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STATEMENT OF PERFORMANCE EXPECTATIONS

2015–16

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

Published in June 2015 by the
Health Quality & Safety Commission,
PO Box 25496, Wellington 6146.

ISBN 978-0-908354-03-8 (online)

This document is available on the
Health Quality & Safety Commission website:
www.hqsc.govt.nz

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Board statement

In signing this statement, we acknowledge that we are responsible for the information contained in the Statement of Performance Expectations (SPE) 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 2015–16 Letter of Expectations and the Enduring Letter of Expectations from the Ministers of Finance and State Services. It is consistent with our appropriations.

Professor Alan Merry ONZM
Chair
26 June 2015

Shelley Frost
Deputy Chair
26 June 2015

Health Quality & Safety Commission Board

The Commission is governed by a Board appointed by the Minister of Health. Board members are:

Professor Alan Merry (Chair)

Shelley Frost (Deputy Chair)

Dr Dale Bramley

Dr David Galler

Robert Henderson

Dame Alison Patterson

Heather Shotter

Gwendoline Tepania-Palmer

Chief Executive: Dr Janice Wilson

Statement of Performance Expectations

The Health Quality & Safety Commission (the Commission) is a Crown entity under the New Zealand Public Health and Disability Act 2000 (the Act) and is categorised as a Crown agent for the purposes of the Crown Entities Act 2004.[1]

This SPE is provided under section 149(C) of the Act. It outlines what the Commission will achieve in 2015–16, identifies each reportable class of outputs for the financial year and includes:

- what each class of outputs is intended to achieve
- the expected revenue and proposed expenses for the class of outputs
- how the performance of the class of outputs will be assessed
- any additional information the agency is required to include in its SPE under this Act or another act.

The forecast financial statements for the financial year and out-years are in accordance with generally accepted accounting practices, including:

- a statement of all significant assumptions underlying the statements
- any additional information and explanations needed to reflect fairly the forecast financial operations and financial position of the entity.

Minister's letter of expectations

Annually, the Minister of Health provides the Commission with a number of specific key priorities for the year. In 2015–16 these are:

- "You should remain active in and expand your contribution to supporting clinical leadership. Clinical leadership is a priority for me as Minister, and I encourage HQSC [the Commission] to give a high priority within your existing resources to activities that support it.
- HQSC should take an active role in working cooperatively with other agencies; for example, through the information sharing forum and participation in the Quality Forum. Such cooperation, at the topic level and also at a strategic planning level, continues to be a ministerial priority for how HQSC operates.
- I expect you to leverage off HQSC's experience with the district health board (DHB) patient experience survey, by working, as a priority, to increase the use of the patient experience tool to cover patient experience in other parts of the sector, particularly in general practice and aged care.
- You should continue to focus on collecting good-quality safety-related data, linking with other agencies that provide and use safety-related data, and in putting data to its best use. It is important that HQSC make practical and timely use of information once it has been obtained. This is crucial to the Government's efforts to improve safety in the health sector.

[1] A Crown agent is required to give effect to government policy when directed by the responsible Minister.

- HQSC should actively engage with Health Workforce New Zealand and the Ministry to progress work commenced in 2014/15 in developing a strategic approach to building greater sector capability in quality improvement, including DHB board capability. Training in quality improvement techniques is an important part of HQSC's responsibilities and of your work programme."

The Minister's expectations form a key focus for this SPE – as outlined in the next section, 'About the Commission'. The SPE also contributes to the following Government priorities:

- responsibly managing the Government's finances
- building a more competitive and productive economy
- delivering better public services.

The Commission's strategic direction and outcomes, how we operate, our programmes and how we manage our organisational health and capability can be found in our *Statement of Intent 2014–18*, which is published on our website (www.hqsc.govt.nz).

About the Commission

The Commission's legislation calls for us 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'.

Although all organisations and individuals involved in providing and receiving health and disability support services have a role in ensuring quality and safety, the Commission is the only agency with a mandate to hold the holistic overview of quality and safety across the whole sector and to help providers to improve the quality and safety of their services. We do this alongside our national level strategic partners – notably the Ministry of Health (including the National Health Board), ACC, and the Health and Disability Commissioner (HDC). In particular, the Quality Forum and Information Sharing Forum play an important role in ensuring our combined activities are well aligned and that relevant information is shared. These forums also facilitate joint work programmes. They play an important role in the Minister's expectations that we take an 'active role in working cooperatively with other agencies' and a 'team approach across the health and disability system'.

The Commission has a key role in working with DHBs and other relevant agencies to reduce avoidable harm and death from health care services, reduce waste and improve people's experience of care. As a small agency with no regulatory or assurance mandate, we carry out this role by being a 'change' agent, driving improvement through key activities including:

- measurement and evaluation – focusing on collecting good-quality safety-related data, linking with other agencies that provide and use safety-related data, and putting data to its best use. This is a key expectation in the Minister's letter of expectations along with 'making practical and timely use of information once it has been obtained'. We also have a significant work programme aligned with the Minister's expectation that we increase the use of the patient experience tool, to cover patient experience in general practice and aged care.

- providing expert advice to Government and relevant Government agencies and being a well-informed commentator and advocate for change
- assisting the sector to effect change, including:
  - identifying and supporting implementation of effective improvement programmes; providing expert advice, tools and guidance; sharing information and aligning activities
  - increasing health literacy and building the capability of consumers and providers to work together as partners in care
  - building clinical leadership including demonstrating clinical leadership by ensuring clinicians from the sector lead our work
  - building sector capability for improvement.

Both clinical leadership and building sector capability are key expectations in the Minister's letter of expectations.

These activities will play a significant role in the sector's achievement of the New Zealand Triple Aim for quality improvement:

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

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

Achieving the triple aim depends on two key principles:

- doing the right things – those supported by evidence and that meet the values and needs of individual patients. We cannot afford to spend public money on treatments that are not effective or needed.
- doing things right, first time – so harm and waste are avoided.

Fitting it all together – linking our outputs to improved practice and health system outcomes

The deliverables in this SPE are focused on the key activities in each output class that the Commission will undertake over 2015–16.

