Describing the quality of New Zealand’s health and disability services:

Developing our Health Quality and Safety Indicators

Summary of feedback from the sector engagement process

Engagement and feedback document

6th November 2012

Health Quality & Safety Commission, PO Box 25496, Wellington 6146

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

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Contents

Executive summary...........................................................................................................................................v

1. Introduction..................................................................................................................................................7
  1.1 Purpose of this document 7
  1.2 Background 7
  1.3 Overview of the sector engagement process 7

2. Summary of feedback on indicators..........................................................................................................9
  2.1 Summary of our original proposed set of indicators 9
  2.2 General comments about the indicators and framework 9
  2.3 Feedback on specific indicators 11
    2.3.1 Elective operations cancelled after admission of patient 11
    2.3.2 Ambulatory Sensitive Hospitalisations 12
    2.3.3 Amenable mortality 13
    2.3.4 People aged over 75 with more than two admissions in a year 15
    2.3.5 Day case overnight stay 16
    2.3.6 Unplanned and unexpected readmission (acute within 28 days) 17
    2.3.7 Cervical screening 18
    2.3.8 Age appropriate vaccinations 18
    2.3.9 Healthcare cost per capita (US$ Purchasing Power Parity per capita) and health care expenditure as a proportion of GDP 19
    2.3.10 Hospital days in last six months of life 19
    2.3.11 Mental health readmission rates 20
  2.4 Coverage of the indicator set 21
    2.4.1 Gaps in coverage (general themes): 21
    2.4.2 Suggestions for specific additional measures 21
  2.5 Using the information 23
    2.5.1 What barriers are there to reporting and using quality and safety information? 23
    2.5.2 What are the enablers that will best support reporting of quality and safety indicators? 23

3. Other areas of feedback ...............................................................................................................................25
  3.1 Health Quality Measures New Zealand (HQMNZ) 25
  3.2 Feedback on the Commission’s measurement and evaluation programme 25

4. Process from here .......................................................................................................................................27
Executive summary

In July 2012, the New Zealand Health Quality & Safety Commission (the Commission) published *Describing the quality of New Zealand’s health and disability services: Developing our Health Quality and Safety Indicators - engagement and feedback document*. The document presented an indicator framework and preliminary results for a working set of indicators, and targeted a range of areas for stakeholder feedback.

This publication coincided with the launch of an extensive stakeholder engagement process that involved a number of streams of activity, including: an electronic survey; a series of five seminars around New Zealand; some discussion sessions around specific measures with sector experts; and a targeted request for feedback from consumers by liaising directly with the Commission’s consumer network.

The Commission has been really pleased with the positive response from the sector to the request for involvement in this development process. Discussions and debates have been lively and thought provoking, generating some incredibly useful feedback to shape the development of the indicator set.

People were generally supportive of the purpose of the indicator set and how it is positioned within the context of the Commission’s measurement and evaluation work. We received useful feedback on specific indicators and their construct, and the audiences provided several suggestions for future indicators that would be useful and interesting to investigate further.

This document presents a consolidated summary of feedback received by the Commission during the stakeholder engagement process. It gives an indication of our preliminary conclusions in relation to specific indicators and outlines the next steps from here, towards publication of the first national set of quality and safety indicators in December 2012.
1. Introduction

1.1 Purpose of this document
This paper provides a summary of feedback received by the New Zealand Health Quality & Safety Commission (the Commission) during a stakeholder engagement process regarding the proposed set of health quality and safety indicators ('HQSIs' or the 'indicators').

1.2 Background
The New Zealand Health Quality & Safety Commission (the Commission) was established in 2010 to lead and co-ordinate work on monitoring and improving the quality and safety of health and disability support services to ensure all New Zealanders receive the best health and disability care within our available resources.

As part of its work on measurement and evaluation, the Commission is required under legislation to develop and regularly publish a set of indicators to drive improvement of the quality and safety of health and disability support services provided within New Zealand. It seeks to do this in a way that complements and builds on existing initiatives and learns from and involves stakeholders and key experts in the field of quality measurement.

1.3 Overview of the sector engagement process
In July 2012, the Commission published an engagement and feedback document1 that presented the framework and preliminary results for a working set of indicators. The document highlighted that the Commission was seeking sector views to help shape and refine the first indicator set and the development of this area of work in the longer term. The following questions were identified for consideration by stakeholders:

1. Do you agree with the stated purpose of the indicators?
2. Is the range of topics covered in the scope of the indicator set wide enough?
3. What, if any, other services or quality dimensions would you include?
4. What, if any, barriers do you envisage in reporting quality and safety indicator information?
5. How could the reporting of the quality and safety indicators be facilitated or supported?
6. What use is the information generated by the initial set of indicators to you? What impact will it have on your activities?
7. Which, if any, of the indicators in the initial set are most useful? And why?

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1 Describing the quality of New Zealand's health and disability services: Developing our Health Quality and Safety Indicators. Engagement and feedback document. Published in July 2012 by the Health Quality & Safety Commission, PO Box 25496, Wellington 6146
8. Which, if any, of the indicators in the initial set do you see as problematic? Can you explain why?

9. Are there any other indicators you think should be added to the initial set? If so, which ones and why?

10. Are there any indicators or topics that you think should be included in future sets of indicators? If so, what are they and why?

11. Are you interested in helping the Commission develop the quality and safety indicator set? If you are, please provide details of the perspective or expertise you could contribute and your preferred contact details.

