



Improving Quality (IQ):
A Systems Approach for the
New Zealand Health and
Disability Sector

A Consultation Draft

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MANATŪ HAUORA

Foreword

In the foreword to my *New Zealand Health Strategy* I noted that people had been telling the Government that they wanted a system that put people at its heart. I also noted that higher quality care had been identified as a common goal for the health system. Quality is also reflected in a number of the objectives in the *New Zealand Disability Strategy*.

The *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector* document gives further focus to the importance of quality. It is a commitment to supporting continuous quality improvement by each person who works within the system, by the people cared for and supported by the system, and by the system itself.

We want to put people at the heart of the system, particularly at the interface where those receiving health and disability services, and those delivering them meet.

In this document the term ‘people’ is used in its broadest sense. This is because there should be both an individual and a population perspective to quality improvement within the health and disability system.

The approach in this document is my response to requirements in the New Zealand Public Health and Disability Act 2000, and to advice I have received from the National Health Committee. The Committee highlighted the importance of taking a systems approach to quality improvement. This is consistent with international developments, such as the work of Dr Don Berwick of the United States Institute for Healthcare Improvement, that have highlighted the importance of such an approach. A systems approach recognises that quality is the result of the complex interaction of people, individuals, teams, organisations and systems.

Quality improvement can always be enhanced even though very good work is already happening. This document reflects this approach as it includes an ongoing review and updating process.

I am confident that this document will help all health professionals to provide continually improving health services to all New Zealanders.

Hon Annette King
Minister of Health

Acknowledgements

Development of this document has been informed by advice from the members of a Working Group formed for the project (the members are listed in Appendix 1), by the National Health Committee's advice in its *Safe Systems Supporting Safe Care* report and by informal feedback from various organisations. All of this advice has been carefully considered and incorporated within this draft where appropriate.

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Executive Summary

Purpose

The *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector* document provides a shared approach and language to enable enhanced quality improvement in the New Zealand public and private health and disability system. It is a commitment to supporting continuous quality improvement by each person who works within the system, by people affected by the system, and by the system itself.

The approach in this document is the Minister of Health's response to advice from the National Health Committee on *Safe Systems Supporting Safe Care*. The approach is also being used to meet the Minister of Health's obligations in Part 2 Section 9 of the New Zealand Public Health and Disability Act 2000.

Vision

Improvements in quality are necessary to support a vision of people receiving people-centred, safe and high-quality services that continually improve. 'People-centred' means involving people and being receptive and responsive to their needs and values.

Systems approach

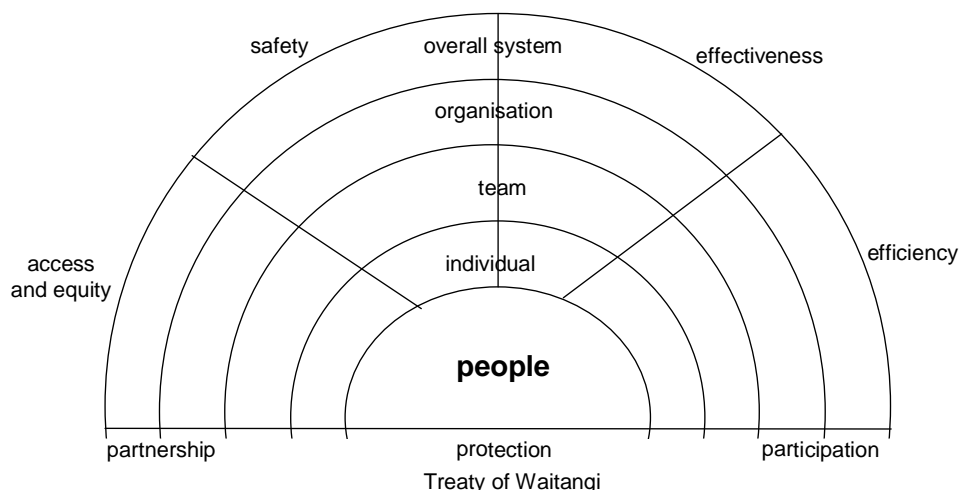
This document enables a greater systems approach to quality improvement and improved co-ordination of quality improvement. A systems approach is necessary because the health and disability system is complex with decision-making and actions occurring across a range of people, individuals, teams, organisations and subsystems. A systems approach is not an end in itself but a means to enhance services for the benefit of people, including consumers.

