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STATEMENT OF PERFORMANCE EXPECTATIONS

2016–17

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 (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 2016/17 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

7 June 2016

Shelley Frost

Deputy Chair

7 June 2016

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 and 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. The objectives and functions of the Commission are set out in Appendix 1, on page 37.

This SPE is provided under section 149C of the Crown Entities Act and describes what the Commission will achieve in 2016–17.

It outlines our reportable output classes, what each will achieve, how they will be assessed, and associated expected revenue and proposed expenses. It also includes any other information we have to include in an SPE under the Crown Entities Act or another act.

The Commission's SPE deliverables include an additional column, 'Why are we doing this?', on the right margin of each page. This explains briefly to which strategic focus each deliverable contributes, and provides examples of the ideal results we would like to see resulting from our programmes. This is intended to show the linkages of outputs to outcomes and demonstrate the value of each deliverable. The column does not form part of the assessment criteria. All outputs will be assessed against the Quantity, Timeliness and Quality criteria set out in the second, third and fourth columns.

The forecast financial statements for the financial year and out-years align with generally accepted accounting practices. The statements include:

- a statement of all underlying significant assumptions
- any other information needed to reflect fairly our forecast financial operations and financial position.

Influences on this SPE

Several strategic documents and principles have influenced this SPE. They are briefly described below.

- Key priorities from the Minister of Health's 2016–17 Letter of Expectations:
    - 'Follow your experience with the patient experience survey at DHB level and in general practice, to expand and embed the use of the patient experience survey tool, as a matter of priority during this year, into the aged care sector.
    - 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).

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

- Work jointly with the Ministry to ensure all proposed publications reflect a comprehensive, contextualised and joined-up picture of the health system.
- Continue to strongly develop greater sector capability in quality improvement.'

- *Statement of Intent 2014–18,*[2] which describes our strategic direction, outcomes and programmes, and how we operate and manage our organisational health and capability.
- The guiding framework of the New Zealand Triple Aim, which aims to achieve:
  - (for the individual) improved quality, safety and experience of care
  - (for the population) improved health and equity for all populations
  - (for the system) best value for public health system resources.
- The 2015 Performance Improvement Framework (PIF) review,[3] which identifies the areas we would like to build on in our future work.
- *Towards 2019*,[4] a document that describes what we want to achieve between 2015 and 2019.
- The *Four year excellence horizon*, a document summarising staff views of what the Commission wants to achieve between 2015 and 2019.
- *Is the Health Quality & Safety Commission making a difference in New Zealand health care?,*[5] an evaluation of the success of our work programmes in bringing about change, reducing harm and cost, and achieving sustainable improvement.
- Government priorities:
  - responsibly managing the Government's finances
  - building a more competitive and productive economy
  - delivering better public services.
- The New Zealand Health Strategy[6] vision statement: 'So that 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 system (see below).

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[2] www.hqsc.govt.nz/assets/General-PR-files-images/Statement-of-Intent-2014-2018.pdf.

[3] www.hqsc.govt.nz/assets/General-PR-files-images/Accountability_documents/PIF-self-review-Dec-2015.pdf.

[4] *Towards 2019* was written to inform discussions with external PIF reviewers, who went on to write the Commission's *Four year excellence horizon*.

[5] The evaluation took place between October 2013 and June 2015, and was conducted by researchers at Victoria University of Wellington and the University of Otago.

[6] www.health.govt.nz/publication/new-zealand-health-strategy-2016.

How the New Zealand Health Strategy informs the Commission's work

The New Zealand Health Strategy's five key themes are reflected throughout the Commission's work programme and our approach to working with the sector and consumers to improve the quality and value of health and disability support services.

Health strategy theme	The way we work	Commission activities
People-powered – people-centred approaches	We are driven by what matters to patients/consumers and their families/whānau, and by what will improve the health of communities and populations. Our consumer panel comments on all key strategic policies and reports. All work programmes are designed with a consumer perspective, and all our expert advisory groups include consumer members.	Partners in care consumer engagement programme Te Roopū Māori (Māori advisory group to the Board) Mortality review committee (MRC) Māori caucus Health literacy Advance care planning Personal stories Consumer panel Patient Safety Week
Closer to home – care at home and in communities	We have a growing focus on community care through our growing primary care and aged care initiatives. Through these initiatives we seek to improve the quality and access to care for all communities.	Falls prevention Aged care medication safety Aged care patient experience survey Primary care patient experience survey Supporting improvement programmes in primary care Primary health organisation quality improvement network
Value and high performance – best use of health investment	We use measurement and evaluation to help to identify problems and key improvement opportunities, as well as monitoring and incentivising improvement. Good measurement and evaluation shows where waste due to poor quality lies and whether or not interventions to reduce waste have worked. Our improvement programmes are focused on reducing harm and related costs, and we are working to develop a broader measure of value in health care to inform better decision-making.	Measurement and evaluation Mortality review Improvement programmes (eg, reducing harm from falls, medication safety, infection prevention and control, safe surgery) Clinical leadership and capability building Simple interventions that make a difference (eg, operating theatre briefings and debriefings)