This publication coincided with the launch of an extensive stakeholder engagement process that involved a number of streams of activity, as outlined below:

**Electronic survey**
An online questionnaire was published on the Commission’s website at the end of July seeking feedback on the engagement and feedback document. A targeted letter inviting engagement on the document was sent to 730 stakeholders. A total of 23 responses were received, with a number of those responses represented consolidated feedback from organisations.

**Seminar series**
The Health Quality and Safety Commission hosted a series of five seminars around New Zealand in October 2012. The purpose of the seminar series was to present and discuss the proposed set of health quality and safety indicators within the context of the Health Quality and Safety Commission’s wider measurement and evaluation work programme. They were each three-hour interactive sessions where attendees could find out more about the Commission’s work programme, ask questions and have their say.

The response to the seminars series invite was great, with around 190 people registering to attend and a good turn-out at all five seminars. Discussions and debates were lively and thought provoking, generating some incredibly useful feedback to shape the development of the indicator set. People were generally supportive of the purpose of the indicator set and how it is positioned within the context of the Commission’s measurement and evaluation work. We received useful feedback on specific indicators and their construct, and the audiences provided several suggestions for future indicators that may be useful and interesting.

**Other activities**
In addition to the activities outlined above, we held some information discussion sessions around specific measures (such as mental health key performance indicators and ambulatory sensitive hospitalisation rates) with sector experts. We also targeted feedback from consumers by liaising directly with the Commission’s consumer network and requesting them to review and provide feedback on the Engagement and Feedback document.
2. Summary of feedback on indicators

2.1 Summary of our proposed set of indicators

The diagram at Appendix 1 provides a summary of the working list of system-level indicators and contributory measures, as published in the engagement and feedback document.[1] We presented a total of 17 indicators, which were categorised (and colour coded) as follows:

- **Fast-track** – Twelve existing defined and tested indicators were identified, where there is likely to be good availability of data from existing collections. In some cases these will be collected as indicators, in others they will be derivable from existing data sets.

- **Under development** – There were 5 indicators where there was a programme of work underway to define the indicator and to better understand the availability of data.

In addition, we flagged a number of important areas as placeholders (colour coded yellow) where there would be significant further work required by the Commission during the next phase to develop an indicator and to derive data.

Subsequent to feedback provided as part of the e-survey and via some discussions with sector experts, we made some minor revisions to the set presented at the seminars, as indicated in Appendix 2.

2.2 General comments about the indicators and framework

In this section we provide an overview of discussion themes about the purpose, positioning and framework for the indicator set.

*Purpose statement*

- Generally, we received strong support for the intended purpose and objectives of the indicator set. From the e-questionnaire, 95% of respondents agreed with the stated purpose of the indicators.

- One seminar participant suggested that we should mention a desire to support improved integration of services across the sector somewhere in the objectives.

*Indicator framework*

- We were asked to ensure that there were clear definitions of the terms ‘indicators’, ‘measures’ and ‘markers’ to support consistent use of language.

- We will cover the composition of the indicator set and identified gaps in coverage in section 2.4 below. However there were two themes raised a number of times that relate more to the general approach:
  
  - There was some discussion on the equity quality domain and the Commission’s approach of stratifying indicators rather than having a specific equity measures. Some felt there was a place for specific measures with an equity focus.

[1] Describing the quality of New Zealand’s health and disability services: Developing our Health Quality and Safety Indicators. Engagement and feedback document. Published in July 2012 by the Health Quality & Safety Commission, PO Box 25496, Wellington 6146
We received a strong direction that ensuring good coverage of the patient experience domain was imperative. The Commission explained that the national satisfaction survey had been postponed and that work was under way to develop a programme to address the gap. The focus will be on patient experience, rather than patient satisfaction (as the latter concept is considered a less satisfactory or appropriate focus for measuring how patients experience care).

**Fit with other indicator sets**
- We were asked how the indicator set compares with international classifications or measures. International comparators are important for this project and this is one of the reasons several of the set’s indicators are based on international ones (e.g. there are some IHI measures, some Australian ones, etc). Of the current set, most indicators have international comparators which will be presented alongside national information. Also, there has been recent connection with the Australian Quality and Safety Commission and with the English NHS around their work on a National Quality Dashboard. Their approach is very much compatible with the Commission’s indicator set.
- It was suggested the following article may be of interest: to stakeholders
- How does the indicator set fit with work around hospital productivity indicators? The Commission noted that the focus is different (i.e. national versus DHB) and that the HQSC Indicator team is liaising with the productivity group. At the seminars participants agreed it is important to align different work streams (e.g. quality and productivity indicators and HQSC Indicators), so as not to burden the sector with measures.

**Presentation of data**
- We had a number of discussions about the intended level of reporting for the indicator set:
  - It was clarified that on a national basis the indicator results will be framed in terms of change over time for the country as a whole, rather than as a league table of performance across DHBs.
  - However, the Commission recognises that it is more useful for DHBs to understand where they sit within the range. The Commission needs to think more about what is published (i.e. available to the general public) and what will be accessible to those within the system. There is a balance between meeting this DHB requirement while protecting against risk of exposure of information by DHB that may lead to league table publication.
  - It was noted that the NHS is developing a very similar framework, supported by two-track reporting mechanisms – a national report and a local dashboard.
- Data should be presented on the basis of a quarterly breakdown.
- In some cases, actual numbers of events may be more meaningful than percentage figures alone.
There is a need for strong commentary on the indicators and measures, which at the first publication is likely to include:

- more about rationale;
- description of the results;
- identification of key questions;
- framing the debate rather than having it.

Over time the position and commentary will be richer and allow for a higher degree of meaningful interpretation.