A systems approach recognises that quality is the cumulative result of the interactions of people, individuals, teams, organisations and systems. Within a systems approach, quality can be defined as the degree to which the services for individuals and populations increase the likelihood of desired health outcomes (Lohr 1990), and the participation and independence of people experiencing a disability.

Quality improvement needs to encapsulate all levels of the system and the interactions between them. The levels are shown diagrammatically in Figure 1. They range from the overall system through the organisations, and teams and individuals within those organisations, to the people receiving and impacted by the services delivered in the system.

People are at the heart of quality in the New Zealand health and disability system. The people include consumers as well as their families and whānau. They include both individuals and population groups receiving services.

Figure 1: Quality dimensions for the New Zealand Health and Disability System



Dimensions of quality

The key dimensions of quality in the health and disability system are access and equity, safety, effectiveness and efficiency. The dimensions rest on the foundations of the partnership, protection and participation principles of the Treaty of Waitangi. The dimensions are shown in Figure 1 as 'slices' through semi-circles representing the different levels of the system. Improving quality requires balancing across the dimensions. It also requires recognising the contributions and interactions across all levels of the system.

Goals and action plans

Eleven goals are identified to support the vision of people receiving people-centred, safe and quality services that continually improve. The goals and their relationship to the aims of this document are outlined in Table 1. Each goal relates to one or more of the levels of the system and quality dimensions.

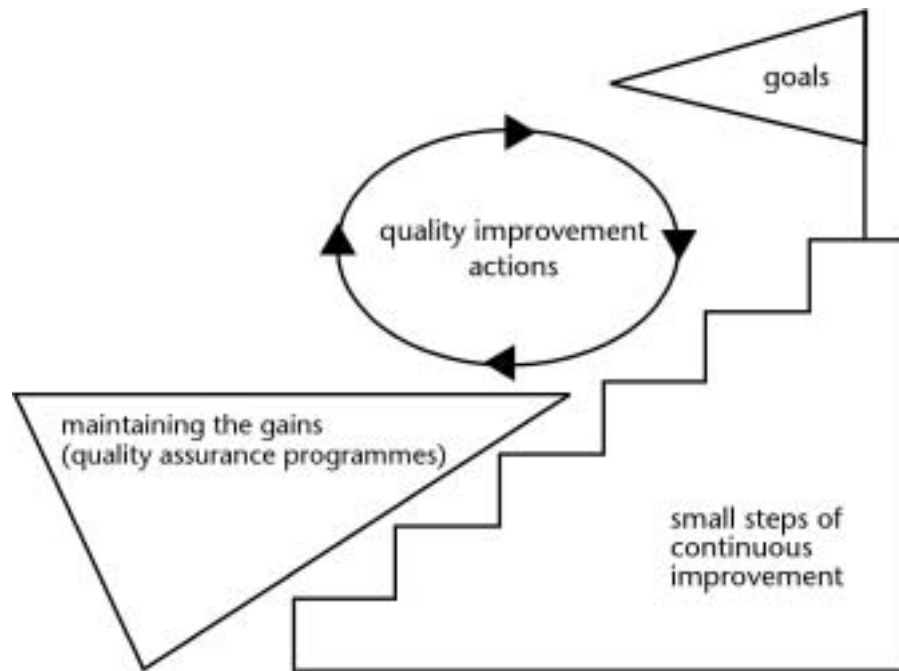
While goals are intended to be enduring, the actions needed to support them will change as improvements are made and priorities evolve. It is hoped that over time both individuals and organisation will give effect to the vision and goals in this document through their quality improvement planning and actions.

In response to this document, the Ministry of Health has prepared an action plan of activities. These are activities that it and some other national agencies are committed to implementing. Over time this action plan will be updated and supplemented by the plans and actions of other agencies who are more actively involved in service delivery.

Quality improvement and quality assurance

Maintenance of quality through quality assurance activities, as well as quality improvement, is important. The relationship between quality assurance, quality improvement, goals and actions is illustrated in Figure 2.

Figure 2: Relationship between quality assurance and quality improvement



Standards and quality assurance programmes

Part 2 Section 9 of the New Zealand Health and Disability Act 2000 requires a strategy for development, use and monitoring of nationally-consistent standards and quality assurance programmes. This involves:

1. reinforcement of key nationwide standards, quality assurance mechanisms and requirements
2. a focus on the standards and quality assurance expectations of District Health Boards
3. the use of advisory committees as a quality assurance and improvement mechanism for the health system
4. use of the *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector* document as it is a quality assurance mechanism for the overall system.

