

**First annual update on increasing transparency in New Zealand health care**

**28 June 2017**

**Background**

In June 2016, the Ombudsman Professor Ron Paterson ruled on a complaint by Martin Johnston of the *New Zealand Herald*.1 Johnston had requested the volumes and types of operations performed by individual surgeons at five district health boards (DHBs) under the Official Information Act (the Act). He also requested rates and total, unadjusted numbers of mortality, readmissions and complications by individual surgeon, and was either turned down or provided with number s at abstracted levels by DHBs.

The Ombudsman noted in his opinion that one of the purposes of the Act is “to progressively increase the availability of official information to the people of New Zealand.” The Ombudsman has also suggested, in his 2014 opinion, that “New Zealand lags behind [international] developments” in the “proactive disclosure of performance and outcome information.”2 For these reasons, the Ombudsman appended to his opinion the following new recommendation:

“that the Ministry of Health and Health Quality & Safety Commission [the Commission] work together to provide a publicly available, annual update (commencing in June 2017) on the sector’s progress towards, in five years (ie, by June 2021), the selection, development and public reporting of a range of quality of care measures (including outcomes data) across specialties that:1

* are meaningful to health care consumers;
* are meaningful to the clinicians who provide their care;
* are meaningfully attributable to the clinicians or service providing that care; and
* increase the availability of information to the people of New Zealand.”