In addition to measuring our deliverables, the Commission measures both the impacts and outcomes of those activities. Impacts measure how people have changed their practice in certain activities. Outcomes are the result of this changed practice and are usually measured in terms of reduced harm and dollars saved. Changes in outcome are our ultimate aim, but these can take longer to see as they are 'lagging' indicators. The immediate result of the Commission's work is seen in the impact measures – especially uptake of good practice. However, even in the short term, an emphasis on outcomes provides a clear indication of the results we are trying to achieve.

The Minister of Health's Letter of Expectations 2015–16 notes the importance of agencies being able to 'demonstrate the difference you are making'. As well as being included in the Commission's annual report, the impacts and outcomes of the Commission's work will be reported in a new public-facing six-monthly report, *Open4 results,* on the harm prevented and money saved by the Commission's work and the work of the wider health sector.

The Commission's annual State of the Nation report focuses on the quality and safety of the healthcare system in New Zealand more generally and includes international comparisons.

Output classes

The Commission groups its activities into three output classes:

- Output class 1: Measurement and evaluation
- Output class 2: Advice and comment
- Output class 3: Assistance to the sector to effect change.

1 Output class 1: Measurement and evaluation

1.1 Background

One of our key roles, established in legislation, is surveillance and broad assessment of the quality and safety of the sector, including national and international comparisons to identify areas where improvement in quality of health care is needed. Effective and transparent reporting and analysis of quality and safety data, incidents and trends can be a powerful way to stimulate improvement, and to prioritise problem areas for action. Used wisely, reports of this type encourage discussion and promote learning and improvement.

1.2 The Commission's 2015–16 measurement and evaluation work programme

New Zealand quality and safety markers

Quality and safety markers are a mix of structural, process and outcome measures designed to track progress of the sector against targets in a number of key Commission work

programmes, and, through public reporting, stimulate debate and improvement. Our current markers focus on reducing harm from inpatient falls, safe surgery (perioperative harm), healthcare associated infections and medicines reconciliation. In 2015–16 we are planning to add medication safety outcome measures and a new perioperative harm measure (for implementation in 2016–17). The markers measure uptake of good practice and, in many cases, reduction in harm and dollar savings.

Progress reports will be provided quarterly to the Ministry of Health and DHBs, and published on our website. We will continue to work with the sector and provide tools, resources and capability development to help meet the targets.

New Zealand Atlas of Healthcare Variation

Reporting variation in health care has been shown to be a powerful tool for improving appropriateness of care through highlighting overuse, underuse and misuse of interventions. The Commission publishes Atlas domains through an interactive web tool that displays easy-to-use maps, graphs, tables and commentary highlighting variations by geographic area in the provision and use of specific health services and health outcomes.

All domains of the Atlas reflect variation by factors such as ethnicity, age and gender, making it a powerful tool for improving equity.

The Atlas is designed to prompt debate and raise questions among clinicians, users and providers of health services about why differences in health service use and provision exist and to stimulate improvement through this debate. Internationally, in high income countries, evidence suggests that overtreatment is an important factor in waste of resource and creation of unnecessary risk. At the same time, in most countries, some people fail to access services that they need. The Atlas aims to reduce both overuse and underuse of treatments and ensure that all New Zealanders get the treatments they need (that are justified by evidence or, at least, expert consensus).

The Commission's Atlas programme has attracted much positive international interest and there are strong linkages with those countries. The Atlas is also increasingly being seen by the sector as a way of developing indicators and presenting data for quality improvement.

We will publish at least two new Atlas domains including an equity atlas in 2015–16, bringing the total number of domains to 19.

We have started a programme of regularly updating the existing Atlas domains with at least four domainsupdated in 2014–15. Some updates use the existing indicators to measure progress while others will revisit the topic and may include a number of new or improve indicators. In 2015–16 we will upate at least four domains.

An increasing focus for us is providing tools, resources and advice to help providers, clinicians and managers analyse, interpret and respond to variation between regions. This includes our innovative *Find my patient* tool, which helps GPs and other primary care health professionals, via their patient management systems, identify patients so that they can review their management and address the issues appropriately. Often this will be by

providing more appropriate treatment – for example, in relation to optimising the treatment of gout. Sometimes it will be by seeing whether there is an opportunity to reduce or revise treatment – for example, in the case of polypharmacy generally and certain categories of medication in particular.

New Zealand quality and safety indicators

Quality and Safety Indicators report

The health quality and safety indicators are a relatively small set of summary indicators organised to cover an internationally recognised range of aspects of quality – safety, patient experience, effectiveness, access/timeliness, efficiency and equity. The data is presented for the country as a whole and show changes over time. During 2015–16 we will deliver at least one full national report against the indicators.

'Open4 results' reports

This is a new public-facing report on the harm prevented and money saved by the Commission's work and the work of the wider health sector, which will be published six-monthly.

Patient experiences in GP and aged care services

The Ministry of Health has contracted the Commission to develop a system for collecting patient experiences in GP services in 2015–16, mirroring the existing Commission survey in hospitals.

During 2015–16 the Commission will also provide the Minister with a costed proposed solution for measuring patient experience in aged residential care.

Quality accounts/dashboard of key quality and safety measures

Quality accounts require health care providers to account for the quality of their services in a similar way to financial accounts showing how an organisation used its money. In 2015–16 the Commission will continue to support this work by working with the Ministry of Health to:

- review and comment on DHB quality accounts
- help DHBs develop a dashboard of key quality and safety measures to assist regular monitoring of their performance. The Commission will publish a document which contains clear guidance for DHBs on measures, content, presentation and use of quality dashboards at a local level. These dashboard measures will form the basis for improved reporting in DHB quality accounts.
- encourage DHB boards to review their quality accounts at each Board meeting, in the same way that the financial accounts are reviewed.

Adverse events learning programme

Most patients are treated safely and successfully, but some still suffer serious harm or even die from preventable adverse events. Our aim is to learn from the events and identify opportunities to reduce their risk of recurrence, and to promote a culture of openness and transparency in which improvement can flourish.

