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STATEMENT OF PERFORMANCE EXPECTATIONS

2017/18

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

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Board statement

In signing this statement, we acknowledge we are responsible for the information contained in the Statement of Performance Expectations for the Health Quality & Safety Commission. This information has been prepared in accordance with the requirements of the Public Finance Act 1989 and the Crown Entities Act 2004, and to give effect to the Minister of Health's 2017/18 Letter of Expectations and the Enduring Letter of Expectations from the Ministers of Finance and State Services. It is consistent with our appropriations.

Prof Alan Merry ONZM FRSNZ
Chair
21 June 2017

Shelley Frost
Deputy Chair
21 June 2017

Introduction

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

This Statement of Performance Expectations (SPE) is provided under section 149C of the Crown Entities Act and describes what the Commission will achieve in 2017/18.

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

Please read the SPE alongside the:

- Commission's *Statement of Intent 2017–21*, which sets out our medium-term objectives over the next several years
- New Zealand Health Strategy, which sets the direction for the health system for the 10 years from 2016 to 2026.

The tables describing how we will assess the SPE deliverables include an additional column, 'Why are we doing this?'. This column explains briefly the strategic focus to which each deliverable contributes. It also provides examples of the ideal results we would like to see from our programmes. The column does not form part of the assessment criteria.

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

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

Influences on this SPE

The following strategic documents and principles influence this SPE:

- The New Zealand Health Strategy's[2] vision: 'All New Zealanders live well, stay well, get well, we will be people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system'.
- The New Zealand Health Strategy's guiding principles for the health system. These are reflected throughout the Commission's work programme and in our approach to working with the sector and consumers, families and whānau to improve the quality and value of health and disability support services. For further details of how our work supports the Health Strategy, please see page 5.
- Key priorities from the Minister of Health's 2017/18 Letter of Expectations, which the Commission received on 17 February 2017. General expectations for all agencies include demonstrating the links between the Health Strategy and our performance story, managing our financial performance and service improvement, demonstrating the

[1] A Crown agent must give effect to government policy when the responsible Minister directs it.
[2] Minister of Health. 2016. *New Zealand Health Strategy: Future direction*. Wellington: Ministry of Health. URL: www.health.govt.nz/publication/new-zealand-health-strategy-2016 (accessed 22 March 2017).

difference we make, and working with partner agencies to deliver effective results. Specific priorities for the Commission to focus on in 2017/18 are:

  - support implementation of system-level measures in the health sector, by raising improvement science capability in both primary and secondary care settings
  - develop and support a collaborative learning platform to enhance capacity and capability for quality improvement in the health sector, including the integration of primary and secondary care services
  - lead the implementation of patient experience surveys in primary care; provide governance, analysis and monitoring, and strategies to increase the uptake of these surveys in primary and secondary care settings
  - actively support and contribute to the Ministry of Health's work on better capturing performance information about the quality and safety of New Zealand's health services, including work related to the eventual publication of health data (transparency of health information)
  - work jointly with the Ministry to ensure all proposed publications reflect a comprehensive, contextualised and joined-up picture of the New Zealand health system.

- Our *Statement of Intent 2017–21*, which describes our strategic direction priorities and values, and how we operate and manage our organisational health and capability. The Statement of Intent is being prepared at the same time as this Statement of Performance Expectations.
- Our commitment to improve health equity, in particular for Māori, in accordance with our responsibilities under the Treaty of Waitangi and as described in our Māori advancement framework, Te Whai Oranga.
- The New Zealand Triple Aim's key platform of quality improvement across three aspects: for individuals, populations and the system. The Triple Aim's goal of improved health and equity for all populations underpins everything we do. A range of our work in 2017/18 contributes to this goal of reducing systemic inequalities in access and outcomes, which will help to make the health system more sustainable and affordable. For more details, see our *Statement of Intent 2017–21*, which features improving health equity as one of its four key strategic intentions.
- Broader Government priorities:
  - responsibly managing the Government's finances
  - building a more competitive and productive economy
  - delivering better public services.

Supporting the New Zealand Health Strategy

The five themes and comprehensive action plan set out in the New Zealand Health Strategy, released in April 2016, guide the strategic outlook and operational planning of the Commission and the rest of the health sector. Each of the Health Strategy's themes influences our approach to quality and safety improvement, as we describe below.