**Technical verification**

- It was suggested that the Commission should seek review of the construction of the indicators and measures by the Ministry of Health.

### 2.3 Feedback on specific indicators

In this section we have provided a summary of the key discussion themes in relation to specific indicators.

It is important to emphasise that the feedback was not always entirely consistent, due to individual perspectives and opinions. For example, where ASH rates were viewed by many including sector experts to be problematic for a range of reasons, in the e-questionnaire they were identified as being one of the most useful measures in the set!

#### 2.3.1 Elective operations cancelled after admission of patient

**Summary of rationale for inclusion and important considerations**

This indicator measures the percentage of elective surgeries (excluding maternity surgeries) that was cancelled by the hospital after the patient has been admitted.

This will provide insight into how close the system is running to capacity and is itself a measure of patient experience that is shown in other systems to be of importance to patients.

We recognise that hospital capacity requires close management and that this analysis does not take into account the reason for cancellation. There may be a seasonal impact, with medical acute conditions likely to dominate during winter so that bed availability for elective surgical cases would diminish. That said we believe that this remains a valid measure of patient experience and indeed of the efficiency of related processes. It recognises the need for hospitals to have in place systems to manage capacity issues in relation to the interface between acute and planned care, in a timely and efficient way.

**Key points of clarification and discussion**

- It was noted that particularly for this indicator, presentation of annual data does not allow for consideration of seasonal variation; showing quarterly data would provide a richer set of information.
- The measure definition encompasses all cancellations, including those cancelled due to influenza, etc. It also includes all ‘rebooked’ procedures.
- The data does not currently include admissions to private hospitals; if data were available, this may be a feasible inclusion in the future.
The measure is not intended to facilitate drilling down into the details such as reasons for the cancellation (e.g. staffing issues). Within the context of the HQSI set, it is presented at a high level to trigger questions.

There has been some debate over whether the reasons for the cancellation mattered or not from a patient experience perspective. Some stakeholders felt hospitals cannot really control unexpected circumstances and therefore the measure was of limited use; others felt that cancellations were a good measure of patient experience, regardless of the reasons behind these.

Is data available prior to 2008? A view was expressed that four years does not allow us to tell if the rates are stable.

There was a question about whether it was possible to distinguish between cancellations of surgeries planned for day of admission versus those that were brought in the day before their surgery was planned.

We received queries about the way the data was presented; we show a national average and the maximum/minimum rates (without mentioning specific DHBs). People felt it would be most useful to know where their own DHB sat, and to understand which DHBs are performing best. It was suggested that understanding the top five DHB performers would be useful.

It was highlighted that differences by hospital may be explained by proportions of electives performed at each hospital. At sites that only do elective surgery there are less potential disruptions.

How do you set an optimum performance level? Is 1% as an average level acceptable? Is one event too many?

There was a concern that focus on this may lead to an incentive to lower the level of cancellations, which may in turn lead to decreasing the number of people scheduled and thus providing decreased access to services. However, it was noted that there are many incentives in the system to work against this, and there was a view that this is a useful balancing measure.

A clinician suggested that it may be useful also to consider DNAs for elective operations.

There was a suggestion to include an indicator related to acute operations (e.g. how many fractured necks of femur have surgery within 24 hours?).

**Preliminary conclusions and further work**

- We will include this indicator in the first publication, with caveats and concerns identified in the commentary.
- Instead of presenting data by quarter, data will be presented on a monthly basis to show any effects of seasonality.

### 2.3.2 Ambulatory Sensitive Hospitalisations

**Summary of rationale for inclusion and important considerations**

Ambulatory sensitive hospitalisations (ASH) are those admissions (mostly acute) that are considered by expert opinion to be potentially preventable through interventions out of the hospital setting. This was included as a National Health Target from July 2007.

The rate of ambulatory-sensitive hospital admissions is often used as a measure of the effectiveness of the interface between primary and secondary health care.
assumption is that better management of chronic conditions such as diabetes and cardiovascular disease within local communities has the potential to reduce the number of avoidable hospital admissions (and to moderate demand on hospital resources). This indicator can also highlight variation between different population groups that will assist with DHB planning to reduce disparities.

There has been much debate, within New Zealand and beyond about the usefulness or otherwise of Ambulatory Sensitive Hospitalisations as a measure of access to and effectiveness of system performance. There is evidence of their validity as proxy indicators of access, but this remains a contested and controversial indicator.

From a practical perspective, measuring change over time requires consistency in definition of both the basket of conditions and exclusions from the underlying data. Periodically there have been changes to the definition of this indicator. As such, it is important to ensure comparability of data presented according to the same definition.

**Key points of clarification and discussion**

- As noted above, we received mixed feedback about use of the ASH indicator within this set.

- Some people felt that ASH rates were useful in providing a lens with a population health focus that worked as a proxy for effectiveness of community based interventions and integration with hospital services. Others pointed to methodological concerns, regarding changing definitions leading to lack of comparability over time and issues around the age cut off at 75 years.

**Preliminary conclusions and further work**

- Following the receipt of early feedback, the Commission convened a discussion with sector experts around this indicator. It was agreed that this was more of “a can opener than a dial” (in terms of raising interesting questions about variation in practice and outcomes across different areas).

- As such, it has been proposed that ASH is excluded from the HQS indicator set and is instead included as one of the domains in the Atlas of Clinical Variation. The Atlas Steering Group has agreed to this and an Expert Advisory Group was established to develop this domain.