Improving quality is a process that can always be made better even though very good work is already happening. Improving quality requires constant attention and effort enabled by a shared sense of purpose and vision.

Table 1: Relationship between vision, aims and goals

| Quality improvement approach | | | | |
|--|---|--|---|---|
| Vision | Aims | Goals | | |
| People in the New Zealand health and disability system receive people-centred, safe and quality services that continually improve. | Providing a shared purpose, vision and language to enable enhanced quality improvement in the New Zealand health and disability system. | <ul style="list-style-type: none"> • More effective service outcomes for Māori by acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi and applying the principles of participation, partnership and protection. | <ul style="list-style-type: none"> • The goals in this document and associated actions are reviewed and updated on an ongoing basis. | <ul style="list-style-type: none"> • A shared vision toward safe and high-quality care is engendered through committed leadership at all levels that supports constant maintenance and improvement in service quality. • People are encouraged and supported to participate in the planning, delivery and assessment of health and disability services and programmes. |
| | Enabling a systems approach to quality improvement in the New Zealand health and disability system. | | | <ul style="list-style-type: none"> • Widespread awareness, understanding and commitment to a quality improvement culture at all levels of the health and disability sector. • Evolutionary redesign of systems of care to support delivery of quality services. • Unexpected adverse outcomes managed in an open and supportive manner that builds trust and confidence in the system and is fair to all participants. |
| | Enabling improved co-ordination of quality improvement activities in the New Zealand health and disability system. | | | <ul style="list-style-type: none"> • Effective and open communication, co-ordination and integration of service activities that recognises the value of teamwork. • A supportive and motivating environment that provides the workforce with appropriate tools for continuous learning and ongoing improvement in planning, delivery and assessment of health and disability services. • Useful knowledge and information, including clinical evidence, readily available and shared to support a quality-conscious culture. • Regulatory protections that assure safe care in place to support people and service providers. |

1 Introduction

Purpose

Quality is important in the New Zealand health and disability system. It is identified as a cornerstone of a high-performing system in the *New Zealand Health Strategy*. Quality is also a dimension of the objectives in the *New Zealand Disability Strategy*.

The *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector* document provides a shared approach and language to enable enhanced quality improvement in the New Zealand health and disability system. It is a commitment to supporting continuous quality improvement by each person who works within the system, by people affected by the system, and by the system itself.

The approach in this document is the Minister of Health's response to advice from the National Health Committee on *Safe Systems Supporting Safe Care*. The approach is also being used to meet the Minister of Health's obligations in Part 2 Section 9 of the New Zealand Public Health and Disability Act 2000.

Vision

Improvements in quality are necessary to support a vision of people receiving people-centred, safe and high-quality services that continually improve. 'People-centred' means involving people and being receptive and responsive to their needs and values.

Aims

Improving quality is a process that can always be made better even though very good work is already happening. Three aims have been identified to enable ongoing improvements in quality. The aims have been informed by the work of the National Health Committee (2001, 2002). It identified areas of focus for improvement in the system.

The aims are to:

- provide a shared purpose, vision and language to enable enhanced quality improvement in the New Zealand health and disability system
- enable a systems approach to quality improvement in the New Zealand health and disability system
- enable improved co-ordination of quality improvement activities in the New Zealand health and disability system.

The *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector* document is intended to enable all participants in the system to improve the quality of health and disability service delivery on an ongoing basis. It is intended that its direction will support quality improvement in both public and private providers of health and disability services.

The direction is primarily focused at the interface where those receiving health and disability services, and those delivering them, meet. This is distinct from a focus on the overall quality of the system. The latter is the subject of the overriding objectives, priorities and principles outlined in the *New Zealand Health Strategy* and the *New Zealand Disability Strategy*.

Goals and action plans

Eleven goals are identified in this document that support the vision of people receiving people-centred, safe and high-quality services that continually improve. They are outlined in Chapter 4.

While goals are intended to be enduring, the actions needed to support them will change as improvements are made and priorities evolve. It is hoped that over time both individuals and organisations will give effect to the vision and goals in this document through their quality improvement planning and actions.