Some of the key activities of the adverse events learning programme in 2015–16 are:

- reporting on serious adverse events, which will describe the serious adverse events reported to the Commission in 2014/15
- providing data on mental health adverse events for inclusion in the Director of Mental Health's Annual Report
- a revised Reportable Events Policy
- continuing to host the Information Sharing forum with ACC, the Ministry of Health (including the Director of Mental Health) and the HDC to look at initiatives to share information and lessons across the health and disability sector
- regular reports to the sector which provide learning from adverse events such as Open Book reports, regular bulletins and alerts
- a programme to build capability in adverse event review
- strengthening regional networks.

Mortality review

Every preventable death matters, but deaths occurring in a pattern are usually an indication of larger system failures. Mortality review is used to identify and address systematic issues with the aim of improving systems and practice within services and communities.

There are currently five statutory mortality review committees.

- The Child and Youth Mortality Review Committee (CYMRC) reviews deaths of children and young people aged 28 days to 24 years.
- The Perinatal and Maternal Mortality Review Committee (PMMRC) reviews the deaths of babies and mothers in New Zealand.
- The Family Violence Death Review Committee (FVDRC) reviews all deaths relating to family violence in New Zealand.
- The Perioperative Mortality Review Committee (POMRC) reviews all deaths relating to surgery.
- The Suicide Mortality Review Committee (SuMRC) which is trialling a suicide mortality review mechanism.

During 2015–16 each of these four committees will provide at least one report based on review and analysis of mortality in their area of focus including recommendations that will influence and lead to system changes that are expected to lead to mortality and morbidity reduction. Each of the committees will work across agencies to encourage implementation of recommendations and will monitor the implementation of recommendations made in the previous year to see if the advice is being implemented. The two clinically focused committees (PMMRC and POMRC) will coordinate conferences to educate their particular sectors about clinical practice change to improve quality and safety (see deliverable in output class 2).

The age-standardised rates for suicide in New Zealand are above the OECD average for women, and near the top of the OECD for males 15–25 years of age. Māori are over-

represented in suicide statistics. Reducing the rate of suicide in New Zealand, particularly in high-risk groups, is a quality and safety priority for the health system.

A time-limited Suicide Mortality Review Committee (SuMRC), funded by the Ministry of Health as part of the New Zealand Suicide Prevention Action Plan 2013–2016, was established in 2014–15 to "trial a suicide mortality review mechanism to improve knowledge of contributing factors and patterns of suicidal behaviour in New Zealand and to better identify key intervention points for suicide[2]. The term of SuMRC expires in September 2015. During 2014–15 the Committee trialled various mortality review mechanisms in three priority populations: Māori youth, men of working age, and mental health and addiction service users. The Committee draft report will be delivered to the Ministry of Health in September 2015 and will provide useful insights into suicide prevention in those three priority populations as well as the feasibility of an ongoing suicide mortality review mechanism.

Following the report, decisions will be made on possible ongoing suicide mortality review work, building on the work already started. Even if an ongoing function is not able to be established, the SuMRC will continue when its term expires (with reduced functions and scope) to enable stewardship of the data collected to date.

Māori Caucus: Māori are over-represented in New Zealand's mortality statistics and a Māori caucus works across the committees to ensure they have access to appropriate engagement and Māori advice. The first partnered Māori caucus/mortality review committee report will be on Māori child and youth mortality and work will start during 2015–16.

Survey of safety culture in DHBs

The culture of an organisation has been found to influence safety outcomes. Measuring an organisation's culture can provide insights into areas for improvement. The Commission has a commitment to measure the safety culture and support organisations to take active steps to improve the quality and safety culture.

During 2015–16 a survey of safety culture in DHBs will be completed. The survey will provide baselines against which to measure improvement in safety culture in a repeat survey in three to five years.

[2] Action 11.1 of the New Zealand Suicide Prevention Action Plan 2013–16

1.3 How the performance of output class 1 will be assessed

	Deliverable	Quantity	Timeliness	Quality	What the deliverable is intended to achieve[3]
1	Progress reports to the Ministry of Health and DHBs against quality and safety markers (QSMs) for: • falls • infection prevention: – hand hygiene – surgical site infection • perioperative harm • medicine reconciliation	Four QSM reports published which include process and/or outcome information	September 2015 December 2015 March 2016 June 2016	Reports and data are subject to expert clinical and technical peer review.	• Demonstrable progress/results in quality and safety improvement including inproved patient outcomes • Identification and prioritisation of significant quality issues – setting the quality agenda • Informed discussion and debate leading to improvements in practice and patient outcomes
2	Report against the full set of national and international measures of quality and safety	At least one Quality and Safety Indicators report published	30 June 2016	Report and data are subject to expert clinical and technical peer review.	

[3] This column is not part of the deliverable, but is included to show what the deliverable is intended to achieve.

	Deliverable	Quantity	Timeliness	Quality	What the deliverable is intended to achieve[3]
3	New and updated Atlas of Healthcare Variation domains	Delivery of a minimum of two new domains (including an equity atlas) and an update of at least four domains	30 June 2016	Reports and data are subject to expert clinical and technical peer review.	• Informed discussion and debate about variation • Thought and discussion about appropriate interventions to reduce under-treatment and over-treatment • Changed practice where appropriate, reducing waste, increasing appropriate care and reducing disparities
4	Patient experience indicators for hospital services	Four reports on patient experience in hospital services published	August 2015 November 2015 February 2016 May 2016	Reports and data are subject to expert clinical and technical peer review. Response rate to surveys increase over time.	
5	Patient experience indicators for primary care services	Deliver to the Ministry of Health a system for collecting patient experiences in primary care services	31 January 2016	Delivery meets Ministry of Health contract expectations.	• Improved service delivery models, increasing responsiveness to patients • Improved health and better experience of care
6	Patient experience indicators for aged care	Provide the Minister with a costed proposed solution for measuring patient experience in aged residential care	30 June 2016	Proposed solution is based on best available evidence.	

	Deliverable	Quantity	Timeliness	Quality	What the deliverable is intended to achieve[3]
7	Serious adverse events	Public reporting on serious adverse events	30 December 2015	Reports and data are subject to expert clinical and technical peer review.	• An open and safe environment for reporting and learning from adverse events • Multidisciplinary team reviews leading to fewer adverse events, better health outcomes and reduced harm and cost.
8	Mortality review committee reports	Child and youth mortality report published	31 January 2016	Any advice or recommendations made in the reports will be consulted on with parties that may be involved in their implementation. An annual analysis is undertaken by each committee of implementation of recommendations from previous reports.	• Better system and process design across government and other agencies preventing recurrence of preventable deaths – with associated reduction in costs, both in human terms and financially
		Perinatal and maternal mortality report published	30 June 2016		
		Family violence death report published	30 June 2016		
		Perioperative mortality report published	30 June 2016		
9	Survey of safety culture in DHBs	Report on a survey of the safety culture in DHBs published	September 2015	The survey will provide baselines against which to measure improvement in safety culture in a repeat survey in 3–5 years.	