2.3.3 **Amenable mortality**

**Summary of rationale for inclusion and important considerations**

This indicator is effectively a measure of deaths that are potentially avoidable through the timely provision of appropriate health care, or the extent to which available treatments are applied to certain diagnosed conditions.

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2 http://www.treasury.govt.nz/publications/informationreleases/health/primaryhealthcare/ddd-primhealthcare-may08.pdf

3 Ansari (2007). *The concept and usefulness of Ambulatory Care Sensitive Conditions as Indicators of Quality and Access to Primary Health Care* Australian Journal of Primary Health 13(3) 91-110

4 HSAC (2008) *The effectiveness of interventions for reducing ambulatory sensitive hospitalisations: a systematic review*

In the area of effectiveness, amenable mortality helps to answer questions around the potential for gain in health outcome and the cost effectiveness of the health system: What health gain has resulted from the increase in health expenditure?\footnote{Over the past decade, health expenditure in NZ funded via Vote Health has grown at an annual rate of 4.9% in real terms (3.7% per capita). See: \url{http://www.health.govt.nz/publication/saving-lives-amenable-mortality-new-zealand-1996-2006}}

We intend to report this indicator at a national level, providing opportunity for international comparisons. Monitoring trends in performance will be more informative than a single point-in-time analysis, although the timeliness of cause of death data is currently problematic.

**Key points of clarification and discussion**

- Amenable mortality was viewed by many to be a well-tested indicator that has been consulted upon widely and is accepted in academic circles as a whole-of-system health outcome indicator.

- Three important caveats were noted: the definition of what is considered to be ‘amenable’ changes over time; there may be differences in what is measured by different countries; and there is a significant time-lag for construction of indicator.

- There has been a significant amount of discussion about possible alternative measures, including: life expectancy at birth; and Potential Years of Life Lost (PYLL). However, there is concern regarding the number of confounding contributors to these and it was noted that amenable mortality at least in theory relates directly to diseases that are amenable to health care. There was general agreement that the set should include a measure relating to mortality, even if there are constraints with all potential measures. The key message is to pick a clearly defined measure and use it, although consideration should also be given to using both amenable mortality and PLLY.

- Stratification by ethnicity was viewed to be important against this indicator.

- It was emphasised again that the narrative was important to make the data meaningful. For example, percentage rates might not have great value but to understand actual volumes might make this feel more relevant.

- There was some discussion on whether the 35 conditions included in this measure could be used as ‘markers’ for the unplanned readmission measure. This would need some further exploration and analysis.

- Following queries we have clarified that the indicator definition includes suicide and accidents.

**Preliminary conclusions and further work**

- Amenable mortality was, on the whole, viewed to be a useful measure and will be included in the indicator set. Data will be stratified by ethnicity.

- The definition standard for amenable mortality should be amended to provide the detail of the 35 conditions that are inclusions.
The project Steering Group has agreed to present PYLL alongside amenable mortality.

2.3.4 People aged over 75 with more than two admissions in a year

**Summary of rationale for inclusion and important considerations**

This is the rate of occupied bed days for people aged 75 & over who had more than 2 emergency admissions in a financial year per 1,000 (or 100,000) population aged 75 & over. The definition excludes both elective and mental health admissions.

This measure is shown in both England and Scotland\(^7\) to be a useful proxy for the effectiveness of integration of primary, acute and long stay care, showing both effectiveness of avoiding unnecessary admissions, and ability to ‘step down’ to less intensive forms of care.

Some variation seen in the results of this measure may be related to demographic factors.

**Key points of clarification and discussion**

- The cut off age of 75 may introduce bias from a NZ perspective, as we won’t have Maori and Pacific populations represented proportionally in older populations (they either don’t get admitted to hospital or die earlier). The Commission will need to include an earlier cut off age, say 55+, for Maori and Pacific populations and to look at any differences to understand the impact of ethnicity.

- The question was raised as to whether we should exclude e.g. RTA events (subsequent to the original admission) that have nothing to do with the first hospital admission or age-group? It was noted that this would be the same effect across the population (a similar pattern is shown across DHBs over time) and that it would be difficult to work out all required exclusions.

- In most DHBs, patients admitted to AT&R receive two admissions; however these would have been excluded from this data.

- Some people proposed that this measure should be published in the Atlas of Clinical Variation, rather than as part of the HQS indicator set, as it would be more useful to see variation by DHB.

- A view was expressed by some that mental health admissions should not be excluded.

**Preliminary conclusions and further work**

- Recalculate using an earlier cut off age, say 55+, for Maori and Pacific populations to understand the impact of ethnicity, if any.

- Further analysis to show admission rates alongside this data.

- Recalculate with MH conditions included.

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2.3.5 Day case overnight stay

Summary of rationale for inclusion and important considerations
This indicator measures the proportion of planned day case admissions which turn into overnight stays. An unplanned overnight stay from a day case is always a diversion from the ‘planned approach to care’, even if we do not know the cause of why the extended stay occurred (and there may be a very good clinical reason for the change).

However, it is an area where both cause and proper response is uncertain. It may reflect an adverse incident in a procedure, unrealistic assessment about what may be treated as a day case or some other local factor. This makes it a rare sort of indicator that both raises questions and provides an assessment of performance, with both quality and efficiency dimensions.

We would anticipate variation in results between DHBs in relation to demographic or geographic factors (for example, in rural settings a potentially longer distance to hospital may affect ability to travel within the same day). As such, the results should be presented at a national level.

