NZMA
New Zealand Medical Association

22 September 2015

Dr Iwona Stolarek
Chair of the Health Quality and Safety Capability and Leadership Building Programme Expert Advisory Group
Health Quality & Safety Commission
PO Box 25496
Wellington 6146

By email: Iwona.Stolarek@hqsc.govt.nz

Discussion paper: A framework for quality improvement and patient safety capability and leadership-building for the New Zealand health system

Dear Iwona

Thank you for inviting the New Zealand Medical Association (NZMA) to provide feedback on the above draft discussion paper. The NZMA is New Zealand's largest medical organisation, with more than 5,500 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of New Zealanders. Our feedback has been informed by input by our advisory councils and Board.

The NZMA welcomes the work the HQSC is doing to develop and support capability and leadership in quality improvement and patient safety, to ensure that the delivery of health care is consistent with HQSC's overarching framework, the Triple Aim. We note that the discussion paper describes a "high level framework that is intended to guide the development of quality and safety capability across all levels in the health care sector". We also note that the framework is intended "to provide the basis for a common understanding of the expected knowledge, skills and underpinning values required to achieve better quality and safer patient centred health care".

We think the draft discussion paper as written is very difficult for busy frontline health professionals to understand. To make the framework more accessible and make clearer the concepts it is attempting to convey, we suggest the framework be revised to read more simply, use fewer words and be visually more attractive. A framework document intended for a wide audience should be written using a 'Plain English' style. The WriteMark organisation, which adjudicates the annual New Zealand Plain English awards, describes Plain English as "a style of writing in which the language, structure, and presentation of a document all work together to help the reader.

A document written in plain English is easy to read, understand, and act upon after just one reading".[1] The NZMA would welcome the opportunity to provide more substantive and specific feedback on a revised iteration of the discussion paper, but provide feedback on several overarching issues at this stage.

We have major reservations at the frequent use throughout the discussion paper of the term 'consumers'. We note the Commission's footnote on page 5 saying that: *"In this document the words 'consumer' and 'patient' are considered interchangeable. It is assumed that these terms embody the broader concept of individuals and/or their whanau/families as applicable"*. While we recognise that this is a complex issue, we are strongly opposed to the use of the term 'consumer' in this document. The term 'consumer' implies a transactional relationship, reflects a particular market ideology, and is associated with individual consumption. Its use also denies the complexity of the relationship between people (with or without health and disability states) and those providing health care services. For example, across much of acute medicine and surgery, patients are bedbound and supine (if conscious) and depend on others for care.

New Zealand research suggests that most people prefer the term 'patients' over other terms such as 'clients' or 'customers'.[2] In the United Kingdom, the Royal College of Psychiatrists has recently reverted to using 'patients' over 'service users'.[3] We do appreciate that the discussion paper extends beyond just those who are currently patients, so our preference is for the term 'people' instead of 'consumers' throughout the document. When referring to specific health and disability states, we prefer the term 'people with [specific health and disability states]', eg, people with mental illness. We hope the HQSC can incorporate this revised nomenclature in the next iteration of the paper. As an alternative, we suggest the Te Reo Māori term 'tangata whai ora' which essentially means 'persons in search of wellbeing'. Tangata whai ora has been used instead of 'patient' or 'consumer' in much of the New Zealand mental health literature. We consider it entirely appropriate for the term 'tangata whai ora' to be used by the HQSC in this discussion paper as an alternative to 'consumers'.

While we broadly support people having greater participation in advisory roles in the planning, design and delivery of health care services, we note that there are significant structural barriers to facilitating this. For example, budget holders and the providers of health care pathways often determine whether or not a particular patient will receive a specialist appointment and an operation. Nevertheless, our experience is that bringing patients onto advisory groups is very valuable, and we are pleased to see this incorporated in the discussion document.

We are disappointed that the framework largely fails to identify how important it is that the healthcare system has the capacity to develop/implement the framework. It is one thing for all members of the health system to have the *capabilities* described in the framework, but if they do not have the *capacity* (eg, time, money, staffing resource, education) to do these things, then capability alone is insufficient. We suggest that capacity be elevated to a separate priority/domain in a revised iteration of this framework.

Costs are also a key factor to consider in the provision of quality, comprehensive and safe health care to patients. The lack of a single mention of cost anywhere in the discussion document is a conspicuous omission. A realignment of funding models is a key factor in organisational improvement for quality and safety, and we suggest that the discussion document specifically address the relationships between funding and quality.

---

[1] Definition available from http://www.plainenglishawards.org.nz/what-is-plain-english/
[2] White H. All patients. NZ Med J 1990; Aug:382; Elliot J & White H. Patients are patients. NZ Med J 1990; 12 Dec:593
[3] Scottish Recovery Network. Should patients be patients? Available from http://www.scottishrecovery.net/Latest-News/should-patients-be-patients.html

We consider the document is characterised by definitional redundancy. For example, page 7 defines safety as an aspect of quality, which then makes it redundant to talk of quality *and* safety. Furthermore, the draft suggests that leadership is just one of several identified dimensions of capability. We suggest that the authors give greater attention to these definitional issues when developing the next iteration of this document. The title should also be simplified and shortened. A possible alternative could be: *Quality improvement in the New Zealand health system: a framework for capabilities.*

We note that the document draws attention to the importance of innovative practices and creativity, to improve quality. We are concerned that Domain 6 ('Improvement is evidence-based and data-driven') could stifle innovation in quality development. Ideas/solutions/processes for quality improvement often lack an evidence base, precisely because they are new and/or innovative. Quality improvements must be underpinned by strong and transparent decision making, and also tested in a rigorous and robust manner. We are also concerned that the document does not specifically mention research. We suggest that if innovative practice is to be fostered, then comment is needed about systemic support for innovation and research that occurs in a quality/safety conscious paradigm.

Finally, we believe that a collaborative approach to quality and safety is essential. If the Commission has not already done so, we suggest that it seek input from all DHB/PHO clinical leadership teams to inform the development of this discussion paper. The formal collaboration of DHBs to help inform such high-level strategy documents by the Ministry of Health and other agencies such as the HQSC should be encouraged as much as possible.

Thank you for the opportunity to provided feedback on this draft. We hope our comments are helpful and we would welcome the opportunity to provide further substantive comment on a revised version that addresses the issues we have flagged.

Yours sincerely

Dr Stephen Child
NZMA Chair