Introducing the Health Quality & Safety Commission

The Health Quality & Safety Commission was established in November 2010, with an expectation from the Government that it would lead quality and safety improvements in the health sector.

The aim of the Commission is to work with clinicians and health managers to support and encourage quality and safety improvements, to identify areas where improvements can take place, and to drive change.

The Health Quality & Safety Commission is a clinically-focused Crown Entity, determined to make a real difference to consumers' experience of health care. It is led by clinicians and other professionals with expertise in health quality and safety. The Chief Executive is Dr Janice Wilson, a psychiatrist, former manager of mental health services, and former Deputy Director-General of the Population Health Directorate at the Ministry of Health. The Chair of the Board is Professor Alan Merry, a practising cardiac anaesthetist and chronic pain specialist, and he chairs the Quality and Safety Committee of the World Federation of Societies of Anaesthesiologists.

Others members of the Commission's Board include:

- Dr Peter Foley, a GP in Hawkes Bay and former chair of the New Zealand Medical Association
- Shelley Frost, a registered nurse with extensive experience in primary health care, and the director of nursing at Pegasus Health
- Dr David Galler, an intensive care specialist at Middlemore Hospital, and previously the Ministry of Health's principal medical advisor
- Dr Peter Jansen, a GP and a senior medical advisor to ACC
- Geraint Martin, CEO of Counties Manukau DHB
- Anthea Penny, a qualified health professional, an experienced chief executive in New Zealand's health sector and a management consultant

The priorities of the Health Quality & Safety Commission are to ensure systems and processes are in place to enable the safest and highest quality care, to use proven innovation, and to encourage learning from mistakes so they do not happen to others. The Commission is focusing on:

- Consumer engagement and participation
- Supporting improvement and innovation
- Reportable events, including serious and sentinel events
- Infection prevention and control
- Medicine safety (including medicine reconciliation)
- Evaluation and reporting on the quality and safety of the system

New Zealand's four mortality review committees are also now operating under the umbrella of the Health Quality & Safety Commission. The committees are; the Child and Youth Mortality Review Committee the Perinatal and Maternal Mortality Review Committee the Perioperative Mortality Review Committee and the Family Violence Death Review Committee

The Commission is currently developing programmes of work for each of its priority areas, forming groups to draw on the clinical expertise in the sector, and building

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relationships with key agencies and organisations. As part of that, the Commission is investigating how it can engage effectively with all clinicians and health managers.

Many people are familiar with the Health Quality & Safety Commission in relation to the annual serious and sentinel events report. This report details the errors and mishaps that have occurred in New Zealand's hospitals in the previous 12 months, e.g. falls, medication errors, delays in treatment. The report focuses solely on hospitals and the systems and processes which District Health Boards have in place to prevent patient harm.

However, the Commission is equally concerned with quality and safety issues within primary care. As general practitioners, practice nurses, community pharmacists and other health professionals, the systems in place for managing treatment and the accompanying risks have a direct bearing on the quality and safety of the health experience for patients.

New Zealand has an excellent health system but there is no room for complacency. Significant numbers of people are harmed in the course of receiving treatment, and much of this harm is preventable.

We can definitely do better.

The challenge for primary care is to deliver coordinated, high quality treatment across a wide range of institutional, professional and clinical configurations to provide patients with a seamless journey through the healthcare system.

We still have a way to go to make that journey seamless. The processes for identifying and managing clinical risk and improving performance are variable, and we lack a single plan of action for quality improvement in primary care. In our sometimes complicated funding and organisational structures, quality procedures can be viewed as an imposition in clinicians' busy professional lives, and we would all benefit from a quality framework that enables integration of performance management with quality initiatives and education programmes. There is jostling for funding, which runs the risk of pitting initiatives against each other instead of viewing them as part of the overall quality landscape.

There is also a challenge for primary care – as for secondary care – to involve the public, as consumers and potential consumers, in designing and reviewing better systems of delivering health care. There are some excellent quality initiatives underway, such as Cornerstone and Patients First, and primary care clinicians are to be congratulated for developing and engaging with these programmes.

The message to us all is that there is room for improvement – and the Health Quality & Safety Commission looks forward to your continued active involvement in making our health system better.

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