Key points of clarification and discussion
- There was a view that this measure was relevant from both an efficiency (process) and patient experience perspective. However, there was some discussion about the fact that it is difficult to understand what rate is appropriate for this measure.
- There were concerns raised about the accuracy of data, particularly doubting the areas that illustrated zero overnight stays.
- There was a concern that a focus on this type of indicator might constrain innovation, by incentivising those selecting the lists to reduce the average risk level of patients (i.e. only offering day case surgery to patients that you know you will be able to be discharged).
- It was suggested that it may be useful to map these results against day case rates too.
- It was noted that small DHBs had been excluded from the analysis.
- Presentation of actual volumes (rather than percentages alone) was viewed to be important information to make the measure more meaningful.
- Some felt it was difficult to understand based on this indicator what the reasons behind a day case becoming an overnight stay are. It was suggested an indicator such as unexpected return to theatre may provide a better understanding of quality.
- Some people proposed that this measure should be published in the Atlas of Clinical Variation, rather than as part of the HQS indicator set, as it would be more useful to see variation by DHB.

Preliminary conclusions and further work
- The raw data needs to be cleansed further.
- Map results against day case rates
- Present actual volumes as well as percentages
- Consider an indicator such as unexpected return to theatre as an alternative
2.3.6 Unplanned and unexpected readmission (acute within 28 days)

**Summary of rationale for inclusion and important considerations**

This measures the percentage (standardised) of discharges readmitted within a set period (attributed to the DHB of the initial discharge). The denominator excludes zero or one day stay initial admissions and ACC funded initial events.

This measure can be a proxy of both the care received in the hospital and the coordination of care back to the outpatient setting and within the outpatient setting. It is important to include measures such as this that cross boundaries, highlighting the interaction between the different parts of the system.

However, this is a fairly crude indicator that does not take account of the nature of unplanned readmission, and indeed whether there is appropriate care available in the community that may have prevented the need for admission.

It is likely to be influenced by demographic factors, such as the proportion of older people within a district population, and by existing levels of co-morbidity.

**Key points of clarification and discussion**

- **Inclusions/exclusions:**
  - It was clarified that this definition:
    - used a 28 day cut-off (some documentation referred to a 30-day cut-off in error);
    - does not include mental health admissions; and
    - does not include public admissions following a recent private admission, given lack of data.
  - Should the indicator relate to only readmissions that relate to the original admission?
  - Should haematology patients be excluded from the data?
  - Further detail about the reasons for excluding ACC funded initial events should be included in the definition.

- **Potential for additional analysis:**
  - There was some interest in mapping the results of this indicator against Average Length of Stay.
  - Would the data allow stratification by readmission within 7, 14, 21, 28 days? It was felt that there may be an interesting pattern over-time that pushed readmission rates out by some days, but that they still were occurring, just later.

- It was noted that the measure linked to complications/failure of care and may be driven by earlier discharge of patients/ reduced average length of stay.

- Some clinicians felt this was an important and useful balancing indicator, that helped to pick up the impact of a range of ‘streamlining’ activities such as reducing length of stay, waits in ED etc.

- The title should be clarified, including removal of the word ‘unexpected’ and inclusion of the word ‘acute’.
Preliminary conclusions and further work

- Further detail about the reasons for excluding ACC funded initial events should be included in the definition.
- Mapping the results of this indicator against Average Length of Stay.
- Stratification by readmission within 7, 14, 21, 28 days.

2.3.7 Cervical screening

Summary of rationale for inclusion and important considerations
This measures the percentage of eligible women (aged 20 to 69 years) who have received a cervical smear in the past 3 years. It is a PHO performance measure.

Early detection and treatment of cervical cancer and other abnormalities lowers the rate of premature death for women. The available international evidence suggests that women between the ages of 20 and 69 years should be screened for cervical cancer once every three years.

This measure can be viewed as an indication of levels of access to Primary health care services. It also considers a preventative service, which is not reflected in any other proposed indicator.

Key points of clarification and discussion
- It was noted that cervical screening was selected rather than breast screening, given that there was a higher degree of evidence around the cost benefit of screening practice.
- A number of people recommended strongly that the Commission should consider using NSU national register rather than PPP data.
- People noted that against the PPP measure, coverage of screening has increased over time. There will be a natural limit as to how much further improvement can be made. Is it enough of a challenge?
- It would be useful to further disentangle/understand the high needs information.

Preliminary conclusions and further work
- The Commission is in discussion with the National Screening Unit about available data and definitions for this indicator. As part of that, we will consider whether it is possible to further disentangle/understand the high needs information.

2.3.8 Age appropriate vaccinations

Summary of rationale for inclusion and important considerations
This measures the number of children within the 2 year old age cohort (between 24-35 months of age) who have received a complete set of age appropriate vaccinations. It has been part of the PHO Performance Programme's National Indicator Set since 1 January 2006.

Children who receive the complete set of age appropriate vaccinations (in this case for the 2 year old age group) are less likely to become ill from certain diseases. Consideration of immunisation rates gives a perspective on prevention that may not be provided from other indicators within our set; it also provides an indication of access to primary health care services.
The measure, as collected through the PHO Performance Programme, will include only 2 year olds enrolled with a PHO.

**Key points of clarification and discussion**

- A number of people recommended strongly that the Commission should use Ministry of Health national immunisation register rather than PPP data.
- There was an interest in seeing international comparisons for this indicator. This may be difficult, given the variation in vaccination programmes by country (including different age limits, etc).

**Preliminary conclusions and further work**

- The Commission is in discussion with the Ministry of Health about available data and definitions for this indicator.