In meeting these deliverables we work in association with the Health Sector Forum; DHBs; the Ministry of Health (including the National Health Board, National Health IT Board and HWNZ); ACC; the HDC; clinical/health leaders; consumers and families; Roopu Māori; hospitals (public and private); primary care providers; the aged care, mental health and disability sectors; non-governmental organisations (NGOs); international experts and contracted providers.

2 Output class 2: Advice and comment

2.1 Background

The Commission has specialist skills and expertise which enables us to provide expert advice on quality and safety matters, alongside the Ministry of Health. This includes skills and expertise developed through our programme work, measurement and evaluation functions, and local and international networks.

2.2 The Commission's 2015–16 advice and comment work programme

Strategic advice to Government

The legislative framework sets the scene for the Commission's strategic advice role, and the role it plays in the sector as a leader of the quality and safety discussion. The Commission's legislative responsibilities as set out in section 59C(1) of the Act include several aspects with a strategic advice function.

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

Strategic advice includes discussions with Ministers and Government agencies about priorities for improvement, the potential benefits of investing in targeted interventions or reducing wastage, and posing questions about the appropriateness of variation in service provision or outcomes.

Expert advice to other agencies

The Commission was established in November 2010. During this time we have built strong credibility across health and other government agencies as experts in quality and safety improvement. This has resulted in an increasing demand from these agencies for us to provide advice and guidance.

Commission staff will continue to provide this expert advice service. This will include assisting the Ministry of Health in broad areas such as reviews of DHB annual and regional plans and quality accounts and providing expert advice on quality and safety related legislation and regulation. At a more targeted level, we will provide advice and assist the Ministry of Health and other agencies on working groups and review groups and on issues such as consumer engagement and partnership, collection and use of quality- and safety-related data, improvement education and training, family violence, child and youth mortality, methodologies and specific programme areas. We will also continue to work with agencies such as Statistics New Zealand; the Ministry of Business, Innovation and Employment; and the Treasury.

Providing informed public comment and promoting sector and public debate

During 2015–16 we will provide informed public comment and promote sector and public debate by:

- producing our second State of the Nation report, which uses the information from the quality and safety indicator sets as the backbone of the report but adds information from international sources such as the Commonwealth Fund survey and the OECD, and information from the Atlas where this demonstrates an aspect of quality. The broad aim of the report is to describe the quality and safety of the New Zealand health care system and to generate discussion, in a simple and widely accessible manner.
- publishing evidence-based reports and discussion papers on health quality and safety in peer-reviewed journals, on our website and via other media, to spread knowledge, promote sector debate and sustain change. This intelligent commentator role enables us to raise important issues that need robust and open discussion by the sector and community, and provides an opportunity for the Commission's position on issues to be communicated widely.
- facilitating debates within the sector and public to improve health quality and safety. Communication vehicles will include newsletters, online and social media, general and medical media, the *Open for better care* campaign, workshops featuring international speakers, conferences and journal publications.
- publishing Open Book reports, which provide learnings from adverse events in the sector.

2.3 How the performance of output class 2 will be assessed

	Deliverable	Quantity	Timeliness	Quality	What the deliverable is intended to achieve[4]
10	Annual overview of quality and safety across the system	One State of the Nation report published	April 2016	Report includes comment and discusses process improvements and reduction in harm and cost.	• Progress in the areas covered by the markers and indicators, including improved processes, better health outcome an reduced harm and cost • Identification and prioritisation of significant quality issues – setting the quality agenda • Informed discussion and debate leading to changes in practice and thinking, resulting in better health outcomes and reduced harm and cost
11	Articles in peer-reviewed journals	At least two articles published	30 June 2016	Acceptance of an article for a peer reviewed journal is evidence of quality.	• Public discussion and sector debate leading to improvements in practice and thinking an resulting in better health outcomes an reduced harm and cost
12	Opinion papers	At least two white (opinion) papers disseminated	30 June 2016	Publication stimulates debate as measured by uptake by print, broadcast and social media.	
13	Workshops featuring international speakers	At least two workshops featuring international speakers held	30 June 2016	An evaluation of workshops is undertaken to inform future choice of speakers and the most effective way to conduct the symposium. This will include analysis of stakeholders represented and the key learnings they take from the	• Increased sector capability for health quality and safety improvement – resulting in better health outcomes and reduced harm and cost.

[4] This column is not part of the deliverable, but is included to show what the deliverable is intended to achieve.

	Deliverable	Quantity	Timeliness	Quality	What the deliverable is intended to achieve[4]
				sessions. A survey is undertaken no later than three months after each speaking engagement to analyse application of key learnings to practice.	• Public discussion and sector debate leading to improvements in practice and thinking
14	Mortality review committee conferences	Perioperative mortality conference	30 June 2016	Conferences are approved for credit towards relevant professional college/society continuing professional development programmes.	• Better system and process design across government and other agencies preventing recurrence of preventable deaths – with associated reduction in costs, both in human terms and financially
		Perinatal and maternal mortality conference	30 June 2016		
15	Systematic way of informing the sector about adverse events	Open Book reports published, which provide learning from adverse events from the sector	Monthly	Oversight by the adverse events learning programme expert advisory group, subject matter experts and expert input from an editorial committee of senior Commission staff.	• An open and safe environment for reporting and learning from adverse events • Multidisciplinary team reviews leading to fewer adverse events, better health outcomes an reduced harm and cost

In meeting these deliverables we work in association with the Health Sector Forum; DHBs; the Ministry of Health (including the National Health Board, National Health IT Board and HWNZ); ACC; the HDC; clinical/health leaders; consumers and families; hospitals (public and private); primary care providers; the aged care, mental health and disability sectors; NGOs; international quality and safety organisations and experts; and contracted providers.