People-powered – people-centred approaches: We are driven by what matters to patients/consumers and their families and whānau, and by what will improve the health of communities and populations. All work programmes are designed with a consumer perspective, and all our expert advisory groups include consumer members. Our consumer panel comments on all key strategic policies and reports.

Our key ‘people-powered’ activities and groups include:

- Partners in Care consumer engagement programme and consumer network
- Te Roopū Māori (Māori advisory group to the Board), and Māori caucus for mortality review committees
- Patient Safety Week focusing on consumer safety.

Closer to home – care at home and in communities: We are strengthening our focus on better-integrated community care through our growing primary care and aged care initiatives. In taking these initiatives we seek to improve the quality of and access to care for all communities.

Our key ‘closer to home’ activities include:

- falls prevention (see Health Strategy action 10E)
- supporting improvement programmes in primary care, and the primary health organisation quality improvement network
- the work of mortality review committees (eg, Family Violence and Child and Youth Mortality Review Committees) with other agencies, supporting mortality reduction, and maternal and neonatal improvement
- contributing to cross-government family violence initiatives
- scoping improvement work in aged residential care.

Value and high performance – best use of health investment: Our improvement programmes are focused on reducing harm and related costs, and we are developing a broader measure of value in health care to inform better decision-making. We use measurement and evaluation to help to identify problems like overtreatment and undertreatment, as well as to find key improvement opportunities. This approach also helps to motivate people to make improvements and to monitor them once they are implemented. Good measurement and evaluation show where waste is happening because of poor quality and whether interventions to reduce waste have worked.

Our key ‘value and high performance’ activities include:

- measurement and evaluation (see Health Strategy actions 13A ‘measures of service user experience’ for hospitals and primary care, and 19C ‘analyse and share data on patient safety and treatment injury’)
- mortality review to reduce preventable deaths
- improvement programmes to improve patient safety in specific areas (eg,, reducing harm from falls, medication safety, infection prevention and control, safe surgery; see Health Strategy action 19B ‘initiatives to reduce patient harm’)
- Atlas of Healthcare Variation, quality and safety markers (QSM) and quality and safety indicators (QSI), the Window on Quality report on the quality and safety of the health system.

One team – integrated and cohesive, collaboration, leadership: We partner with others in the health and wider social sector, particularly our colleagues in the Ministry of Health, but also the Health and Disability Commissioner, Accident Compensation Corporation (ACC) and district health boards (DHBs), to learn and share together. We use consumer experience, expert knowledge and current information to develop new ways of thinking and better ways of working. We work closely with DHBs and other providers to drive change and improvement. We participate in cross-agency information-sharing forums and work with partner agencies to improve health quality and safety.

Our key ‘one team’ activities include:

- supporting national, regional and local networks for improvement
- clinical leadership (see Health Strategy action 23D ‘equipping clinical networks to lead quality improvement’) and building improvement science capability in the sector
- Open forum international speaker series
- *Open for leadership awards* for emerging health sector leaders
- Safety culture survey promoting consumer engagement in care.

Smart system – having and sharing good information: We recognise the potential for technology to reshape improvements in health quality. We provide the Minister of Health and government agencies with high-quality advice based on data, and promote informed public comment and debate on health quality and safety.

Our key ‘smart system’ activities include:

- sharing best practice with the sector
- supporting enabling technology in specific programmes (eMedicine partnership with the Ministry of Health, healthcare acquired infections, and deteriorating patient vital signs)
- delivering better information on the quality and safety of care to providers (quality and safety dashboard).

Output classes

The Commission groups its activities into two output classes:

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

This approach refines the grouping of previous SPEs, which featured three output classes: measurement and evaluation, advice and comment, and assistance to the sector to effect change. To simplify reporting and to better reflect internal work responsibilities, the new ‘intelligence’ output class covers the measurement and evaluation programmes and the former ‘advice and comment’ output class, while the ‘improvement’ output class covers the previous ‘assistance to the sector’ output class.

Output class 1: Intelligence

Background

One of our key statutory roles is to monitor and assess the quality and safety of the sector. This includes making national and international comparisons to identify areas where people are following evidence-based practice or where improvement is needed. Effective and transparent reporting and analysis of quality and safety data, incidents and trends stimulates improvement, encourages discussion and helps us to prioritise areas for improvement. We also acknowledge our data collection does not come ‘free of charge’, with compliance costs for the sector being weighed against the potential benefits before we gather information.