2.3.9 **Healthcare cost per capita (US$ Purchasing Power Parity per capita) and health care expenditure as a proportion of GDP**

**Summary of rationale for inclusion and important considerations**

These two measures are different and complementary ways of considering what New Zealand is spending on its healthcare. Purchasing Power Parity (PPP) US$ is a way of saying absolutely how much is spent on healthcare per person using a technique to equalise the purchasing power of local currencies. In contrast, the proportion of GDP spent on healthcare is a relative measure which shows how much of a country’s income goes to fund health services. Combined, the two allow us to consider both the cost and relative affordability of a country’s health system, and, when combined with quality measures, provides a starting point for considering the efficiency of the system.

However, there is no “right” level of expenditure for healthcare. It is certainly not the case that more expenditure will necessarily drive better outcomes; equally low spend does not necessarily equal greater efficiency.

**Key points of clarification and discussion**

- There was a general consensus that these two measures provide a fuller picture of costs of the NZ health system in comparison with other countries.
- The Commission confirmed these include both private and public expenditure.

**Preliminary conclusions and further work**

- These two indicators will be included within the set with no change to definition or presentation format.

2.3.10 **Hospital days in last six months of life**

**Summary of rationale for inclusion and important considerations**

The definition for this indicator was developed by the Institute for Healthcare Improvement. In summary, the indicator identifies the total per patient days for all hospitalisations during the last six months of life.

While it was not possible to present NZ data for this measure, it was included in the consultation package given that it potentially provides an interesting perspective on end-of-life care, associated resource intensity and patient experience.
Key points of clarification and discussion

- There were some further issues to be worked through in relation to this indicator, for example to determine inclusions/exclusions. This was an ethical rather than technical consideration.

- There was a view that this was potentially a useful and laudable measure, but it must be positioned from the perspective of reducing barriers to care in the community, as opposed to increasing barriers to coming into hospital.

- Would it be possible to look at location of death rather than focus on hospital alone? It was noted that the data may not be readily available to do this.

- It was suggested that the Commission liaise with palliative care clinicians about this measure and its definition.

- One participant suggested the NZMJ paper: Healthcare services funded by Counties Manukau District Health Board for people in the last year of life (2011) would be useful.

- Can you look at this measure through a primary care lens? There was discussion around the lack of planning for end of life care in primary care.

- It is difficult with this measure to be clear about an optimum level we should be attaining.

- It was clarified that the data-set excludes hospice-based care.

Preliminary conclusions and further work

- The Commission has decided to move this indicator to ‘placeholder’ status. Further work is required on confirming the definition and analysing data for New Zealand before we can be clear about the value of the measure.

2.3.11 Mental health readmission rates

Summary of rationale for inclusion and important considerations

This measures the percentage of overnight referral closures from the organisation’s acute inpatient unit that result in readmission to an acute inpatient unit within 28 days of discharge.

Similarly to hospital care, an indicator of unintended consequences of care, for example, may be influenced by reducing Average Length of Stay or poor coordination of care between primary/secondary services.

Key points of clarification and discussion

Further discussion has occurred with representatives from the National Mental Health KPI project. The Commission received advice if the selection is limited in the first instance to only one indicator then Post-discharge follow-up care within 7 days of discharge (excluding day of discharge) may be a more appropriate choice. This is because these seven days are when patients are at their most vulnerable and there is a high rate of suicide and relapse during this time. There is a lot of evidence to support this as an indicator and clinicians agree with this.

Preliminary conclusions and further work

- The Commission has decided to accept the advice from the KPI group and proposes to include the Post-discharge follow-up care within 7 days of discharge within the first
set of published indicators. (The KPI group needs to liaise with stakeholders to confirm that it is acceptable for this to be included within the national publication.)

2.4 Coverage of the indicator set

2.4.1 Gaps in coverage (general themes):
As noted in section 2.3 above, there were two themes raised a number of times that relate more to the general approach:

- There was some discussion on the equity quality domain and the Commission’s approach of stratifying indicators rather than having a specific equity measures. Some felt there was a place for specific measures with an equity focus relating to reducing health inequalities for vulnerable populations.
- We received a strong direction that ensuring good coverage of the patient experience domain was imperative. The Commission explained that the national satisfaction survey had been postponed and that work was under way to develop a programme to address the gap. The focus will be on patient experience, rather than patient satisfaction (as the latter concept is considered a less satisfactory or appropriate focus for measuring how patients experience care).

Other general themes relating to the coverage of the indicator set are outlined below:

- The set should include a measure relating to workforce.
- It was viewed to be important to cover each part of the H&H sector, relating to services across the continuum of care.
- There was a strong interest in ensuring appropriate coverage of access/timeliness of primary health care services. It was felt there was a need to get below the current level, e.g. to development a way to measure ability to access primary health care appointments.
- There was an interest in including child health focussed quality indicators.
- It was felt that measures of preventative care could cover a wider spectrum than screening and vaccinations only.
- A number of people expressed a view that the preliminary set was too hospital services centric. There should be a greater focus on integration across the whole of the health system; it would be better to start with a smaller number of higher level indicators covering the full scope rather than including detail within one segment i.e. hospital services.
- Public health indicators should be included particularly where they span the realm of health and socio-economic impacts.
- There should be a greater focus on both separate mental health indicators and the mental health component of the proposed set of indicators.
- There was an interest in including disability service focussed quality indicators.

2.4.2 Suggestions for specific additional measures
The following proposals were put forward for consideration for inclusion in the HQS indicator set, either for the first or future publications. We have mapped them against the relevant domain of quality.
**Safety**
- An indicator relating to ‘never events’.
- Overall hospital preventable events.
- Measures with a specific focus on medication safety.