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

3.1 Background

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

- building leadership capability, including clinical leadership
- building quality and safety capability in the sector
- building the capability of providers and consumers to work as partners in care.
- increasing uptake of evidence-based practice through translating evidence into easy-to-use tools and resources for frontline staff. This work provides an important link to frontline staff – ensuring that we understand their environment and keeping us relevant.
- supporting networks that can build momentum, champion and lead quality improvement, and sustain change in the longer term.

We do not need to reinvent the wheel. The Commission continues to take every opportunity to tap into the considerable expertise in the sector and overseas, and to identify and learn from existing innovative quality and safety practices. This includes establishing expert advisory groups with clinical leaders, consumers and other expertise as needed for each of our programmes. These expert advisory groups are an important way to link with the sector and play a major role in guiding the direction of programmes and providing independent clinical, consumer and/or technical advice. The expert advisory groups are supported by Commission staff who provide administrative and secretariat support, develop policy and position papers for the expert advisory groups' consideration and maintain associated networks.

The number of expert advisory groups has increased, with the inclusion of primary care and capability-building.

3.2 The Commission's 2015–16 work programme to assist the sector to effect change

Developing consumer and family/whānau engagement and partnership

The Partners in Care framework is the basis of our work to improve health literacy, improve consumer participation and develop leadership capability for providers and consumers. There is growing evidence that partnerships between health service organisations/health professionals and patients and their families and carers results in improved health, better experience of care, more appropriate care, lower health care costs and increased workforce satisfaction.

During 2015–16 we plan to support another eight-month Partners in Care co-design education and training programme for teams of consumers and health care personnel. This will be the fourth time the course has been run, having proved very successful over the previous three years.

We also plan to continue to build the evidence base for engaging consumers as partners in care through an evaluation of the previous three years of the Partners in Care programme and how the Commission has assisted the sector in raising awareness of and facilitating consumer engagement. This will guide the future consumer engagement work programme in the Commission and the sector.

As awareness of the importance of consumer participation and engagement has increased within the sector, our support and advisory function has had to increase. We are increasingly asked to assist with support for national programmes (with the Ministry of Health) and, at regional and district levels, to assist DHBs with establishing and improving their consumer engagement.

Health quality and safety capability and leadership building programme

Building sector capability and leadership in quality and safety has been a key strategic priority for the Commission since its establishment and good progress has been made.

During 2014–15 we consolidated this capability and leadership building work into a 'Health Quality and Safety Capability and Leadership Building Programme'. An expert advisory group for the programme was established including HWNZ, the Ministry of Health and other key sector experts.

A regular forum has been established between the Commission, HWNZ and the Ministry of Health to ensure a joint approach to clinical leadership and clinical governance. This is consistent with the Minister of Health's letter of expectations. In addition, the Commission's Chief Executive is a member of the governance group of the HWNZ leadership and management workforce programme.

The Commission will play a key role in the HWNZ five-year kaiāwhina workforce work programme, leading the development of the quality and safety workstream for that programme.

Key components of the health quality and safety capability and leadership building programme for 2015–16 are:

Effective governance and leadership, both clinical and managerial, across all levels within the health and disability sector to improve quality and safety

- developing and promoting a quality and safety self-assessment tool for DHB boards
- developing and promoting national guidance on clinical governance for quality and safety in the sector
- continuing engagement with senior leadership (boards, CEOs, senior leaders, quality and risk managers and regional groups) to provide support, maintain an active network for shared learning and promote the quality improvement and patient safety agenda
- continuing to support networking and learning opportunities for the Commission's clinical leads (and including the ACC Chief Clinical Advisor) to support their development as leaders of quality and safety in the sector

- working with key stakeholder to create a framework for leadership development in quality improvement and patient safety and plan for implementation. This will include a focus on 'leadership for quality and safety' as the topic for the next *Open for better care* campaign.

A culture across all levels within the health and disability sector where quality and patient safety are the central focus

- continuing to ensure capability and leadership building is addressed across all the Commission's campaigns, improvement programmes and collaboratives
- using the results of the safety culture survey carried out in 2014–15 by Otago/Victoria universities to identify opportunities to inform future Commission work and to provide a baseline against which to measure improvement over time.

Consumers as effective partners in co-designing healthcare to improve quality and safety

- reviewing DHB strategic plans to determine how a focus on quality improvement and patient safety knowledge and consumer engagement could be improved
- supporting the development of consumers as representatives and advisors in the health and disability sector.

Health care staff having quality improvement and patient safety knowledge and skills appropriate to their role

- finalising a New Zealand competency based framework for quality and safety that will ensure that everyone in the health and disability sector has a basic understanding of quality and safety that they can confidently apply in everyday practice. Consumer competencies will be included as part of this framework.
- continuing to work with universities on developing undergraduate learning/content and postgraduate programmes in quality and safety
- creating and populating a website that acts as a knowledge hub for resources
- using the established shared workspace to connect people and share ideas.

Professional development and opportunities for shared learning

- continuing to support people to attend local and international conferences
- hosting workshops, symposiums and meetings covering topics such as improvement science, perioperative harm, perinatal and maternal mortality, infection prevention, safe use of opioids, serious adverse events reporting and quality accounts. Some will involve internationally recognised experts.
- supporting capability-building through site visits and regional meetings
- publishing exemplar reports of successful New Zealand quality improvement projects on the Commission's website.

An infrastructure in place to support and sustain capability in quality and safety across the sector

- maintaining the Commission's knowledge hub and shared workspace

- continuing to support the expert network of people with an active interest in quality improvement and patient safety through the established portal and communication processes
- providing newsletter pieces to keep the sector informed about capability- and leadership-building opportunities and using social media mechanisms to disseminate ideas.

Improvement programmes

Improvement programmes fall into two categories:

- high harm and cost areas that will require a continued strategic focus from the Commission to support lasting improvement:
  - medication safety
  - preventing infections
  - reducing harm from falls

  The rationale for these programmes is outlined in the Commission's *Statement of Intent 2014–18* (www.hqsc.govt.nz).
- focused improvement projects that eventually transition to sustainable 'business as usual'. Key elements for sustainability includes the strength of the evidence to support the change, ease of implementation, measuring progress, involving clinicians and consumers in the change, building networks and infrastructure for sustainability and building capability for improvement and leadership. Existing improvement projects that will be continuing in 2015–16 include:
  - surgical site infections
  - perioperative harm
  - falls
  - opioid collaborative.