Our 2017/18 measurement and evaluation work

Measuring quality and safety in New Zealand health care

Our yearly report, *A Window on the Quality of New Zealand’s Health Care*, helps to show the public how our health system is performing and how it compares internationally. We develop

the report in consultation with the Ministry of Health, and it aligns with the Ministry's work to collect and publish information on the health system's performance.

We will also publish a series of integrated quality dashboards to display progress on quality performance in DHBs. The revised quarterly publications will provide a more detailed understanding of DHBs' quality achievements and challenges, so they can measure the impact of their improvement initiatives.

Patient experience

Our patient experience survey for general practice services was developed in partnership with the Ministry of Health and launched in 2016. If possible, the survey results will be publicly released for the first time in 2017/18. This will join our patient experience survey for adult inpatients, which has operated in all DHBs since August 2014 to gather feedback about the care people receive in public hospitals.

New Zealand Atlas of Healthcare Variation

In 2017/18 we will update at least six Atlas of Healthcare Variation domains. We will continue to widen the clinical audience of the Atlas by implementing the key recommendations of the Atlas evaluation aimed at increasing the sector's use of the Atlas. We will also continue to advance our strategic priority of reducing unwarranted variation.

Adverse events reporting

In 2017/18 our national reporting on adverse events will describe the adverse events reported to us in 2016/17 and the report will include a chapter focused on consumer experience of adverse events.

Quality and safety markers

Quality and safety markers are a mix of structural, process and outcome measures designed to track the sector's progress against targets in key Commission work programmes. They also stimulate debate and improvement through public reporting. The markers measure how much the sector is taking up good practice and, in many cases, how much harm is reduced and money saved.

The 2017/18 quality and safety markers will continue to be published quarterly. They will focus on reducing harm from inpatient falls, hand hygiene, healthcare associated infections, medicines reconciliation and safe surgery. We are also investigating if it is feasible to develop new quality and safety markers for consumer engagement, patient deterioration, opioids and pressure injuries.

Mortality review

Mortality review is used to improve systems and practice within services and communities to prevent deaths. The mortality review committees work across agencies to encourage them to implement recommendations. The committees also monitor the progress those agencies have made with recommendations they have implemented in previous years.

In 2017/18 at least two mortality review committees will publish reports based on review and analysis of mortality in their area of focus. Reports include recommendations to influence and make system changes to reduce mortality and morbidity.[3]

Māori are over-represented in New Zealand's mortality statistics. A Māori caucus works across the mortality review programme to provide appropriate engagement and Māori advice, particularly as mortality review committees interpret the findings and develop recommendations in their reports and workshops. In 2017/18 the caucus will further build on

[3] Mortality review national conferences are discussed under output class 2.

guidance developed in 2016/17 and continue to provide a Māori worldview on the methodology, reporting and recommendations of mortality review committees.

Providing informed public comment and promoting sector and public debate

We will publish, on our website and via other media, at least four evidence-based reports and discussion papers on health quality and safety in peer-reviewed journals in 2017/18. We will also provide regular advice to the Associate Minister of Health on important health quality and safety issues as appropriate, and on key Commission reports and results.

How we will assess the performance of output class 1

	Deliverable	Quantity	Timeliness	Quality	Why are we doing this?
1	Report against the full set of national and international measures of quality and safety	Publish one Window on Quality report	30 May 2018	Clinical and technical experts will peer-review report and data.	Leads to: informed discussion and debate that in turn prompt improvements in practice and patient outcomes, by highlighting comparators and placing New Zealand performance in an international context. This also helps the Commission determine its strategic priorities for quality improvement.
		Publish four integrated quality dashboards	July 2017 October 2017 January 2018 April 2018	Clinical and technical experts will peer-review reports and data.	
2	Patient experience indicators	Publish four reports on patient experience of hospital services	August 2017 November 2017 February 2018 May 2018	Clinical and technical experts will peer-review reports and data.	Leads to: improved health and better experience of care by measuring baselines and fluctuations in patient perception of services and treatment. It also provides valuable information on access to care and patient trust.
		Produce four reports on patient experience of primary care	August 2017 November 2017 February 2018 May 2018		