**Patient experience**
- A measure of informed consent.
- A measure that allows for patient and family feedback.

**Effective care**
- An indicator that maps readmission rates against day case rates.
- Rate of unexpected returns to theatre.
- Venous thrombo-embolism risk assessment and prophylaxis.
- Clinician competency.
- Some broader population health indicators e.g. smoking (perhaps youth uptake via ASH yr 10 survey) or alcohol-related harm (sourced from hospital/ACC data).
- Existing CVD +/- diabetes indicators could probably be added to the initial indicator set.
- Life expectancy trends and age standardised mortality rates could be reported, by DHB and by ethnicity; this would give better consistent comparisons than avoidable mortality.
- Quality indicators that build on existing health targets, e.g. number of smokers in a practice that had received smoking cessation medications at one point in time.
- Overall effectiveness of services for the older population e.g. % of the eligible over 75 year population who are not accessing subsidised age related residential care.

**Access/timeliness**
- An indicator related to acute operations (e.g. how many fractured neck of femurs have surgery within 24 hours?).
- Copayments paid by patients at each general practice.
- Other ‘screening’ measures e.g. breast screening.
- Primary care measures, such as the number of people who had accessed publicly funded health services (derived from linked health system administration datasets) not enrolled in a PHO.

**Efficiency**
- DNA rates for elective operations.
- Consider analysis of acute medical admissions against length of stay, to identify number of days admission prevented by primary health care; this was proposed as a strong whole of system measure that can easily be calculated without going out to the whole of system for collection of new data.
- Proportions of people who had attended primary health care a week prior to hospitalisations.
• Acute surgical admissions experiencing a delay in getting to theatre.

2.5 Using the information

2.5.1 What barriers are there to reporting and using quality and safety information?
The following barriers were identified primarily by respondents to the e-questionnaire:

Data
• Be careful not to overburden the sector with additional data collection.
• There is an imperative to ensure data reported is robust and accurate.
• It is important to ensure consistency and to provide a means of comparison across DHBs.
• Ensure clear documentation of data sources.
• Acknowledge where indicators are already published on a regular basis.
• There is currently an absence of baseline information, trend information and benchmarking information.

Timing issues
• There is a need to maintain indicators over time to reveal true trends.
• Avoid indicators that have significant lags in reporting.

Construct of indicators
• Need to ensure clear definitions are provided in all cases.
• Ensure there is clarity about the intent of the measure.

Interpretation
• Be aware and guard against perverse unintended consequences. (For example, in relation to the efficiency measures (e.g. cost per capita) you would not want an interpretation that began to drive ‘cost-cutting’ leading to a decline in quality.
• Measures need to be scalable down to DHB level/ service level to be viewed as meaningful on a local basis.

Engagement
• Need to ensure buy-in from different sector perspectives.
• Not feeling engaged due to ‘parking’ of patient experience measures – this is such a key area there needs to be a transparent plan
• Poor engagement to date of the private sector and NGOs.

2.5.2 What are the enablers that will best support reporting of quality and safety indicators?
The following enablers were identified primarily by respondents to the e-questionnaire:
• Clear description of the purpose/rationale for measurement and specification of limitations.
• Validating the set with consumers and including measures of patient experiences of healthcare.
• Engaging clinicians and explaining implications for clinical practice.
• Supporting dedicated time/resource to focus on indicators and complete reporting requirements.
• Providing evidence that the information and discussion is used to shape policy making and quality improvement.
• Addressing the risk of duplication of work (where measurements are reported elsewhere).
• Ensuring people are informed and receive feedback and providing mechanisms to support this e.g. setting up a user group or a blog site on the HQMNZ website where people can post queries and share information.
• Undertake robust long term evaluation of the indicators.
• Ensuring where feasible that indicators are consistent with DHB performance indicators and annual planning and performance reporting. Consider whether these measures should replace the current reporting requirements (which are too onerous)?
• Integrated IT systems.
• Consistency of reporting across all DHBs.
• Reports summarised in plain language and accessible to public.
• Nation-wide secure database.
3. Other areas of feedback

3.1 Health Quality Measures New Zealand (HQMNZ)
As part of the seminar series, Patients First presented an overview of the HQMNZ website, which provides a repository and collaborative learning platform for quality and safety measures.

The following questions and discussion points were raised during the seminars:

- It was suggested HQMNZ should include a space to support discussion and ask questions on the development of quality and safety measures, for example a blog area.
- It was agreed it would be useful to add the Commissions indicators that are currently placeholders to the HQMNZ to start creating some debate around these.
- A participant enquired about other countries contributing measures to HQMNZ. Currently it remains NZ based, but HQMNZ is keen to explore this opportunity further and create linkages.
- Quality markers will be added to the HQMNZ website and the Commission welcomes comments on these via HQMNZ.
- How do you avoid HQMNZ as being used for people’s hobby horses? The approach has been intentionally permissive and collaborative. It was suggested that the library can act as an incubator for measures; good measures that are of value are more likely to be picked up and raised through the hierarchy.
- There is a potential utility for the library to support clinical networks and audit processes. It will enable people to access measures and adapt them where necessary to support their work.

3.2 Feedback on the Commission’s measurement and evaluation programme
As part of the seminar series, Gillian Bohm provided an overview of the Commission’s work in the measurement and evaluation space.