In response to this document, the Ministry of Health has prepared an action plan of activities. These are activities it and some other national agencies are committed to implementing to give effect to the direction in this document. Over time this action plan will be updated and supplemented by the plans and actions of other agencies who are more actively involved in service delivery.

Quality improvement and quality assurance

Quality improvement includes both quality assurance and continuous quality improvement activities. While both are important, there is growing international evidence indicating that focusing on quality improvement leads to better outcomes than a focus on quality assurance activities alone.

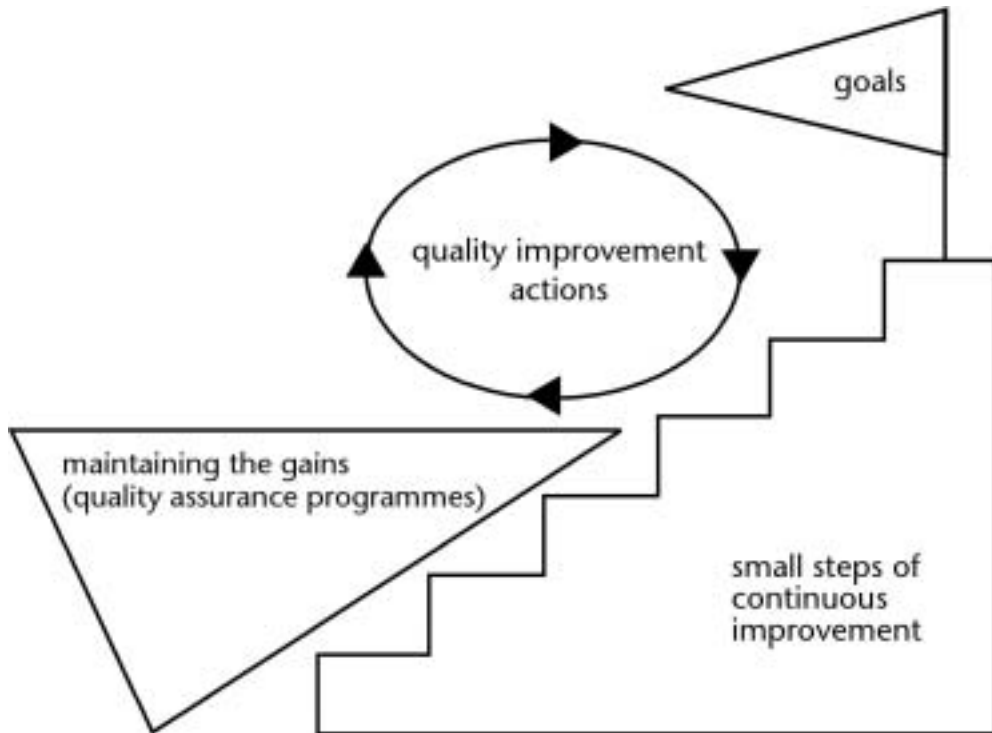
Quality is the cumulative result of the interactions of people, individuals, teams, organisations and systems. It can be defined as the degree to which the services for individuals and populations increase the likelihood of desired health outcomes (Lohr 1990) and the participation and independence of people experiencing a disability.

Quality improvement includes:

- an explicit concern for quality
- the viewing of quality as the search for continuous improvement
- an emphasis on improving work processes to achieve desired outcomes
- a focus on developing systems and investing in people to achieve high-quality health outcomes (Harvey 1996).

Maintenance of quality through quality assurance activities as well as quality improvement is important. The relationship between quality assurance, quality improvement, goals and actions is illustrated in Figure 3.

Figure 3: Relationship between quality assurance and quality improvement



The environment in which quality assurance and quality improvement occur has a major impact on their success. The next chapter focuses on the context in which this document has been developed.

2 Context

Culture

Enabling a culture of quality improvement is the best way to enhance quality improvement in the New Zealand health and disability system. Without a supportive culture the system is less likely to foster the co-operation and transparency of information necessary for successful quality improvement. Quality improvement requires openness and co-operation (Associate Minister of Health 2001).

An infrastructure that supports quality improvement is also important. Infrastructure includes information systems that support appropriate sharing of information and learning from it. It also includes tools that people, including consumers, individuals, teams and organisations can use for quality improvement.

A quality improvement culture and infrastructure are mutually reinforcing (Weick 1987). A supportive culture encourages the development and use of quality improvement practices. Likewise, the development and use of a quality improvement infrastructure fosters a quality improvement culture.