3	Updated Atlas of Healthcare Variation domains	Update at least six domains	30 June 2018	Clinical and technical experts will peer-review reports and data.	Leads to: publication stimulates interest in variation and concern to address this. Additional tools provided by the Commission (eg, QI tools and Find My Patient) are used to understand variation and any reduce overtreatment and address undertreatment. Leads to: changed practice where appropriate, reducing waste, increasing appropriate care and reducing disparities. For example, local improvement activity has reduced over-prescribing of opioids, inequitable access to management of diabetes in primary care, and polypharmacy in older people.
		Implement key recommendations of the Atlas evaluation to increase the sector's use of the Atlas.	30 June 2018	As part of implementing recommendations, we will consult the parties affected by them. We will conduct a survey to analyse how the implemented recommendations have affected Atlas use.	
4	Adverse events	Publicly report on adverse events	30 March 2018	Clinical and technical experts will peer-review reports and data.	Leads to: adopting nationally consistent best practice, which in turn result in fewer adverse events, better health outcomes, reduced harm and cost, and greater transparency.
5	Progress reports to the Ministry of Health and DHBs against quality and safety markers	Publish four reports on quality and safety markers, including process and/or outcome information	September 2017 December 2017 March 2018 June 2018	Clinical and technical experts will peer-review reports and data.	Leads to: demonstrable progress in improving quality and safety, including improved patient outcomes. For example, through the falls campaign the number of broken hips in public hospitals dropped by 20% from 2013 to 2015.

6	Reports from mortality review committees	Publish at least two mortality review committee reports	30 June 2018	We will consult on any advice or recommendations from the reports with parties that may be involved in implementing them. Each committee conducts an analysis every year that focuses on implementation of recommendations from previous reports.	Leads to: better system and process design across government and other agencies to stop preventable deaths from occurring again – which reduces both human and financial costs. For example, in 2015 the Child and Youth Mortality Review Committee noted that over the past five years there had been 42 fewer sudden unexpected deaths in infancy among Māori whānau and 34 fewer deaths among non-Māori babies, compared with the five years to 2009.
7	Informing the sector	Publish at least four articles or opinion papers	30 June 2018	When a peer-reviewed journal accepts an article, it is evidence of quality.	Leads to: public discussion and sector debate on our recommendations, which in turn prompt improvements in practice and thinking, improve health outcomes and reduce harm and cost. Valuable data is made available; citations of our work contribute to the Commission's role as the sector's 'thought leader' for quality improvement and show that stakeholders are engaging with our information and ideas.

Output class 2: Improvement

Background

One of our key roles is to 'lend a helping hand' to the sector in improving the quality and safety of services. This work includes:

- building the sector's quality and safety capability
- increasing the number of health professionals who take up evidence-based practice[4] by translating evidence into easy-to-use tools and resources for frontline staff
- supporting networks to build momentum, champion and lead quality improvement, and sustain change in the longer term
- building the capability of providers, consumers, families and whānau to work together as partners in care
- building leadership capability, including clinical leadership.

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

Our 2017/18 work to help the sector to achieve change

Expert advice, tools and guidance

We will provide expert advice, tools and guidance to the sector to support quality improvement initiatives. These include initiatives for teamwork and communication in DHB operating theatres, reducing surgical site infections for people having hip, knee or cardiac surgery, a patient deterioration recognition and response system, and supporting the 2017 national reportable events policy.

Primary care improvement

In 2017/18 we will implement the initiatives chosen in our Whakakotahi primary care improvement challenge,[5] and work with the sector to identify the next set of these initiatives to implement in 2018/19. We will support the PHO improvement network, and work to align Whakakotahi with service level measures (SLMs). Our work to develop quality improvement facilitator skills will also contribute to advancing primary care improvement capability.

Other new improvement initiatives

We will scope a new mental health improvement programme and establish the regional networks to support that programme by 30 June 2018. This will see us working closely with the DHBs who are funding the programme.

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[4] David Sackett describes evidence-based practice as 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients [which involves] integrating individual clinical expertise with the best available external clinical evidence from systematic research' (*British Medical Journal*, 13 January 1996).

[5] Whakakotahi ('to be as one') consists of three programmes for 2017/18, which were selected from proposals submitted by primary care organisations. The three chosen projects for 2017/18 are detailed here: www.hqsc.govt.nz/our-programmes/primary-care/news-and-events/news/2809.

By March 2018 we will also scope a potential improvement programme for aged residential care, working with the sector to establish priorities and determine how to add value to our existing work programmes

Sharing good practice and innovation

We will hold conferences, workshops and events to share good practice and innovation in the sector. These include workshops featuring international speakers, scientific symposiums, national and regional improvement programme workshops, and mortality review national conferences. For example, our adverse events learning programme uses regional workshops to increase learning from adverse events and find ways to stop similar events from happening again.