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, 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 district health boards (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.	Clinical leadership Partnerships with stakeholders Patient Safety Week *Open for better care* national patient safety campaign Open Forum: International Speaker Series Building improvement science capability in the sector MRCs' work with other agencies
Smart system – having and sharing good information	We provide high quality advice to the Minister of Health and government agencies, and promote informed public comment and debate on health quality and safety. We recognise the potential for technology to reshape health quality improvement.	Sharing best practice with the sector eMedicine partnership with the IT Board Surgical site infection surveillance (ICNet) Deteriorating patient (electronic vital signs) MRC reports and engagement Atlas of Healthcare Variation Quality and safety indicators Quality and safety markers (QSMs) Window on quality report Adverse events reporting

How this SPE addresses inequity in access to health care and health outcomes

Improved health and equity for all populations is a key platform of the New Zealand Triple Aim, which underpins everything we do. A range of our work in 2016–17, including some of which is prioritised as an SPE deliverable, contributes to this goal of reducing systemic inequalities in access and outcomes. This range includes:

- the equity dimension of the health quality and safety indicators
- a strong focus by MRCs and the MRC Māori caucus on identifying and making recommendations to reduce inequities
- the Commission report, *A window on the quality of New Zealand's health care*, which considers whether New Zealand provides an equitable system with good health care for all, regardless of sex, ethnicity, age and resources used
- promoting the new Atlas of Healthcare Variation 'Equity Explorer'

- every Atlas of Healthcare Variation domain including detailed results by population group supporting Te Roopū Māori, the Commission's Māori advisory panel
- implementing *Te Whai Oranga*, the Commission's Māori Advancement Framework
- the new focus on primary care, which will contribute to reducing inequity and barriers to access
- new work to reduce maternal morbidity, which will have a strong focus on equity.

Work outside the SPE deliverables

The SPE is a balanced representation of the Commission's work programmes. Due to our wide range of individual programmes and MRCs, we have had to make a judgement about how many items to include as SPE deliverables. Too few, and the SPE does not provide a comprehensive overview of our work; too many, and the SPE and its associated reporting becomes overloaded with detail on multiple programmes, some of which, though valuable, are comparatively small.

New and existing work programmes outside this SPE include the following:

- Selecting primary care-focused quality improvement projects in partnership with PHOs and general practices, with a view to implementing several projects addressing equity, consumer engagement and integration outcomes in 2016–17, and implementing a new SPE deliverable in 2017–18.
- The deteriorating adult patient, which is being discussed with the sector with a view to developing proposals for a Commission-led improvement programme in 2016–17. In the meantime SPE deliverable 17 below includes a programme of regional and national workshops to share good practice and innovation. The programme will focus in 2016–17 on developing and piloting standardised rapid response systems across New Zealand, and consumer engagement through the 'patient and family/whānau escalation' and 'goals of treatment' interventions. The programme commences implementation in 2016–17 (to be completed by 30 June 2018).

Existing programmes, which are not listed as SPE deliverables either because they are programmes we are transitioning to 'business as usual' in providers, or because the work is not likely to be sufficiently advanced in 2016–17 to warrant a full deliverable, include the following:

- Reducing harm from falls – providing further information, evidence and resources to inform the annual April Falls promotion in 2017.
- Medication safety – measurement and data analysis to strengthen clinical leadership and medication safety networks; assisting the sector to implement and spread the opioids package that will come out of 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 that reduce surgical site infections, with support from the Accident Compensation Corporation (ACC). DHBs are encouraged to drive surgical site infections improvement against a 'bundle' of practice interventions. Also potential expansion of the bundle into private hospitals, and continued support for hand hygiene improvement.