Evidence for quality improvement

There is growing international evidence suggesting that the effectiveness of quality improvement practices depends on the context in which they are applied (Walshe and Freeman 2002). There is no 'quick fix' or 'one size fits all' approach. Attention to many different factors and multiple approaches are needed (Solberg 2000). The intent of this document is therefore to set a high-level direction through goals that enables locally-appropriate quality improvement practices to evolve and improve on a continual basis.

Disciplined, well informed and intelligent application of quality improvement tools can make health services more effective (Taylor 1998). However, international and New Zealand research and evidence into what tools work best in the context of a complex health and disability system is still relatively limited (Grol et al 2002). We need to keep tracking developments in the evidence and to apply the various quality improvement tools in the contexts where they are shown to be effective.

Balancing control and autonomy

Getting an appropriate balance between control and autonomy of participants in the system is very important. This is because of the evidence indicating that context is very important to the success of quality improvement initiatives. Too much control may mean that initiatives are mandated in situations where they do not work. Too much autonomy risks a lack of consistency and integration. The focus of the approach in this document is therefore on enabling the sector to implement initiatives that work in particular contexts by minimising additional constraints to quality improvement. At the same time it is enabling a degree of consistency across the sector with a shared vision, purpose and language. The approach does not in itself impose new regulatory requirements on the sector.

The balance between control and autonomy influences the ability of the system to address novel problems and seize new opportunities. This is important because the adaptability of the system impacts on the quality and safety of services delivered within it. It is often unforeseen problems that lead to poor quality outcomes (Sitkin 1994; Rudolph 2002).

Setting an appropriate balance between control and autonomy is also important from a motivational perspective. This is because autonomy is a key factor motivating participants in the system (Deci et al 1996). People are motivated by the need to be valued and respected, to see the results of their actions, and to have some degree of control (Pencheon and Mien Koh 2000). Having a well-motivated workforce, as well as an adequate workforce in place is important.

Leadership and teamwork

Leadership at all levels is critical to securing a culture and infrastructure that supports quality improvement. Leaders create a sense of shared purpose, build effective relations and make connections between action and reflection (Carroll and Edmondson 2002).

Multi-disciplinary teamwork is a key aspect of quality improvement and is linked with leadership. Teamwork requires good relationships between all participants. Good relationships, particularly between those delivering and those receiving care and support, are critical to good quality services. Quality improvement tools should therefore include techniques for team-based problem-solving and team-based care (Kizer 2002).

Cost of quality improvement

Poor quality consumes resources that could be used for more and/or better care. This happens through waste, rework and avoidable escalation of issues. In this sense, poor quality costs.

While improving quality can save resources, the actual activity of improving quality uses resources. In fact, doing more and/or better quality improvement may require a greater share of resources than currently allocated to this activity. The balance between the costs of improving quality relative to the benefits of doing so is at the heart of decisions on how much resource should be allocated to quality improvement activities. These decisions are not always straightforward given that the benefits of investing in quality improvement sometimes occur well after the investment. Taking a perspective beyond the immediate term is therefore important.

Good quality can also cost. This is because at some point ongoing investment in quality improvement leads to smaller and smaller improvements. The relationship between the cost of undertaking quality improvement and the resulting improvements in quality can be represented on a 'U-shaped' curve. The cost of each increment of additional quality becomes less and less to a point and then it increases again.

Decisions on how much resource should be devoted to ongoing improvements are ones that are guided by the constraints and values at the time. These decisions should not inhibit ongoing activities to minimise poor quality. All of these decisions have to take place within the resources that are available.

Accreditation, certification and quality improvement

Some of the key quality improvement tools in use in the New Zealand health and disability system are accreditation and certification.

Accreditation is the process by which organisations demonstrate adherence to specific levels of practice defined by an accreditation agency, often expressed as standards, with the subsequent right to associate themselves with the agency. The practices may cover quality assurance and/or improvement activities.

Certification is the process by which organisations meet the standards of the Health and Disability Services (Safety) Act 2001. It is a legislative requirement. Standards cover both quality assurance and quality improvement activities. Audit agencies that have been designated by the Director-General of Health will undertake certification audits.

Some accreditation organisations have aligned some of their requirements with the standards under the Health and Disability Services (Safety) Act 2001.