Developing engagement and partnerships with consumers, family and whānau

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

In 2017/18 we will support another Partners in Care co-design education and training programme for teams of consumers and health care personnel. We will also deliver targeted support to at least two health providers to respond to lower-scoring areas of the national inpatient experience survey.

Health quality and safety capability, including leadership building

Building capability, including leadership, in the sector has always been a key strategic priority for us and we are making good progress in this area. This helps us to develop a workforce skilled in quality improvement, that can pass on these skills within organisations to build a sustainable improvement culture. In 2017/18 this work will involve two key aspects. First, we will gather data on the outcomes and sustainable improvement that our quality improvement advisor courses have achieved. Second, we will review the implementation and outcomes of the Commission's 'Knowledge to action' framework for building quality and safety capability in the sector, which we launched in October 2016.

Working with stakeholders

To meet our deliverables, we work with DHBs; the Ministry of Health; the Health and Disability Commissioner; ACC; clinical/health leaders; consumers, families and whānau; our Roopū Māori consultative panel; hospitals (public and private); primary care providers; the aged care, mental health and disability sectors; non-governmental organisations; and international experts and contracted providers.

Work outside the SPE deliverables

As in previous years, the two output classes do not cover every programme the Commission will work on in 2017/18. Because the Commission has such a wide range of individual programmes and mortality review committees, we make a judgement about how many items to include as SPE deliverables. Some programmes outside the listed deliverables are established workstreams that we are moving over to become 'business as usual' with providers. Others involve work that is not likely to be sufficiently advanced in 2017/18 to warrant a full deliverable.

Work programmes outside this SPE include:

- reducing harm from falls – providing further information, evidence and resources to inform the annual April Falls promotion in 2018
- medication safety – working with the Ministry of Health to implement electronic medicines management nationwide; measuring and analysing data to strengthen clinical leadership and medication safety networks; helping the sector to implement and spread the opioids bundle from the safe use of opioids national collaborative; strengthening existing and developing new medication safety networks and expertise
- infection prevention and control – promoting culture change and providing guidance on practice improvements to reduce surgical site infections, with support from ACC. This programme encourages DHBs to reduce surgical site infections using a 'bundle' of practice interventions. We will also continue to support improving hand hygiene
- maternal morbidity – supporting the Commission's maternal morbidity work through the Perinatal and Maternal Mortality Review Committee; reporting case reviews and making recommendations to inform quality improvement activities; and developing related quality improvement initiatives
- to focus on improving health equity and using kaupapa Maori improvement methods and work towards a kaupapa Maori health quality improvement programme.

For more information on existing programmes, see www.hqsc.govt.nz/our-programmes.

How we will assess the performance of output class 2

	Deliverable	Quantity	Timeliness	Quality	Why are we doing this?
8	Expert advice, tools and guidance to support specific improvement programmes	Provide expert advice, tools and guidance to the sector on: • improving teamwork and communication in DHB operating theatres • reducing surgical site infections for people having hip, knee or cardiac surgery • implementing a patient deterioration recognition and response system • implementing and supporting the 2017 national adverse events policy	30 June 2018	Resources and tools are based on evidence and developed in partnership with consumers, families and whānau.	Leads to: reducing patient harm by improved levels of teamwork, a more inclusive culture, improved communication, improved preparation for operations and better recognition and response to patient deterioration.
9	Primary care improvement	• Implement chosen primary care improvement programmes • Identify and choose the next set of primary care improvement initiatives to implement in 2018/19	30 June 2018	• An evaluation of programme implementation will provide us with lessons to apply to the next set of initiatives. • We will choose initiatives prioritising consumer engagement, equity and integration, and alignment with service-level measures (SLM), in partnership with the expert advisory group.	Leads to: reducing patient harm by health professionals taking up new methods and improving their practice, and passing on their improvement skills and expertise to others.