The following questions and discussion points were raised during the seminars:

NZ Atlas of Clinical Variation
- It was noted that the CVD domain will be published in the near future.
- How does the Commission choose what domains to publish on the Atlas?
  - Sector suggestions will be reviewed by an External Steering Group against a set of criteria to identify those domains that will be taken forward.
- How does the Commission decide what measures to include within each domain?
  - Once a domain has been selected a condition specific group of experts will work up the scope and detail of data to be presented.
- How does the Commission ensure that work is not duplicated e.g. with elective team work around the CPAC tool?
o Discussion across teams takes place to ensure there is not undue duplication.
o Also, there is a criterion that checks whether existing work has been published –the focus for the Atlas will generally be on areas that have received less attention through other activities and work-streams.

Other
- There was some discussion about the work programme having a focus on hospitals versus community/primary care measurement. The Commission acknowledged the need to ensure a focus on a ‘whole of system’ approach. To a certain extent, it was a feature of inherited work programme from e.g. QIC; the Commission was keen to ensure that the prior investment was maintained to secure benefits from previous work. They understand that there is a pressing need to move towards a wider coverage of measures and they will be looking into possibilities during the next financial year. There are some developments underway (e.g. the development of a national medication chart for aged residential care). They recognise challenges of working in evaluation and measurement of community/primary field (e.g. there is less evidence to call on etc).

- It was emphasised that there is an overlap between the indicators, quality accounts and DHB annual reports. It is important to consider how DHBs can align their stories and to tell them from different perspectives (e.g. a consumer versus an accountability perspective).

- Robust data is necessary for any measurement and evaluation work and good information systems are an essential requirement for this. Following a question, the Commission confirmed that they do have input into the National Health IT plans and they are part of the Health Sector Forum. The Commission and the NHITB also share a communications manager. Finally Anton Venter is employed by the Commission as programme director for e-medicines management and is situated in a team of three in the NHITB. The Commission does not see itself as a data warehouse, but rather as providing analytical and reporting support to the sector.
4. Process from here

The Commission is extremely appreciative of the time and commitment provided to this engagement process by busy sector stakeholders.

We have made a commitment to disseminate the feedback received and to work through your suggestions and recommendations in order to refine the first set of indicators and to identify priorities for our work programme moving forward.

**Consolidation of feedback**

In terms of dissemination of your feedback, this report is published on the Commission’s website (from the second week of November 2012), along with:

- our original engagement and feedback document published in June 2012;
- copies of the three presentations used to support the seminar series; and
- detailed notes from each of the five seminars.

In addition, specific comments in relation to fast-track indicators have been reflected through the HQMNZ website and definition standards for ‘placeholder’ indicators will be added shortly.

**Next steps**

Over November 2012, the Commission will be working through the feedback received on the indicator set as a whole and in relation to specific indicators. This document has provided an indication of our preliminary conclusions and additional work required to refine existing indicators. As noted, in some cases this requires discussion with sector experts and potentially refining the definition and/or utilising a different data set.

The Commission is committed to publishing a public HQS indicators report at a national level in December 2012. We are considering options on how best to do that, for example using software that provides some interactivity and the ability to cluster and look at measures together.

We will also be working on confirming our priorities for development of this work programme next year. A key message we have taken away is the need for us to confirm what is reported publicly at a national level, versus what is made available at a local level to DHBs. We will be considering this and identifying ways to meet the need for DHB comparative data early in 2013.
Appendix 1 – Original proposed set of indicators and measures, by quality domain

New Zealanders live longer, healthier and more independent lives

New Zealand’s economic growth is supported

GOVERNMENT GOALS

NZ TRIPLE AIM OUTCOMES

Improved quality, safety and experience of care

Improved health and equity for all populations

Best value from public health system resources

Services throughout the patient journey, across the health and disability sector

SYSTEM LEVEL INDICATORS

Safety

1. Number of falls resulting in harm in hospitals
2. Health care acquired infections
3. Measure of surgical harm
4. Measure of safe medication management
5. Cancellations of elective surgery by hospital after admission

Patient experience

6. Amenable (preventable mortality)
7. Ambulatory sensitive (avoidable) hospitalisation
8. Placeholder: measure of patient experience

Effective

9. Day case surgery turns into unplanned and unexpected overnight stay
10. Hospital unplanned and unexpected readmission %
11. Mental health readmission rates (and potentially length of stay)
12. Measure of CVD management

Equity

13. % of eligible population up to date with cervical screening
14. Age appropriate vaccinations for 2 year olds
15. Health care cost per capita
16. % GDP spent on health care

Access/timeliness

17. Hospital days during last six months of life

CONTRIBUTORY MEASURES

1. Pressure ulcers acquired in hospitals
2. Measure of adverse events
3. Ambulatory sensitive (avoidable) hospitalisation
4. Placeholder: functional health outcomes scores
5. Ambulatory sensitive (avoidable) hospitalisation
6. Placeholder: measure of patient experience
7. Pressure ulcers acquired in hospitals

8. Occupied bed-days for people aged 75+ admitted 2 or more times per year
9. Day case surgery turns into unplanned and unexpected overnight stay
10. Hospital unplanned and unexpected readmission %
11. Mental health readmission rates (and potentially length of stay)
12. Measure of CVD management

9. Placeholder: measure of adverse events
10. Placeholder: measure of patient experience
11. Placeholder: measure of adverse events
12. Placeholder: measure of adverse events
13. Placeholder: measure of adverse events
14. Placeholder: measure of adverse events
15. Placeholder: measure of adverse events
16. Placeholder: measure of adverse events
17. Placeholder: measure of adverse events
Appendix 2 Updated proposed set of indicators and measures, by quality domain (reflecting sector feedback)