Anaesthesia, the Health Quality and Safety Commission, and Us

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The Health Quality and Safety Commission (HQSC) was formed in 2010 as a crown agent (and therefore independent of the Ministry of Health) to monitor, guide, support, influence, and encourage improvement in health and disability services in New Zealand (NZ) [1]. In absolute terms, we have one of the least expensive and best value health care systems in the world, and patients have good access to effective and reasonably timely care. Unfortunately, as with most countries, our spending on health care has increased as a proportion of GDP every year since 1999[2]. Despite this, there are persistent challenges in providing high quality services safely to all our patients, and adverse events continue to be reported. Social determinants of health are as important as healthcare services, and inadequate housing and child poverty are of increasing concern.

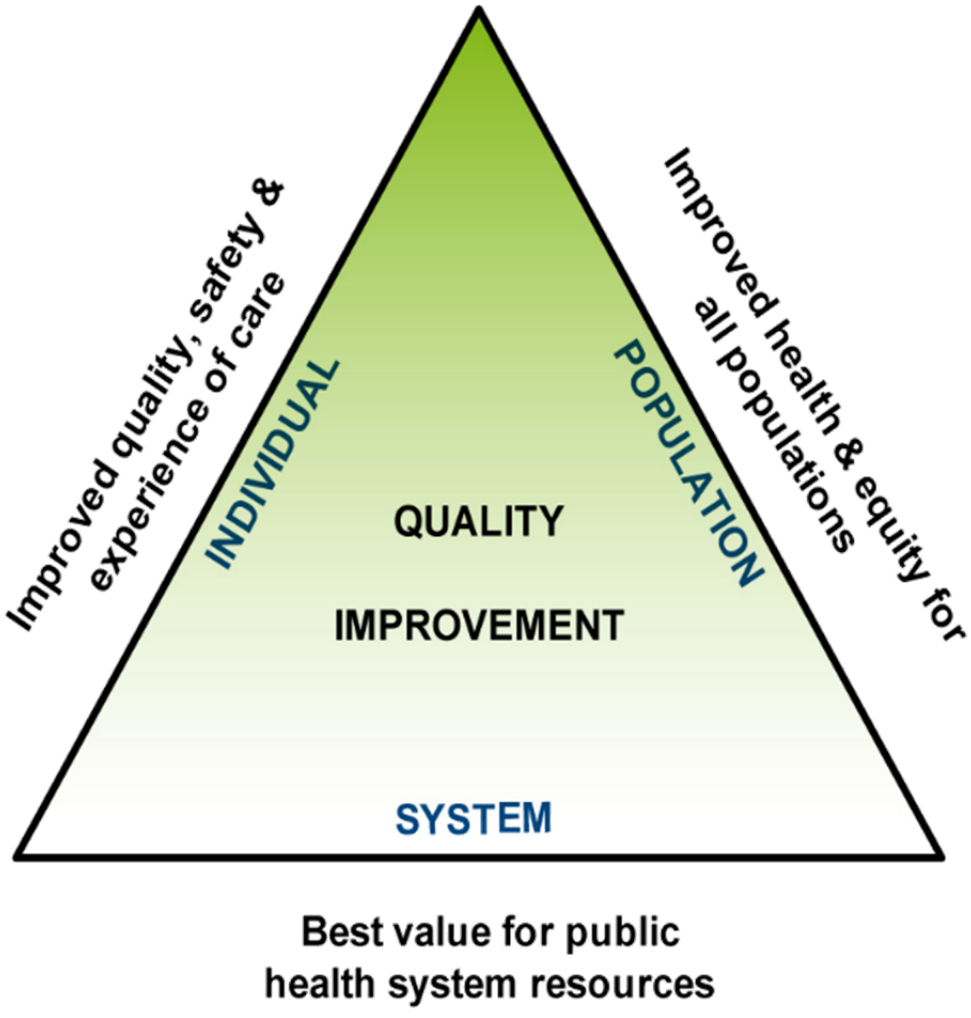

Figure 1. The New Zealand Triple Aim (source, HQSC).

The New Zealand Triple Aim[3-5] (figure 1) has now been widely adopted as the overarching goal of our health and disability services, promoting the Government's two high level outcomes:

1. New Zealanders living longer, healthier and more independent lives; and
2. New Zealand's economic growth is supported.

The three aims are:

1. improved quality, safety and experience of care;
2. improved health and equity for all populations; and
3. best value for public health system resources.

These are underpinned by two fundamental objectives:

1. doing the right things; and
2. doing things right, first time.

Measurement is integral to improving quality in any endeavour, including healthcare[6]. However, there are costs in measurement, and with limited resources it is important for every aspect of measuring the quality and safety of healthcare that the burden is kept low and that the value is clear. In this light, the HQSC has introduced a framework of interacting measures [5]. These include:

1. quality and safety indicators (QSIs), which are measures of the whole system;
2. quality and safety markers (QSMs), which are measures of specific interventions to improve the quality or safety of particular aspects of our services;
3. the New Zealand Atlas of Healthcare Variation;
4. Quality Accounts with which District Health Boards report on the quality and safety of their services in parallel with their financial reports;
5. the reports of the four mortality review committees; and
6. annual reports of serious and sentinel adverse events.

The QSMs are unique to NZ. In general they consist of a measure of process (e.g., compliance with the World Health Organization's five moments of hand hygiene) and an indicator measure of one related outcome (e.g., the rate of staphylococcus aureus infection in hospitals). The initiatives evaluated by these QSMs have direct relevance to specific problems in our services, but they also serve to engage healthcare professionals in quality improvement and thereby build capability and capacity in improvement and implementation science. Local context is critically important in the delivery of healthcare, and improvement depends on the engagement of local practitioners. This is certainly true in the operating room generally and for anaesthetists in particular. There are several examples of outstanding engagement and leadership by anaesthetists in the Commission's work, and also in quality improvement more generally. The work of Simon Mitchell on the effective use of the WHO Surgical Safety Checklist[7-10], of Leona Wilson leading the Perioperative Mortality Review Committee[11], and of John Barnard chairing the Medication Safety Expert Advisory Group illustrates the former point, and of Kerry Gunn on the rational use of blood exemplifies the latter.

The HQSC is expected to provide advice to the Minister and to others within the sector. Recently requests have been made under the official information act for the release of the following information for the past five calendar years, broken down first by each surgical department, and then by each individual surgeon (including their name and area of expertise): the number of procedures/operation performed and the numbers...

- with consequent complications;
- with consequent infections;
- which consequently required secondary corrective surgery; and
- with consequent deaths arising from the surgery.

DHB CEOs have been reluctant to comply, and the Health Ombudsman has been asked to rule on this dispute. The HQSC has undertaken an extensive review of the relevant issues. These include:

- Statistical considerations in the identification of outlying performance of individual practitioners on the basis of outcomes such as perioperative mortality 12.
- The contribution of other practitioners to perioperative mortality, notably anaesthetists 13 14 and intensivists.
- The potential contribution of other practitioners to postoperative infections, notably anaesthetists 15-28, junior doctors and nursing staff 29.
- The importance of driving teamwork rather than idiosyncratic behaviour 30,31.

The HQSC is presently consulting with the sector and consumers before formulating advice on this matter. The contribution of members of the Australian and New Zealand College of Anaesthetists' NZ National Committee to this process of consultation has been particularly helpful.

I am convinced that the culture prevailing in NZ healthcare is overwhelmingly positive, notably amongst anaesthetists. This contributes to the excellent results achieved for the vast majority of our patients at very modest cost. The Commission's role is to work with practitioners, including anaesthetists, to make good healthcare better.

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