New improvement programmes that will be either scoped or implemented in 2015–16 include work on pressure injuries and the deteriorating patient.

Pressure injuries

During 2014–15 a scoping project on pressure injuries was undertaken in partnership with the Ministry of Health and ACC. Pressure injuries are a major cause of preventable harm for health care services (including hospital, aged residential care and home care) and have significant impacts on patients, carers and their families, as well as increasing length of stay, ACC treatment injury claims and costs to the health system. An improvement programme could result in significant reductions in pressure injuries with associated reduction in cost. The Commission is working with ACC and the Ministry of Health on how this improvement programme might proceed during 2015–16.

The deteriorating patient

The Commission has been asked by the sector to support national coordination and leadership of work to reduce harm related to the failure to recognise clinical deterioration in patients and underestimating the severity of a patient's condition. An investment case was

completed which confirmed the benefits of investing in such a programme and implementation of an improvement programme may start in 2015–16.

The Commission intends to increase its focus on primary care and community services, aged residential care and disability services. In 2014 the Commission hosted a workshop with opinion leaders for primary care to identify the important quality and safety issues for primary care and how the Commission may best contribute. An expert advisory group will be established in 2015–16 to support the Commission's engagement with primary care, provide a primary care perspective to the Commission's current work and advise on future initiatives.

The Commission has work underway with primary care to improve health literacy through *Let's PLAN for better care.* Other work in primary care involves use of the Atlas of Healthcare Variation, developing measures for consumer experience in primary care, supporting the medication error reporting programme, and work on medication safety and reducing patient falls.

The Commission also has work underway with the aged residential care sector, focusing on reducing falls in aged residential care settings, early work on a national medication chart in aged residential care and the polypharmacy atlas.

Severe Acute Maternal Morbidity (SAMM) Audit

The SAMM audit is a project currently based at Otago University which aims to assess potential preventability of maternal 'near misses' and delineate themes of preventability. The SAMM process has now recruited all 20 DHBs and six panels have been formed with multidisciplinary representation. To date, the project has been funded by the Ministry of Health and the Health Research Council. The Minister of Health announced on 26 March 2015 that *"The Ministry will invest $2 million over the next four years into the audit programme which will sit under the Health Quality an Safety Commission".* On this basis, further scoping is being undertaken to determine the best way to progress this work and the most appropriate framework for the protection of information. Following scoping, work will commence on implementing the agreed programme in 2015–16.

The revenue in this SPE includes new funding of $0.5 million for 2015-16 for the SAMM programme.

Medication safety

The programme objectives are:

- improving safe prescribing, dispensing, administration and monitoring of medicines, including implementation of electronic prescribing and administration, and electronic medicines reconciliation on admission and discharge from hospital
- improving the transfer of medicine information at transition points of care
- reducing harm from high-risk medicines and situations
- providing expert advice and strategic thinking on medication safety.

During 2015–16 the Commission will continue to support improved prescribing and administration practices, promote the use of medicine reconciliation as measured by the QSMs and provide advice on high-risk medicines and situations.

Much of our work in medication safety involves working in partnership with the National Health IT Board, particularly those elements that involve electronic processes.

We are also partnering with DHBs to implement a national 'breakthrough collaborative' on the safe use of opioids in DHB hospitals. The collaborative will enable DHBs to learn from each other in a collaborative environment, share their experiences and trial interventions that identify best practices. The collaborative commenced in October 2014 and will run for a period of 18 months through to April 2016.

A test of a revised standardised aged residential care medication chart is being planned.

Infection prevention and control

Our aim is to significantly reduce harm and costs associated with preventable health care associated infections. The programme is currently implementing a bundle of quality improvement interventions for reducing infection in hip and knee surgery as well as cardiac surgery. The programme also collects and reports data (surveillance). In 2015–16 the focus will be on embedding the cardiac surgery changes and ensuring infection prevention interventions and surveillance for orthopaedic surgery are sustained.

We will also work towards building an understanding of the importance of infection prevention and control in the national health care system at senior levels within DHBs nationally, regionally and locally. This will be augmented by strengthening clinical leadership, and driving the development of a national network of clinical champions equipped with quality improvement knowledge and skills which will lead to change.

The Commission has entered into a final contract with Hand Hygiene New Zealand until January 2016 to continue to build DHB capability to sustain hand hygiene improvement in the long term.

Reducing harm from falls

Reducing harm from falls is a national multi-agency programme which includes the Commission, ACC and the Ministry of Health. The key falls prevention activity for the Commission in 2015–16 will be the annual, regionally driven, 'April Falls' focus, which will work across all sectors. We will also be completing the second *Open for better care* campaign on falls reduction, which runs from April to September 2015 and will focus on reducing falls in care settings with an emphasis on falls in community care settings. Progress on reducing falls in hospital settings will continue to be measured through the quality and safety markers. The markers focus on completion of risk assessments, individualised care plans and numbers of falls in hospitals resulting in fractured hips. The falls atlas published in 2014–15 will be used by the Commission to inform regional work.

Strengthening the regional falls networks and linking them to Health of Older People networks will be important during the year to assist in the transition of the falls programme to a sustainable 'business as usual' activity.

Reducing perioperative harm (improving surgical safety)
During 2015–16 the Commission's national programme to reduce perioperative harm will focus predominantly on implementing previously piloted strategies to improve teamwork and communication in operating theatres. In support of this aim, during 2015–16 the Commission will be working with DHBs to roll out a set of 'teamwork and communication' interventions. A new QSM is being developed during 2015–16 (for implementation in 2016–17) to measure uptake and improvements. The previous QSM focused on checklist compliance and has now been retired.

All DHBs will be expected to have started implementation of the bundle before the end of the 2015–16 financial year.

'Open for better care' national patient safety campaign
2015–16 will be the third year of *Open for better care*, the Commission's national patient safety campaign. The campaign's overarching aim is 'to inform and mobilise the New Zealand population to ensure safety and quality improvement in health care by preventing harm, avoiding waste and getting better value from resources'.