	Deliverable	Quantity	Timeliness	Quality		Why are we doing this?
10	Aged residential care improvement	Scope a potential improvement programme in aged residential care	31 March 2018	Clinical and technical experts will peer review the scoping project.		Leads to: reducing patient harm by health professionals taking up new methods and improving their practice, and passing on their improvement skills and expertise to others.
11	Mental health and addiction improvement programme	• Scope a potential improvement programme in mental health and addiction to begin in July 2018 • Establish four regional networks to support the potential programme	30 June 2018	Clinical and technical experts will peer review the scoping project.		Leads to: reducing patient harm by health professionals taking up new methods and improving their practice, and passing on their improvement skills and expertise to others.
12	Workshops featuring international speakers	Deliver at least two workshops featuring international speakers, including one scientific symposium	30 June 2018	We will undertake an evaluation to guide us in our future choice of speakers and the most effective way to conduct the workshops.		Leads to: reducing patient harm by local sharing of overseas expertise that is otherwise hard-to-reach, along with public discussion and sector debate, which in turn prompt improvements in practice and thinking.
13	Mortality review national conferences	Deliver at least two mortality review national conferences to share results and recommendations	30 June 2018	We will undertake an evaluation of conferences to guide us in our future choice of speakers and the most effective way to conduct the conferences. This will include analysing the stakeholders represented and the key lessons they take from the sessions.		Leads to: reducing patient harm by sharing ideas and best practice for better system and process design across government and other agencies, to prevent recurrence of preventable deaths, with associated reduction in cost, both in human terms and financially.

	Deliverable	Quantity	Timeliness	Quality	Why are we doing this?
14	Engage consumers and providers as partners in care	Deliver a co-design programme for consumer–provider teams focused on key providers	30 June 2018	We will publish summaries of each completed co-design project on the Commission's website. They will show the process of working in partnership, and the service development and changes that result from the co-design process.	Leads to reducing patient harm by: • people-centred services that involve consumers, families and whānau and being receptive and responsive to their needs and values • better understanding of issues that contribute to communication between providers and consumers, families and whānau, helping providers to improve practice and boost health literacy.
		Support at least two DHBs to respond to the lower-scoring areas of the national adult inpatient experience survey by understanding the context of the scores and testing small-scale interventions in response	30 June 2018	We will evaluate the interventions to inform further work and identify the improvements they made.	
15	Build sector capability in quality improvement, including leadership	Review the outcomes and sustainable improvement that our quality improvement advisor courses achieved	30 June 2018	We will base the reviews on quality improvement principles, will involve providers and consumers, and will target them at continued improvement in the Commission's quality improvement methodology.	Leads to: improved clinical leadership at all levels across the sector to drive continuous improvement, resulting in better health outcomes and reduced harm and cost.
		Review the implementation and outcomes of the Commission's 'Knowledge to action' quality and safety framework	30 June 2018		

16	Build sector knowledge	Run annual conferences, workshops and events to share good practice and innovation: • national workshops for infection prevention • strengthening and maintaining regional networks to support clinical leadership for medication safety • four regional workshops to support sector capability in learning from adverse events • safe surgery regional workshops • supporting primary care improvement network • deteriorating patient regional and national workshops.	All deliverable dates: 30 June 2018	For each event, we conduct a survey that includes an analysis of stakeholders represented and the specific lessons they take from the event and implement in practice.	Leads to: informed discussion and debate, which in turn prompt improvements in practice and thinking. For example, health professionals consistently identify and respond to patient deterioration, reducing harm and preventing inappropriate care.

Forecast financial statements

Expected revenue and proposed expenses to be incurred in 2017/18 for each output class

Expected revenue and proposed expenses for 2017/18

	Output class 1 Intelligence $000s	Output class 2 Improvement $000s	Total $000s
Revenue			
Crown revenue	6,469	7,271	13,740
Interest revenue	16	24	40
Other revenue	52	2,265	2,317
Total revenue	6,537	9,560	16,097
Expenditure			
Operational and internal programme costs	4,078	7,065	11,143
External programme cost	2,459	2,585	5,044
Total expenditure	6,537	9,650	16,187
Surplus/(deficit)	0	(90)	(90)

Note: Numbers are rounded. See 'Key assumptions for proposed budget in 2017/18 and out years' on page 25 for key assumptions and explanations.

The 2017/18 deficit of $0.090 million relates to maternal morbidity improvement programme activity to be delivered in 2017/18 rather than 2016/17.