- Safe surgery – local and regional engagement with local safe surgery teams and sector-wide communication to promote learning sessions and training; surgical teamwork and communication interventions in three regional cohorts.
- Maternal morbidity – embedding the Commission's new maternal morbidity function following the transfer of an existing university-based programme; case review reporting and recommendations to inform quality improvement activities; developing related quality improvement initiatives.
- A reportable events policy review, to confirm and fine-tune the set of activities to be undertaken in the following year.

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

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.

To meet our deliverables we work with the Health Sector Forum; DHBs; the Ministry of Health; ACC; the Health and Disability Commissioner; clinical/health leaders; consumers and whānau; Te Roopū 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.

1 Output class 1: Measurement and evaluation

1.1 Background

One of our key roles, established in legislation, is to monitor and assess the quality and safety of the sector. This includes making national and international comparisons to identify areas where improvement is needed. Effective and transparent reporting and analysis of quality and safety data, incidents and trends can, used wisely, stimulate improvement, encourage discussion and help us prioritise areas for improvement.

1.2 Our 2016–17 measurement and evaluation work

A window on the quality of New Zealand's health care report

This annually published public-facing report is developed in consultation with the Ministry of Health and feeds into the Ministry's work to capture and publish health system performance information. The report helps to show how our health system is performing and how it compares internationally.

Patient experience

We will launch a new system for capturing patient experience in general practice services in 2016–17. The system has been developed in partnership with the Ministry of Health. It is similar to the existing Commission survey for hospital inpatients.

Rollout of the system will start with four quarters of private reporting to develop and refine the reporting model. The survey results will be publicly released for the first time in 2017–18.

In 2015–16 we produced a costed proposed solution for measuring patient experience in aged residential care. This survey will be implemented once a preferred option is selected.

New Zealand Atlas of Healthcare Variation

Reporting variation in health care is a powerful way to improve the appropriateness of care. It highlights overuse, underuse and misuse of interventions.

The Atlas of Healthcare Variation 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 stimulate improvement through this debate. This helps to reduce both overuse and underuse of treatments. Our approach to developing the Atlas has been recognised internationally by the Dartmouth Collaborative as being the most actionable tool of this type for influencing quality improvement. The value of the measures used within the Atlas domains have been recognised in many of them being used as contributory measures in the Integrated Performance Improvement Framework (IPIF).

We have already seen increases in value in some domains we have covered. For example, since the publication of the surgical procedures domain, and following work we undertook with the associated professional body, variation in grommet insertion rates has significantly reduced. Nearly 3000 fewer procedures have been carried out between 2012 and 2015, saving approximately $5.4 million. (By way of comparison, this is more than four times our total investment in the Atlas over four years.) The Atlas focus on variation in polypharmacy resulted in several PHOs adapting their prescribing behaviour and between 2012 and 2014 we have seen 7000 fewer people over the age of 65 receiving five or more medications. There have also been 2000 fewer people over the age of 65 receiving both an anticoagulant and an antiplatelet, an example of unsafe prescribing which can lead to serious patient harm.

In 2016–17 we will update at least six existing Atlas domains. No new domains are planned. Some updates use existing indicators to measure progress, while others revisit the topic and may include new or improved indicators. We will also continue to focus on bringing the Atlas to a wider clinical audience.

Report on the value of the Commission's work

Demonstrating the value of the Commission's work is essential. We have made some progress over the past three years. In 2016–17 we have added a new deliverable to report regularly on this progress every six months, including both direct costs avoided and a broader calculation of value using value of statistical life (VoSL)[7] and quality adjusted life years (QALY)[8] analyses.

[7] www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/guide/wpc133827.pdf

[8] www.medicine.ox.ac.uk/bandolier/painres/download/whatis/qaly.pdf

Adverse events learning

Most patients are treated safely and successfully, but some still suffer serious harm or even die from preventable adverse events.

Our adverse events learning programme aims to increase learning from these events and find ways to stop them from happening again. We promote a culture of openness and transparency in which improvement can flourish.

A key activity in 2016–17 will be national reporting on adverse events. This will describe the adverse events reported to us in 2015–16 and help providers learn from them. We will also continue our work with ACC, the Ministry of Health and the Health and Disability Commissioner to reduce treatment injury.

New Zealand quality and safety markers

QSMs are a mix of structural, process and outcome measures designed to:

- track progress of the sector against targets in key Commission work programmes
- stimulate debate and improvement through public reporting.