The campaign focuses on one key topic at a time. Each campaign identifies changes in practice that can make a big difference to patient safety. While we provide tools, interventions, collaborations, promotions, resources and workforce development opportunities, the campaign is implemented regionally by the health sector. DHBs and other providers adopt the national approach and associated resources in a way that best suits their local environment and situation. We will continue to support and build the regional campaign networks – they are critical to the success of the campaign and to supporting development of increased quality and safety improvement capability and ongoing ownership by the sector beyond the life of the campaign.

In 2015–16 the falls topic, which runs from April to August 2015, will be completed and at least one other topic launched. This will focus on leadership for quality and safety. November 2015 will be New Zealand's second Patient Safety Week, coordinated by the Commission and working with First, Do No Harm in the Northern Region.

3.3 How the performance of output class 3 will be assessed

	Deliverable	Quantity	Timeliness	Quality	What the deliverable is intended to achieve[5]
16	Engage consumers and providers as partners in care	A nine-month co-design programme for consumer/provider teams is delivered	30 June 2016	Summaries of each completed co-design project published on the Commission's website.	• People-centred services that involve consumers and are receptive and responsive to their needs and values • Improved health, better experience of care, more appropriate care, lower health care costs and increased workforce satisfaction
17	Build the ongoing evidence base for engaging consumers as partners in care to guide future consumer engagement work in the Commission and the sector	An evaluation of the previous three years of the Partners in Care programme is completed	30 June 2016	Draft report is reviewed by the consumer network and a selection of providers.	
18	Build sector leadership	Quality and safety self-assessment tool for DHB boards completed	December 2015	Senior clinicians and managers and Board members are involved in development.	• Improved clinical leadership at all levels across the sector to drive continuous improvement, resulting in better health outcomes and reduced harm and cost
		National guidance provided on clinical governance for quality and safety in the sector	March 2016		

[5] This column is not part of the deliverable, but is included to show what the deliverable is intended to achieve.

	Deliverable	Quantity	Timeliness	Quality	What the deliverable is intended to achieve[5]
19	Build sector capability	Annual conferences, workshops and events to share good practice and innovation: • Scientific symposium on improvement science • National and regional workshops for infection prevention • National learning session for the safe use of opioids • Pilot workshop/s to support learning from adverse events • Perioperative harm workshops for three DHB cohorts • National quality accounts workshop	31 April 2016 National: by 30 June 2016 Regional: by 30 June 2016 November 2015 30 June 2016 30 June 2016 30 June 2016	For each event, a survey is undertaken including an analysis of stakeholders represented and the key learnings they take from the event	• Informed discussion and debate leading to improvements in practice and thinking • Improved sector capability to implement and sustain improvements in practice, resulting in better health outcomes and reduced harm and cost
20	Quality and safety in the kaiāwhina[6] workforce	The quality and safety component of the HWNZ five-year kaiāwhina workforce work programme delivered	30 June 2016	HWNZ, the Ministry of Health and the broader disability, aged care, mental health community care and home support sector are engaged in the development process.	• Improved capability of the kaiāwhina workforce to implement and sustain improvements in practice, resulting in better health outcomes and reduced harm and cost

[6] Essentially the unregulated workforce

	Deliverable	Quantity	Timeliness	Quality	What the deliverable is intended to achieve[5]
21	Expert advice, tools and guidance	Expert advice, tools and guidance provided to the sector on • safe use of opioids in the hospital setting • implementation of teamwork and communication in DHB operating theatres • reducing surgical site infections for people undergoing hip and knee surgery and cardiac surgery	30 June 2016 30 June 2016 30 June 2016	Resources and tools are • based on evidence • developed in partnership with consumers.	• Improved sector capability to implement and sustain improvements in practice, resulting in better health outcomes and reduced harm and cost
22	A national patient safety campaign – *Open for better care*	At least one topic launched	30 June 2016	The number of hits to the website, webinar registrations and download of resources will be measured (and compared where possible with campaign topics with a similar stakeholder base) If QSMs are already established, these will be used to measure improved uptake of good practice in the topic area/s.	
		Patient Safety Week 2015 is held	November 2015	Participation in Patient Safety Week increases from the previous year	

In meeting these deliverables we work in association with the Health Sector Forum; DHBs; the Ministry of Health (including the National Health Board, National Health IT Board and HWNZ); ACC; the HDC; clinical/health leaders; consumers and families; hospitals (public and private); primary care providers; the aged care, mental health and disability sectors; NGOs; international quality and safety organisations and experts; and contracted providers.

4 Expected revenue/proposed expenses to be incurred in 2015–16 for each output class

Expected revenue/proposed expenses for 2015–16

	Output class 1 Measurement and evaluation $000s	Output class 2 Advice and comment $000s	Output class 3 Assistance to the sector to effect change $000s	Total $000s
Income				
Crown revenue	6,342	650	6,639	13,632
Interest income	37	4	39	80
Other income	0	50	0	50
Total income	6,379	704	6,678	13,762
Expenditure				
Operational and Internal programme costs	3,904	584	3,723	8,211
External programme cost	2,475	120	3,045	5,641
Total expenditure	6,379	704	6,768	13,852
Surplus/(deficit)	0	0	(90)	(90)

The $0.09 million deficit relates to expenditure associated with the expansion of the Medicine Error Reporting and Prevention (MERP) programme through the NZ Pharmacovigilance Centre (NZPhvC) revenue received but not expended in 2014–15.

The table below shows that 71 percent of Commission expenditure is on direct programme activity, with 30 percent delivered in-house and 41 percent by external providers. Indirect operational and overheads costs equate to 29 percent of overall expenditure.

	Total $000s	Percentage of overall expenditure
Income		
Revenue	13,762	
Total income	**13,762**	
Expenditure		
Programme delivery		
Internal programme	4,162	30%
External programme	5,641	41%
Total programme delivery	**9,803**	**71%**
Indirect operating and overheads	4,049	29%
Total expenditure	**13,852**	
Surplus/(deficit)	(90)	

Note: Numbers are rounded.

See 'Key assumptions for proposed budget in 2015–16 and out-years' on page 34 for key assumptions and explanations.