Prospective financial statements for the four years ending 30 June 2020

Prospective statement of comprehensive revenue and expense

	Planned 12 months to 30 June 2017	Forecast 12 months to 30 June 2017	Planned 2017/18	Planned 2018/19	Planned 2019/20
	$'000	$'000	$'000	$'000	$'000
Revenue					
Revenue from Crown	14,151	14,172	13,740	13,691	13,191
Interest revenue	80	40	40	40	40
Other revenue	835	2,355	2317	1945	1945
Total operating revenue	**15,066**	**16,567**	**16,097**	**15,676**	**15,176**
Expenditure					
Salaries	6,824	7,799	8,446	8,267	8,030
Travel	313	433	403	360	360
Consultant and contractors	193	303	193	174	141
Board/fees/committees	507	507	609	609	549
Printing/communication	253	253	265	265	265
Overhead and IT expenses	906	1,035	1,069	1,019	979
Other expenses	8	9	8	8	8
Total internal programme and operating expenditure	**9,004**	**10,339**	**10,993**	**10,702**	**10,332**
Quality and safety programmes	4,254	4,215	3,310	3,090	2,960
Mortality review programmes	1,918	1,823	1,734	1,734	1,734
Total external programme expenses	**6,172**	**6,038**	**5,044**	**4,824**	**4,694**
Depreciation and amortisation	140	150	150	150	150
Total expenditure	**15,316**	**16,527**	**16,187**	**15,676**	**15,176**
Operating surplus/(deficit)	**(250)**	**40**	**(90)**	**0**	**0**

Note: Numbers are rounded.

The Commission was planning a $0.250 million deficit for the full year but as additional surgical site infection activity of $0.150 million was completed by the end of June 2016, less was needed to be expended in 2016/17. A further $0.090 million variance to budget relates to maternal morbidity improvement programme activity to now be delivered in 2017/18 rather than 2016/17. Both of these changes result in a $0.040 million forecast surplus for 2016/17.

For 2017/18, revenue assumptions include:

- $12.976 million core Crown revenue
- $1.50 million per year from DHBs as revenue associated with mental health quality improvement
- $0.50 million per year as revenue associated with the maternal morbidity programme
- $0.37 million ACC funding for the Surgical Site Infection Improvement programme
- $0.22 million from the Ministry of Health for the Australia and New Zealand Intensive Care Society Centre (ANZICS CORE) registry
- $0.24 million for DHB funding of the national data warehouse for the Surgical Site Infection Improvement programme
- $0.05 million per year for the primary care patient experience survey
- $0.15 million from adverse event and leadership workshops
- $0.04 million interest.

Prospective statement of changes in equity

	Planned 12 months to 30 June 2017	Forecast 12 months to 30 June 2017	Planned 2017/18	Planned 2018/19	Planned 2019/20
	$'000	$'000	$'000	$'000	$'000
Opening balance	**1,484**	**1,170**	**1,210**	**1,120**	**1,120**
Equity injection	0	0	0	0	0
Total comprehensive income:	(250)	40	(90)	0	0
Net surplus/(deficit)					
Balance at 30 June	**1,234**	**1,210**	**1,120**	**1,120**	**1,120**

Note: Numbers are rounded.

The Commission was planning a $0.250 million deficit for the full year but as additional surgical site infection activity of $0.150 million was completed by the end of June 2016, less was needed to be expended in 2016/17. A further $0.090 million variance to budget relates to maternal morbidity improvement programme activity to be delivered in 2017/18 rather than 2016/17. Both of these changes result in a $0.040 million forecast surplus for 2016/17.

Prospective statement of financial position

	Planned 12 months to 30 June 2017	Forecast 12 months to 30 June 2017	Planned 2017/18	Planned 2018/19	Planned 2019/20
	$'000	$'000	$'000	$'000	$'000
Accumulated funds	**1,234**	**1,210**	**1,120**	**1,120**	**1,120**
Represented by					
current assets					
Cash and cash equivalents	2,020	1,505	1,715	1,780	1,712
GST receivable	318	327	290	278	268
Debtors and other receivables	210	589	354	261	261
Prepayments	52	50	52	54	56
Total current assets	**2,600**	**2,471**	**2,411**	**2,373**	**2,297**
Non-current assets					
Property, plant and equipment	138	218	198	178	158
Intangible assets	65	44	64	85	145
Total non-current assets	**203**	**262**	**262**	**263**	**303**
Total assets	**2,803**	**2,733**	**2,673**	**2,636**	**2,600**
Current liabilities					
Creditors	1,175	1,171	1,066	1,038	1,017
Employee benefit liabilities	394	352	487	478	463
Total current liabilities	**1,569**	**1,523**	**1,553**	**1,516**	**1,480**
Total liabilities	**1,569**	**1,523**	**1,553**	**1,516**	**1,480**
Net assets	**1,234**	**1,210**	**1,120**	**1,120**	**1,120**

Note: Numbers are rounded.

