for the consumer and whānau voice framework
- $0.500 million from Vote Health – Mental Health (with $0.180 million treated as revenue in advance)
- $0.215 million from Vote Health – National Personal Health Services
- $0.312 million from Vote Health – Primary Health Care Strategy.

The Commission has assessed the impact of the COVID-19 global pandemic on the organisation. It has also reviewed its financial statements on a line-by-line basis and made any adjustments necessary in accordance with NZ GAAP.

Overall, the Commission has concluded that the impact of the COVID-19 pandemic was not material to the entity's operations or current year financial statements. The main factors contributing to this conclusion are as follows.

Revenue – this is mainly Crown and DHB revenue, which was not impacted by COVID-19.

Cash – there was no impact to the carrying value of cash on hand.

Receivables – there was no impact to the expected credit loss model when calculating impairment losses. The Commission deals with customers with little or no credit risk.

Property, plant and equipment – the Commission purchases plant and equipment mainly from the all-of-government panel of suppliers.

Payables – no accrued costs related to the expected impact of COVID-19 have been made.

Employee liabilities – no changes have been assessed as being required for calculations of employee liabilities associated with COVID-19.

Part 4: Statement of responsibility

Wāhanga 4: He kupu haepapa

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

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

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

In the board's opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Commission for the year ended 30 June 2022.

Signed on behalf of the board:

Dr Dale Bramley

Chair, Board
21 December 2022

Shenagh Gleisner

Chair, Audit Committee
21 December 2022

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Auditor's report
Pūrongo tātari

Independent Auditor's Report

To the readers of the Health Quality and Safety Commission's financial statements and performance information for the year ended 30 June 2022

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

Opinion

We have audited:

- the financial statements of the Commission on pages 37 to 54, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements including a summary of significant accounting policies and other explanatory information; and
- the performance information of the Commission on pages 13 to 15, 18 to 25, 54 and 55.

In our opinion:

- the financial statements of the Commission on pages 37 to 54:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2022; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with the Public Benefit Accounting Standards Reduced Disclosure Regime; and
- the performance information on pages 13 to 15, 18 to 25, 54 and 55:
  - presents fairly, in all material respects, the Commission's performance for the year ended 30 June 2022, including:
    - for each class of reportable outputs:
      - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
      - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriations; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 21 December 2022. This is the date at which our opinion is expressed.

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

Basis for our opinion

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

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

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

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

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

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

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

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

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

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

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Commission's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Commission's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Commission's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Commission to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 12, 16, 17, 26 to 36, 56 and 60 but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

Stephen Usher

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

Appendix 1: Our outcomes framework, clarified in our 2021/22 SPE

Āpitihanga 1: Tā mātou anga putanga, i whakamāramatia i tā mātou SPE 2021/22

Our contribution to the Government's 'wellbeing priorities'

PHYSICAL AND MENTAL WELLBEING
Supporting improved health outcomes for all New Zealanders

OUR CONTRIBUTION TO THE GOVERNMENT'S GOALS FOR THE HEALTH SYSTEM

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

OUR VISION

Quality health for all

OUR STRATEGIC PRIORITIES (AND THE OUTCOMES WE SEEK)

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

OUR WORK

Supporting and facilitating improvement

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

Te Kāwanatanga o Aotearoa
New Zealand Government

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