5 Prospective financial statements for the four years ending 30 June 2018

5.1 Prospective statement of comprehensive revenue and expense

	Planned 12 months to 30 June 2015 $000s	Forecast 12 months to 30 June 2015 $000s	Planned 2015–16 $000s	Planned 2016–17 $000s	Planned 2017–18 $000s
Revenue					
Crown revenue	13,226	13,385	13,632	13,635	13,529
Interest income	70	100	80	70	70
Other income	0	936	50	50	50
Total operating revenue	**13,296**	**14,421**	**13,762**	**13,755**	**13,649**
Expenditure					
Salaries	4,642	5,587	6,015	6,095	6,095
Travel	314	376	313	300	300
Consultant and contractors	242	586	193	174	141
Board/fees/committees	517	568	507	507	507
Printing/communication	245	219	254	254	254
Overhead and IT expenses	611	787	806	806	806
Other expenses	9	11	10	10	10
Total internal programme and operating expenditure	**6,580**	**8,133**	**8,097**	**8,145**	**8,112**
Quality and safety programmes	4,132	4,051	3,721	3,610	3,506
Mortality review programmes	2,620	2,163	1,920	1,920	1,920
Total external programme expenses	**6,752**	**6,214**	**5,641**	**5,529**	**5,426**
Depreciation and amortisation	149	114	114	131	111
Total expenditure	**13,481**	**14,461**	**13,852**	**13,805**	**13,649**
Operating surplus/deficit	**(185)**	**(40)**	**(90)**	**(50)**	**(0)**

Note: Numbers are rounded.

2015–16 revenue assumptions include: $12.97m core crown revenue, $0.156m per annum Primary Care Patient Experience Suvey (in contract ends 2017–18) and $0.5m per annum new revenue associated with the Severe Acute Maternal Morbidity (SAMM) audit (new revenue).

5.2 Prospective statement of changes in equity

	Planned 12 months to 30 June 2015 $000s	Forecast 12 months to 30 June 2015 $000s	Planned 2015–16 $000s	Planned 2016–17 $000s	Planned 2017–18 $000s
Opening balance	1,679	1,311	1,271	1,181	1,131
Equity injection	0	0	0	0	0
Total comprehensive income:	**(185)**	**(40)**	**(90)**	**(50)**	**(0)**
Net surplus / (deficit)					
Balance at 30 June	**1,494**	**1,271**	**1,181**	**1,131**	**1,131**

Note: Numbers are rounded.

5.3 Prospective statement of financial position

	Planned 12 months to 30 June 2015 $000s	Forecast 12 months to 30 June 2015 $000s	Planned 2015–16 $000s	Planned 2016–17 $000s	Planned 2017–18 $000s
Accumulated funds	**1,494**	**1,271**	**1,181**	**1,131**	**1,131**
Represented by					
current assets					
Cash and cash equivalents	2,347	2,107	2,084	2,052	1,993
GST receivable	331	333	294	289	283
Debtors and other receivables	60	60	0	0	0
Prepayments	50	50	52	54	56
Total current assets	**2,788**	**2,550**	**2,430**	**2,395**	**2,332**
Non-current assets					
Property, plant and equipment	220	182	143	144	211
Intangible assets	70	15	71	47	32
Total non-current assets	**290**	**197**	**214**	**191**	**243**
Total assets	**3,078**	**2,747**	**2,644**	**2,586**	**2,575**
Current liabilities					
Creditors	1,379	1,271	1,116	1,104	1,092
Employee benefit liabilities	205	205	347	352	352
Total current liabilities	**1,584**	**1,476**	**1,463**	**1,455**	**1,444**
Total liabilities	**1,584**	**1,476**	**1,463**	**1,455**	**1,444**
Net assets	**1,494**	**1,271**	**1,181**	**1,131**	**1,131**

Note: Numbers are rounded.

5.4 Prospective statement of cash flows

	Planned 12 months to 30 June 2015 $000s	Forecast 12 months to 30 June 2015 $000s	Planned 2015–16 $000s	Planned 2016–17 $000s	Planned 2017–18 $000s
Cash flows used in operating activities					
Cash provided from:					
Crown revenue	13,226	13,385	13,632	13,635	13,529
Interest received	70	100	80	70	70
Other income	0	1,001	110	50	50
Cash disbursed to:					
Payments to suppliers	(8,724)	(8,781)	(7,880)	(7,593)	(7,456)
Payments to employees	(4,590)	(5,669)	(5,873)	(6,090)	(6,095)
Net goods and services tax	23	48	39	5	6
Net cash flows from (used in) operating activities	**5**	**84**	**108**	**76**	**104**
Cash flows used in investing activities					
Cash disbursed to:					
Purchase of property, plant, equipment & intangibles	(249)	(129)	(130)	(108)	(164)
Net cash flows (used in) investing activities	**(249)**	**(129)**	**(130)**	**(108)**	**(164)**
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	(244)	(44)	(22)	(32)	(60)
Plus projected opening cash and cash equivalents	2,591	2,151	2,107	2,084	2,053
Closing cash and cash equivalents	**2,347**	**2,107**	**2,084**	**2,053**	**1,993**

Note: Numbers are rounded.

6 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 set out in section 8.

7 Key assumptions for proposed budget in 2015–16 and out-years

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

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

Key assumptions are as follows.

- While personnel costs have been assessed on the basis of expected staff mix and seniority, this 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 or limited general inflationary adjustment.
- The timing of the receipt of Crown revenue is based on quarterly payments paid at the beginning of the quarter on the fourth of the month.
- Minimum ongoing equity requirements from 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 1.5 percent per annum increase provision.
- The 2015–16 deficit of $0.09 million relates to planned expenditure associated with the expansion of the MERP programme through the NZPhvC, where revenue was received but not expended in 2014–15.
- Hardware and software replacement is planned for 2016–17 and 2017–18.

8 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's ultimate parent is the New Zealand Crown.

The Commission's primary objective is to provide public services to New Zealanders, as opposed to that of making 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 the 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 upon 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
These prospective financial statements were authorised for issue by the Commission in June 2015.

The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Commission for the preparation of 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 subsequent to publication of these statements.

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

The costs of day-to-day servicing of property, plant and equipment are recognised in the prospective statement of 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 the development and maintenance of 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.