The markers measure uptake of good practice and, in many cases, reduced harm and money saved.

The 2015–16 QSMs have focused on reducing harm from inpatient falls, hand hygiene, healthcare associated infections and medicines reconciliation. In 2016–17 we will add a new safe surgery measure, which will take effect from December 2016.

Mortality review

Mortality review is used to identify and address systemic issues with the aim of improving systems and practice within services and communities. The MRCs work across agencies to encourage implementation of recommendations and monitor the implementation of recommendations made in previous years.

There are currently four statutory MRCs:

- The Child and Youth Mortality Review Committee (CYMRC) reviews deaths of children and young people aged 28 days to 24 years in New Zealand.
- 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 in New Zealand.

In 2016–17 three committees (CYMRC, PMMRC and POMRC) will publish at least one report based on review and analysis of mortality in their area of focus. Reports include recommendations to influence and lead to system changes that will reduce mortality and morbidity.

FVDRC will take a different improvement approach in 2016–17 and hold its inaugural national conference instead of publishing a report.

Suicide Mortality Review Committee (SuMRC)

The Minister of Health is considering the future status of the trial SuMRC. In the meantime, it will operate as a 'holding committee' conducting no substantive business, to legally protect the data collected.

Māori caucus

Māori are over-represented in New Zealand's mortality statistics. A Māori caucus works across the MRCs to give them access to appropriate engagement and Māori advice, particularly as they determine the findings and recommendations in their reports and workshops. In 2016–17 the caucus will develop stronger guidance for committees to address mortality and morbidity issues affecting Māori in their reports, and provide a Māori lens through which to consider the development of new and existing reporting.

Improving the quality of reviews

In 2016–17 the Commission will make improvements to mortality review policy and practice, arising from an evaluation of local review practices for the CYMRC in 2015–16.

1.3 How the performance of output class 1 will be assessed

	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 April 2017	Report and data are subject to expert clinical and technical peer review.	• Improved systems: System design supports and promotes quality and safety practice. • Leads to: Informed discussion and debate leading to improvements in practice and patient outcomes, by highlighting comparators and placing NZ performance in an international context. It also helps the Commission determine its strategic priorities for quality improvement.
2	Patient experience indicators for hospital services	Publish four reports on patient experience of hospital services	August 2016 November 2016 February 2017 May 2017	Reports and data are subject to expert clinical and technical peer review.	• Improved patient focus: Partnerships between consumers and health and disability practitioners. • Leads to: Improved health and better experience of care by measuring baselines and fluctuations in patient perception of services and treatment. • Some hospitals are running more frequent surveys to inform local quality improvement.

3	Patient experience indicators for primary care services	Roll out and publish the primary care survey in four quarterly instalments conducted privately*	August 2016 November 2016 February 2017 May 2017	Reports and data are subject to expert clinical and technical peer review. * Public quarterly reporting is expected to follow in 2017–18.		• Improved patient focus: Partnerships between consumers and health and disability practitioners. • Leads to: Improved health and better experience of care, by measuring baselines and fluctuations in patient perception of services and treatment.
4	Patient experience indicators for aged care	Develop and implement a phased rollout of the chosen option for the aged residential care survey.	30 June 2017	Reports and data are subject to expert clinical and technical peer review.		
5	Updated Atlas of Healthcare Variation domains	Update at least six domains	30 June 2017	Reports and data are subject to expert clinical and technical peer review.		• Improved systems: System design supports and promotes quality and safety practice. • Leads to: Raising questions to stimulate debate and inform discussion about variation. • Changed practice where appropriate, reducing waste, increasing appropriate care and reducing disparities, such as the reduction in grommet insertion and polypharmacy rates following the publication of an Atlas domain on surgical procedures.
6	Report on the value of the Commission's work	Publish two reports on the value of Commission work (VoSL/QALY)	January 2017 June 2017	Reports and data are subject to technical peer review by an economist.		• Improved systems: System design supports and promotes quality and safety practice. • Leads to: Demonstrable progress/results in quality and safety improvement including improved patient outcomes. May lead to better prioritisation of improvement programmes.