**Annual update**

Activities undertaken since the publication of the Ombudsman’s opinion:1

* The literature suggests that a coherent rationale, a clear conceptual framework, and a strategy of public reporting is essential to the success of any regime of public reporting, and for any assessment or evaluation of the effects of such a regime. Marshall and colleagues at the Nuffield Trust identify the many reasons cited for implementing a policy of public disclosure of performance or quality data. They conclude that “a clear and explicit purpose for introducing public disclosure is fundamental to its design, implementation and evaluation”.3 The Ministry of Health and the Commission have collaborated on developing a rationale and strategy for public reporting to be effective in the New Zealand context, informed by the international evidence and local circumstances. In particular, the lack of choice available to consumers of public healthcare in New Zealand, and the simultaneous requirement for reporting of quality of care to inform and reassure those consumers while informing and incentivising quality improvement by clinicians. This rationale is derived from the international evidence as set out in the Evidence Review in the Commission’s *Position paper on the transparency of information related to health care interventions*,4 and is reflected in the following *Guiding Principles: Towards the Publication of Clinical Performance and Outcome Data* (see Appendix).
* The Ministry of Health and the Commission, with the support of the Accident Compensation Corporation (ACC) and the Health and Disability Commissioner, jointly developed and agreed a set of guiding principles that should apply to the future publication of clinical performance and outcome information by the sector, in line with this rationale and strategy (see *Guiding Principles* in the Appendix). These principles are structured in four parts, covering the purpose of such a regime of public reporting, co-design of measures, data capture and analysis, and considerations around publication access and clarity.
* Editorial published in the *New Zealand Medical Journal* on 16 June 2017.5 This commissioned editorial informs the sector on progress towards public reporting of quality of care measures, including the *Guiding Principles* and their development, background developments internationally, and what NZ consumers want from transparency as reported in consumer workshops.6 The editorial sets out the evidence and argument for our rationale and strategy of public reporting.5
* *Guiding Principles* disseminated to the sector.
* A survey of current publication of measures was undertaken.
* A survey of registries and registry activity was undertaken. Registries are good sources of well-validated data that may be harvested for analysis and publication rather than collected, increasing timeliness and statistical power and reducing the burden of collection, including costs.
* Stakeholder engagement. The Ministry and the Commission have approached and engaged stakeholders working in selected registries as potential sources of reporting.
	+ The All New Zealand Acute Coronary Syndrome Quality Improvement programme (ANZACS QI).7 ANZACS-QI is a clinical registry of patients with acute coronary syndrome (ACS) and other cardiac problems admitted to hospitals across New Zealand. The registry currently covers 41 public hospitals across New Zealand where acute cardiac patients are admitted. As at June 2015, 25,273 patients with suspected ACS and 30,696 referred for coronary angiography were registered. The registry explicitly has a quality improvement arm as well as a research arm – to identify and address variation in evidence-based practice (in timeliness of assessments and interventions and in the utilisation of secondary prevention therapy, for example). Publications in the medical literature arising from the registry are numerous and ongoing,7-20 and the clinicians involved working actively with the Ministry and the Commission to explore options for public reporting in line with the Guiding Principles and the rationale and strategy we have developed.
	+ The New Zealand cardiac registry published their first New Zealand annual report in December 2016.21 The report presents analysis of all cardiac surgical procedures undertaken at the five DHBs performing publicly-funded cardiac surgery in New Zealand (Auckland, Waikato, Capital and Coast, Canterbury, Southern) between 1 January 2015 and 31 December 2015. The data present volumes, risk factors, and benchmarked, risk-adjusted outcomes such as mortality and measures of complications including deep sternal wound infection, return to theatre, and readmission rates following isolated coronary artery bypass grafting (CABG), isolated aortic heart valve replacement (AVR), and combined AVR and CABG. The registry also published some additional quality of care measures at national level, including hours of mechanical ventilation, time spent in the intensive care unit and hospital length of stay. Opportunities for public reporting at other levels are in the initial stages of being explored.
* All DHBs are already encouraged to collect and report outcome information. The Upper GastrointestinaI (UGI) & HepatoPancreatoBiliary (HPB) Service at Waitemata DHB have published unit-level outcome information on their website for 2014 and 2015 in relation to upper gastrointestinal, hepatic, pancreatic and biliary surgery.22 The information includes leak rates and 30-day/90-day mortality, with contextual information to assist lay readers. Work on development of a DHB-wide framework of patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) linked to outcomes is in process. (Pers.comm. Grayson D. O’Brien J. May 2017.)
* The Ministry's System Level Measures (SLM) Framework is a system level performance measurement and incentive system co-developed with the sector and designed to demonstrate district alliance progress towards agreed targets in line with the 2016 New Zealand Health Strategy.23 The Framework consists of a set of system level measures with nationally consistent definitions that will be reported nationally. Contributory measures, designed to drive change at a local level and contribute to the system level measures, are selected locally and will not be reported. At present DHBs and PHOs are required to develop and submit an improvement plan to meet agreed milestones for each system level measure on behalf of their district alliance. The System Level Measures implemented from 1 July 2016 (apart from the latter two, which are still in development) and reported publicly are:24
	+ Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
	+ Acute hospital bed days per capita
	+ Patient experience of care
	+ Amenable mortality rates
	+ Number of babies who live in a smoke-free household at six weeks post natal
	+ Youth access to and utilisation of youth-appropriate health services.
* The Commission continues publication of over 250 quality of care indicators for each DHB. These indicators link to the Ministry’s SLM framework. Currently, these indicators are spread across different publication formats, such as the New Zealand Atlas of Healthcare Variation, the Health Quality and Safety Indicator set, and the Quality and Safety Marker set. Work progresses toward the presentation of a selection of these indicators as one DHB-specific dashboard, which can be organised in relation to the Ministry’s SLM framework.

**Next steps**

A more detailed report of specific progress over the following year will be provided as requested to the Ombudsman in June 2018.

The Ministry and the Commission are investigating trial publication of a selection of measures from pre-existing data, developed in line with the *Guiding Principles* and in concert between the data holders and consumers with Ministry and Commission support. This investigation is in its early stages and will be revised accordingly. These next steps are in line with the Commission’s suggestion in our March 2016 *Position paper*:

“The Commission suggests:

* consumers, colleges, professional bodies and employers together define a simple group of outcome and process measures for each specialty group that will serve to assure safety and drive improvement. These measures should reflect the different needs of the interested parties: we suggest one outcome and process measure each that is consumer-focused, clinician-focused and organisation-focused.”4

The Ministry and the Commission now foresee this group or basket of measures (for a specialty group, intervention or set of interventions, condition or set of conditions) will differ and vary depending on the specialty, condition or conditions, and the data available, and should collectively rather than individually satisfy the recommendations outlined in the *Guiding Principles*.