Prospective statement of cash flows

	Planned 12 months to 30 June 2017 $'000	Forecast 12 months to 30 June 2017 $'000	Planned 2017/18 $'000	Planned 2018/19 $'000	Planned 2019/20 $'000
Cash flows used in operating activities					
Cash provided from:					
Crown revenue	14,151	14,172	13,740	13,691	13,191
Interest received	80	40	40	40	40
Other revenue	835	2,072	2,552	2,038	1,945
Cash disbursed to:					
Payments to suppliers	(8,325)	(8,479)	(7,698)	(7,289)	(7,020)
Payments to employees	(6,690)	(7,818)	(8,311)	(8,277)	(8,044)
Net goods and services tax	(16)	(112)	37	12	10
Net cash flows from (used in) operating activities	**35**	**(125)**	**360**	**215**	**122**
Cash flows used in investing activities					
Cash disbursed to:					
Purchase of property, plant, equipment and intangibles	(190)	(47)	(150)	(150)	(190)
Net cash flows (used in) investing activities	**(190)**	**(47)**	**(150)**	**(150)**	**(190)**
Cash flows used in financing activity					
Equity injection	0	0	0	0	0
Net cash flows (used in) finance activities	**0**	**0**	**0**	**0**	**0**
Net increase/(decrease) in cash and cash equivalents	(155)	(172)	210	65	(68)
Plus projected opening cash and cash equivalents	2,175	1,677	1,505	1,715	1,780
Closing cash and cash equivalents	**2,020**	**1,505**	**1,715**	**1,780**	**1,712**

Note: Numbers are rounded.

Declaration by the Board

The Board acknowledges its responsibility for the information contained in the Commission's forecast financial statements. The financial statements should also be read in conjunction with the statement of accounting policies on page 26.

Key assumptions for proposed budget in 2017/18 and out years

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

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

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

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

Key assumptions are:

- While personnel costs have been assessed on the basis of expected staff mix and seniority, these may vary. Total expenditure will be maintained within forecast estimates, even if individual line items vary. In particular, there may be movements between salary, contractor and programme costs.
- Out-year costs in the operating budget are based on a mix of both no and limited general inflationary adjustment.
- The timing of the receipt of Crown revenue is based on quarterly payments made at the beginning of the quarter on the fourth of the month.
- Minimum ongoing equity requirements since 2014/15 for the Commission have been estimated between $1.1 million and $1.3 million to cover approximately one month’s worth of operating and programme expenditure and/or any contingencies.
- Salaries include a provision for an increase of 1.5 percent per year.
- The 2017/18 deficit of $0.090 million occurs because maternal morbidity improvement programme activity will be delivered in 2017/18 rather than 2016/17.
- Hardware and software replacement is planned for each of the three financial years.

Statement of accounting policies

Reporting entity

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

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

Basis of preparation

Statement of compliance

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

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

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

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

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

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

Measurement system

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

Functional and presentation currency

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

Significant accounting policies

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

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

Budget figures

The Commission authorised these prospective financial statements for issue in June 2017.

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

Revenue

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

Revenue from the Crown

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

Interest

Interest income is recognised using the effective interest method.

Operating leases

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

Cash and cash equivalents

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

Debtors and other receivables

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

Bank deposits

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

Inventories

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

Property, plant and equipment

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

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

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

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are included in the prospective statement of financial performance.

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

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

Depreciation

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

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

Intangibles

Software acquisition: Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

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

Costs associated with developing and maintaining the Commission's website are recognised as an expense when incurred.

Amortisation: Amortisation begins when the asset is available for use and ceases at the date the asset is derecognised.

The amortisation charge for each period is recognised in the prospective statement of financial performance.

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

Acquired computer software	3 years	33% SL

Impairment of non-financial assets

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

Appendix 1: Objectives and functions of the Health Quality & Safety Commission[6]

Objectives of HQSC

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

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

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

Functions of HQSC

The functions of HQSC are—

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

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

(i) health epidemiology and quality assurance; or

(ii) mortality; and

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

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

(i) the quality and safety indicators; and

(ii) any other information that HQSC considers relevant for the purpose of the report; and

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

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

(g) to perform any other function that—

(i) relates to the quality and safety of health and disability support services; and

(ii) HQSC is for the time being authorised to perform by the Minister by written notice to HQSC after consultation with it.

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

(a) the Ministry of Health; and

(b) the Health and Disability Commissioner; and

(c) providers; and

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

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

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