7	Adverse events	Public reporting on adverse events	30 March 2017	Reports and data are subject to expert clinical and technical peer review.		• Improved behaviour: Uptake of good practice and transfer of improvement skills and expertise. • Leads to: Multidisciplinary team reviews leading to fewer adverse events, better health outcomes and reduced harm and cost, plus sharing of expertise and lessons learned between DHBs.
8	Progress reports to the Ministry of Health and DHBs against QSMs for: • falls • infection prevention: – hand hygiene – surgical site infection • safe surgery* • medicine reconciliation	Publish four QSM reports including process and/or outcome information	September 2016 December 2016 March 2017 June 2017	Reports and data are subject to expert clinical and technical peer review. * QSM to commence from December 2016 quarter; formerly known as 'perioperative harm'.		• Improved systems: System design supports and promotes quality and safety practice. • Leads to: Demonstrable progress/results in quality and safety improvement including improved patient outcomes, such as seen in the falls campaign: a 20% reduction in numbers of broken hips in public hospitals from 2013 to 2015.

9	MRC reports	CYMRC report published	31 January 2017	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.	• Improved practice: Uptake of good practice and transfer of improvement skills and expertise. • Leads to: Better system and process design across government and other agencies preventing recurrence of preventable deaths – with associated reduction in cost, both in human terms and financially. For example, in 2015 CYMRC noted that over the past five years, there have been 42 fewer sudden unexpected death in infancy deaths among Māori whānau and 34 fewer deaths among non-Māori babies, compared with the five years to 2009.
		PMMRC report published	30 June 2017		
		POMRC report published	30 June 2017		

2 Output class 2: Advice and comment

2.1 Background

The Commission has specialist skills and expertise developed through our programmes, measurement and evaluation functions, and local and international networks. These allow us to provide expert advice on quality and safety matters, in partnership with the Ministry of Health.

2.2 Our 2016–17 advice and comment work

Providing informed public comment and promoting sector and public debate

We will do this by:

- publishing, on our website and via other media, evidence-based reports and discussion papers on health quality and safety in peer-reviewed journals
- facilitating health quality and safety debates within the sector and public, including newsletters, online and social media, general and medical media, workshops featuring international speakers, conferences for mortality review specialists and journals.

Mortality review conferences

The PMMRC and POMRC will hold conferences to educate their particular sectors about clinical practice change to improve quality and safety. The POMRC conference will be held jointly with the Commission's safe surgery programme workshop. Both conferences will be joined by the first national FVDRC conference.

Advice to Ministers

The Commission is responsible for advising the Minister of Health on how quality and safety in health and disability support services may be improved, and to advise the Minister on any matters relating to health epidemiology and quality assurance, or mortality.[9] We fulfil this role chiefly through our advice to the Minister with delegated authority for the Commission's work, Associate Minister of Health, Hon Peter Dunne.

The Associate Minister receives written monthly progress updates from the Commission detailing work across all SPE deliverables and other non-SPE work of note. The Commission Chair and Chief Executive also meet with the Associate Minister every two months to discuss the Commission's work. On matters of interest to both the Commission and the Ministry of Health, joint briefings are prepared for the Associate Minister or, occasionally, for the Minister of Health.

All advice to the Associate Minister is copied to the Minister of Health's office and the Ministry of Health, for information.

[9] s.59C(1)(a–b), New Zealand Public Health and Disability Act 2000.

Partnerships

In meeting these deliverables we work with a wide range of stakeholders (see page 11 for a list of these).

2.3 How the performance of output class 2 will be assessed

	Deliverable	Quantity	Timeliness	Quality	Why are we doing this?
10	Articles in peer-reviewed journals	At least two articles published	30 June 2017	Acceptance of an article for a peer-reviewed journal is evidence of quality.	• Improved systems: System design supports and promotes quality and safety practice. • Leads to: Public discussion and sector debate leading to improvements in practice and thinking, and resulting in better health outcomes and reduced harm and cost. Citations contribute to Commission role as sector 'thought leader' for quality improvement and reflect stakeholder engagement.
11	Opinion papers	At least two opinion papers disseminated	30 June 2017	Publication stimulates debate as measured by uptake by print, broadcast and social media.	
12	Workshops featuring international speakers	At least two workshops featuring international speakers held	30 June 2017	An evaluation of each workshop 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 sessions. A survey is undertaken no later than three months after each speaking engagement to analyse application of key learnings to practice.	• Improved practice: Uptake of good practice and transfer of improvement skills and expertise. • Leads to: Public discussion and sector debate leading to improvements in practice and thinking, with otherwise hard-to-reach overseas expertise shared locally.