That is, no single measure will satisfy all requirements, but a set of measures can address these requirements collectively:

* informing and reassuring patients and the public in an accessible way
* incentivising quality improvement by clinicians, particularly in areas of weakness or opportunity identified by the literature
* inhibiting gaming behaviours
* being meaningfully attributable to the clinicians, teams, units or organisations to which they are attributed.

**The expectation of transparency – with a consumer focus**

The Ministry of Health and the Commission are at present working with a selection of current registries and consumers to increase public visibility around their data, to select data with a consumer focus, and to develop new and accessible ways of presenting that data. By promoting the *Guiding Principles*, and showcasing exemplars such as the Waitemata DHB Upper GI Unit and the ANZACS-QI registry at the different stages of their transparency journeys, we expect to bring along other units, medical and surgical, in the process of responsibly developing similar transparency around their communities. The Ministry of Health and the Commission will work with them to co-design measures with the consumers of their services, including patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) as well as useful outcome measures, to inform both public and clinicians alike.

The future also holds consideration of “closing the gap” – monitoring the implementation of quality improvement activity in response to the measures selected and published, and of the effects of public reporting on the overall performance we wish to improve.

The Ministry of Health and the Commission wish to encourage a system of public reporting that fosters learning and improvement in the work of clinicians and reassurance and trust for the consumers of their services. Clinicians should be able to see the sense, merit and effectiveness of such reporting, and consumers should see the accessibility, value and forthrightness of such a system; one that makes all New Zealanders proud.

**Appendix**

**Guiding Principles: Towards the Publication of Clinical Performance and Outcome Data**

These guiding principles form a common platform from which to operate consistently to achieve effective public reporting of clinical performance and outcome information. They reflect the points in the process of public reporting: purpose; design; data capture and treatment; and publication.

Public reporting of clinical performance and outcome data is currently under development in New Zealand and these principles for such reporting are based on current evidence. Through consultation, these principles have the support of consumers, regulatory and professional bodies, and key groups in the sector. The principles are aligned with key themes of the Health Strategy: ‘people-powered, value and high performance, one team, and smart systems’ and they align with the strategic directions of other key healthcare organizations, and with processes that oversee professional competency. The principles will be regularly reviewed to ensure they remain current with changing strategic and legislative documents. Innovations or changed models in healthcare should, where possible, incorporate these principles prospectively as part of implementation.

**Our purpose is quality improvement and patient safety**

The aim of publication of clinical performance and outcome information is to facilitate continuous improvement in the quality and safety of health services. Focuses for improvement include better service experience for consumers; practitioner learning and performance; and accountability to the public.

**Co-designed publications and measures**

Consumers, colleges, professional bodies, clinicians and employers have an important role to play in defining and selecting relevant outcomes and process measures. Strong measures reflect the different needs of the interested parties, are outcomes-focused, reflect consumer experience, and serve to assure quality and safety and drive improvement. Meaningful data should promote a culture of continuous improvement, stimulate clinical focus and encourage open and honest reporting.

**Data capture and treatment using national standards**

Digital technology supports the management of clinical performance and outcome information via electronic capture and as part of routine care. In a smart system, wherever possible and appropriate there are agreed national standards of data collection, and consistent definitions and measures across New Zealand.

Where possible, data should be risk-adjusted and/or accompanied by relevant contextual information to account for case complexity and risk. Resulting measures should be meaningfully attributable to the clinicians or service providing care, to ensure that they are clinically credible and reliably inform the public, clinicians, healthcare providers, administrators and policymakers.

**Publish accessible, clear and contextualised information**

Data should be published in different formats and media to ensure that the information is accessible to people of all levels of health literacy and acceptable and comprehensible to target audiences.

Data can be analysed and reported at multiple levels (national, regional, service, individual). Choice of level is, where appropriate, related to purpose and audience, to facilitate understanding of causes, contributing factors, and opportunities for improvement.

**Quick Look**

* Co-designed measures
* Co-designed publications
* Outcomes-focused
* Consumer-focused
* Data capture part of routine care
* Electronic capture
* Agreed national standards of data collection
* Consistent national definitions and measures
* Risk-adjusted
* Contextualised
* Meaningfully attributable to clinician/s or service
* Accessible formats and media
* Related to purpose and audience

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