13	MRC conferences	FVDRC conference	30 June 2017	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 sessions.		• Improved practice: Uptake of good practice and transfer of improvement skills and expertise. • Leads to: Better system and process design across government and other agencies preventing recurrence of preventable deaths – with associated reduction in cost, both in human terms and financially. Conferences are the annual focal point for MRC information-sharing, bringing together isolated improvement expertise and fostering valuable network-building.
		PMMRC conference	30 June 2017	Conferences are approved for credit towards relevant professional college/society continuing professional development programmes.		
		POMRC conference/safe surgery workshop	30 June 2017			

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

3.1 Background

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

- building leadership capability, including clinical leadership
- building quality and safety capability
- building the capability of providers, consumers and families/whānau to work together as partners in care
- increasing uptake of evidence-based practice by translating evidence into easy-to-use tools and resources for frontline staff
- supporting networks that can build momentum, champion and lead quality improvement, and sustain change in the longer term.

We regularly tap into the considerable expertise in New Zealand and overseas to identify and learn from innovative quality and safety practices. This includes establishing expert advisory groups with clinical leaders, and enlisting consumers' and others' expertise 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.

3.2 Our 2016–17 work to assist the sector to effect change

Developing consumer and whānau engagement and partnership

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

There is growing evidence that partnerships between health providers and consumers and whānau improves people's health, gives them a better experience of care and more appropriate care, lowers health care costs and increases workforce satisfaction.

In 2016–17 we will support another Partners in Care co-design education and training programme for teams of consumers and health care personnel. We will target these in key DHBs to provide tailored assistance and improvement opportunities.

We will work with the sector to further understand the findings in the communication domain of the patient experience surveys.

Health quality and safety capability and leadership building

Building capability and leadership in the sector has always been a key strategic priority for us and we are making good progress. In 2016–17 we will:

- promote use of an online leadership training module
- build a network of emerging clinical leaders who have completed the module
- promote implementation and use of a capability framework.

Sharing good practice and innovation

We will hold conferences, workshops and events to share good practice and innovation in the sector. These include:

- scientific symposiums on improvement science
- building regional networks to support clinical leadership for medication safety
- workshops to support learning from adverse events
- safe surgery regional and national workshops (in conjunction with the POMRC)
- deteriorating patient regional and national workshops
- supporting the primary care improvement network.

Expert advice, tools and guidance

We will provide expert advice, tools and guidance to the sector to support quality improvement initiatives, including:

- safe and high quality use of medicines
- implementing teamwork and communication initiatives in DHB operating theatres
- reducing surgical site infections for people having hip and knee or cardiac surgery
- primary care improvement initiatives resulting from an expression of interest process.

3.3 How the performance of output class 3 will be assessed

	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 DHBs	30 June 2017	Summaries of each completed co-design project published on the Commission's website, showing the process undertaken to work in partnership, the service development and changes as a result of the co-design process.	• Improved patient focus: Partnerships between consumers and health and disability providers. Leads to: People-centred services that involve consumers and are receptive and responsive to their needs and values. • Better understanding of issues contributing to high quality communication between consumers and providers, helping providers to improve practice and boost health literacy.
15	Build communication between providers and families/whānau	Hold at least two workshops to explore issues in communication between providers and families/whānau. Develop a resource based on information from the workshops to guide providers and families/whānau in approaches to communication	30 June 2017	Evaluate workshops and use material to develop resource.	
16	Build sector leadership	Promote and encourage the use of the clinical leadership online training module, and build a clinical network of participants in leadership workshops	30 June 2017	A survey is undertaken to analyse application of key learnings to practice.	• Improved practice: Uptake of good practice and transfer of improvement skills and expertise. • 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.
		Implement the capability framework across providers	30 June 2017	A survey is undertaken to analyse the application of the framework by DHBs.	

	Deliverable	Quantity	Timeliness	Quality		Why are we doing this?
17	Build sector capability	Annual conferences, workshops and events to share good practice and innovation: • Scientific symposium on improvement science • National workshops for infection prevention • Build regional networks to support clinical leadership for medication safety • Workshops to support learning from adverse events • Safe surgery regional workshops • Supporting primary care improvement network • Deteriorating patient regional and national workshops	31 April 2017 National: by 30 June 2017 Regional: by 30 June 2017 30 June 2017 30 June 2017 30 June 2017 30 June 2017 30 June 2017	For each event, a survey is undertaken including an analysis of stakeholders represented and the key learnings they take from the event.		• Improved practice: Uptake of good practice and transfer of improvement skills and expertise. • Leads to: Informed discussion and debate leading to improvements in practice and thinking. • For example, patient deterioration is consistently identified and responded to, in order to reduce harm and prevent inappropriate care.

18	Expert advice, tools and guidance	Expert advice, tools and guidance provided to the sector on: • implementation of teamwork and communication in DHB operating theatres • reducing surgical site infections for people undergoing hip and knee and cardiac surgery • primary care improvement initiatives selected through an expressions of interest process • develop and pilot national rapid response systems to ensure timely, patient-specific responses to clinical deterioration for adult inpatients	30 June 2017	Resources and tools are based on evidence and developed in partnership with consumers.	• Improved practices: Uptake of good practice and transfer of improvement skills and expertise. • Leads to: Better teamwork and communication in operating theatres can lead to improved levels of teamwork, a more inclusive culture, improved communication and improved preparation for operations. • Improved practices: Uptake of good practice and transfer of improvement skills and expertise. • Leads to: Improved recognition and addressing deterioration, and consistent reductions in length of stay and resulting savings.

4 Expected revenue/proposed expenses to be incurred in 2016–17 for each output class

4.1 Expected revenue/proposed expenses for 2016–17

	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
Revenue				
Crown revenue	6,738	636	6,777	14,151
Interest revenue	36	4	41	80
Other revenue	50	50	735	835
Total revenue	**6,824**	**689**	**7,552**	**15,066**
Expenditure				
Operational and Internal programme costs	4,166	569	4,409	9,144
External programme cost	2,658	120	3,394	6,172
Total expenditure	**6,824**	**689**	**7,802**	**15,316**
Surplus/(deficit)	0	0	(250)	(250)

The $0.250 million deficit relates to:

- $0.050 million expenditure associated with the expansion of the Medicine Error Reporting Programme (MERP) through the New Zealand Pharmacovigilance Centre (NZPhvC) revenue received but not expended in 2014–15
- $0.200 million of Surgical Site Infection Improvement programme activity to be delivered in 2016–17 rather than 2015–16.

The table below shows that 72 percent of Commission expenditure is on direct programme activity, with 31 percent delivered in-house and 41 percent by external providers. Indirect operational and overheads costs equate to 28 percent of overall expenditure.

	Total $000s	Overall expenditure (%)
Revenue	15,066	
Total income	**15,066**	
Expenditure		
Programme delivery		
Internal programme	4,903	32
External programme	6,172	40
Total programme delivery	**11,075**	**72**
Indirect operating and overheads	4,241	28
Total expenditure	**15,316**	100
Surplus/(deficit)	(250)	

Note: Numbers are rounded. See ‘Key assumptions for proposed budget in 2016–17 and out-years’ on page 33 for key assumptions and explanations.

5 Prospective financial statements for the four years ending 30 June 2019

5.1 Prospective statement of comprehensive revenue and expense

	Planned 12 months to 30 June 2016 $000s	Forecast 12 months to 30 June 2016 $000s	Planned 2016–17 $000s	Planned 2017–18 $000s	Planned 2018–19 $000s
Revenue					
Crown revenue	13,632	13,862	14,151	13,681	13,681
Interest revenue	80	80	80	80	80
Other revenue	50	837	835	711	340
Total operating revenue	**13,762**	**14,779**	**15,066**	**14,472**	**14,101**
Expenditure					
Salaries	6,015	6,502	6,824	6,904	6,904
Travel	313	363	313	300	300
Consultant and contractors	193	153	193	174	141
Board/fees/committees	507	495	507	507	507
Printing/communication	254	252	253	253	253
Overhead and IT expenses	806	877	906	906	906
Other expenses	10	9	8	8	8
Total internal programme and operating expenditure	**8,097**	**8,651**	**9,004**	**9,052**	**9,019**
Quality and safety programmes	3,721	3,889	4,254	3,362	3,024
Mortality review programmes	1,920	1,929	1,918	1,918	1,918
Total external programme expenses	**5,641**	**5,818**	**6,172**	**5,280**	**4,942**
Depreciation and amortisation	114	100	140	140	140
Total expenditure	**13,852**	**14, 569**	**15,316**	**14,472**	**14,101**
Operating surplus/deficit	**(90)**	**210**	**(250)**	**0**	**0**

Note: Numbers are rounded.

For 2016–17, revenue assumptions include:

- $12.976 million core Crown revenue
- $0.50 million per annum new revenue associated with the maternal morbidity audit
- $0.49 million ACC funding of 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
- $0.280 million from the Ministry of Health for eMedicines programme
- $0.24 million for DHB funding of the national data warehouse for the Surgical Site Infection Improvement programme
- $0.16 million per annum primary care patient experience survey
- $0.10 million from adverse event and leadership workshops
- $0.08 million interest.

5.2 Prospective statement of changes in equity

	Planned 12 months to 30 June 2016 **$000s**	**Forecast 12 months to 30 June 2016** **$000s**	**Planned 2016–17** **$000s**	**Planned 2017–18** **$000s**	**Planned 2018–19** **$000s**
Opening balance	1,271	1,274	1,484	1,234	1,234
Equity injection	0	0	0	0	0
Total comprehensive income:					
Net surplus / (deficit)	(90)	210	(250)	0	0
Balance at 30 June	**1,181**	**1,484**	**1,234**	**1,234**	**1,234**

Note: Numbers are rounded.

5.3 Prospective statement of financial position

	Planned 12 months to 30 June 2016 $000s	Forecast 12 months to 30 June 2016 $000s	Planned 2016–17 $000s	Planned 2017–18 $000s	Planned 2018–19 $000s
Accumulated funds	**1,181**	**1,484**	**1,234**	**1,234**	**1,234**
Represented by					
current assets					
Cash and cash equivalents	2,084	2,175	2,020	2,052	2,076
GST receivable	294	303	318	284	270
Debtors and other receivables	0	209	209	178	85
Prepayments	52	50	52	54	56
Total current assets	**2,430**	**2,737**	**2,600**	**2,568**	**2,487**
Non-current assets					
Property, plant and equipment	143	146	138	130	122
Intangible assets	71	7	65	33	91
Total non-current assets	**214**	**153**	**203**	**163**	**213**
Total assets	**2,644**	**2,890**	**2,803**	**2,731**	**2,700**
Current liabilities					
Creditors	1,116	1,146	1,176	1,099	1,068
Employee benefit liabilities	347	260	394	398	398
Total current liabilities	**1,463**	**1,406**	**1,569**	**1,497**	**1,466**
Total liabilities	**1,463**	**1,406**	**1,569**	**1,497**	**1,466**
Net assets	**1,181**	**1,484**	**1,234**	**1,234**	**1,234**

Note: Numbers are rounded.

5.4 Prospective statement of cash flows

	Planned 12 months to 30 June 2016 $000s	Forecast 12 months to 30 June 2016 $000s	Planned 2016–17 $000s	Planned 2017–18 $000s	Planned 2018–19 $000s
Cash flows used in operating activities					
Cash provided from:					
Crown revenue	13,632	13,862	14,151	13,681	13,681
Interest received	80	80	80	80	80
Other income	110	934	835	743	433
Cash disbursed to:					
Payments to suppliers	(7,880)	(8,279)	(8,325)	(7,507)	(7,090)
Payments to employees	(5,873)	(6,515)	(6,690)	(6,899)	(6,904)
Net goods and services tax	39	(41)	(16)	35	14
Net cash flows from (used in) operating activities	**108**	**41**	**35**	**132**	**214**
Cash flows used in investing activities					
Cash disbursed to:					
Purchase of property, plant, equipment and intangibles	(130)	(37)	(190)	(100)	(190)
Net cash flows (used in) investing activities	**(130)**	**(37)**	**(190)**	**(100)**	**(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	(22)	4	(155)	32	24
Plus projected opening cash and cash equivalents	2,107	2,170	2,175	2,020	2,052
Closing cash and cash equivalents	**2,084**	**2,175**	**2,020**	**2,052**	**2,076**

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 2016–17 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 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 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 1.5 percent per annum increase provision.
- The 2016–17 deficit of $0.250 million relates to:
    - $0.050 million planned expenditure associated with the expansion of the MERP programme through the NZPhvC, where revenue was received but not expended in 2014–15.
    - $0.200 million of Surgical Site Infection Improvement programme activity to be delivered in 2016–17 rather than 2015–16.
- Hardware and software replacement is planned for each of the three financial years.

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 2016.

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.

9 Appendix 1: Objectives and functions of the Health Quality & Safety Commission[10]

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

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

(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.