Complex system

Fundamental to the approach to quality improvement in the New Zealand health and disability system are assumptions about the nature of the system and how it works. It is assumed that the New Zealand health and disability system is a complex adaptive system. Within this system, quality improvement results from the complex interactions of people, individuals, teams, organisation and systems. The system continually adapts to changes within it and responds to changes from outside of it.

The complexity of the system is also reflected in perceptions of what is a quality issue. As examples, amputation of the wrong limb, the treatment of people in a disabling manner or delivery of a meal different from that requested are all quality issues. Critical to establishing a common direction for the system is the need of participants to value and respond to both technical and people-centred measures of quality.

The systems approach is the focus of the next chapter.

3 Systems Approach

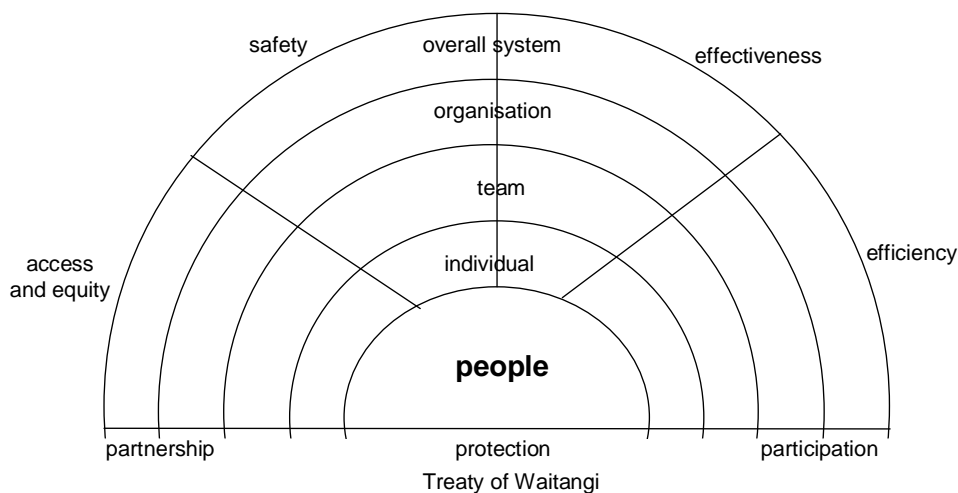
System levels

This document supports a greater systems approach to quality improvement and improved co-ordination of quality improvement. A systems approach is necessary because the health and disability system is complex with decision-making and actions happening across a variety of people, organisations and subsystems. A systems approach is not an end in itself but a means to enhance services for the benefit of people, including consumers. A systems approach recognises that quality is the cumulative result of the interactions of people, individuals, teams, organisations and systems.

Quality improvement needs to encapsulate all levels of the system and the interactions between them. The levels are shown diagrammatically in Figure 4. They range from the overall system through the organisations, and teams and individuals within those organisations, to the people receiving and impacted by the services delivered in the system.

People are at the heart of quality in the New Zealand health and disability system. The people include consumers as well as their families and whānau. They also include both individuals and population groups receiving services.

Figure 4: Quality dimensions for the New Zealand health and disability system



In the past, some individuals have been identified as responsible for poor quality in some instances where systems and not individuals have been the real cause. While a greater focus on systems is required, this should not be at the cost of removing responsibility from professionals, particularly in instances where behaviour has been unacceptable. Professionalism is an important concept that impacts on quality in the health and disability system.

Quality dimensions

The key dimensions of quality in the health and disability system are access and equity, safety, effectiveness and efficiency. The dimensions rest on the foundations of the

partnership, protection and participation principles of the Treaty of Waitangi. The dimensions are shown in Figure 4 as ‘slices’ through semi-circles representing the different levels of the system. Improving quality requires balancing across the dimensions. It also requires recognising the contributions and interactions across all levels of the system.

The dimensions of equity and access, are particularly relevant to Māori health. This is because in the past concerns about quality have often focused on technical safety and effectiveness, and not on access and equity. The failure of health and disability services to reach Māori as effectively as non-Māori is a quality issue. This is particularly the case when services have not been delivered in a manner that is consistent with the partnership, participation and protection principles of the Treaty of Waitangi.

Inequalities in health status for different population groups, for example between the health status of Pacific and non-Pacific peoples, is also a quality issue when they result from poor access to services and/or inappropriate service delivery. While the equity and access dimensions probably most directly relate to inequalities, other dimensions may also be important. For example, services are unlikely to be effective if delivered in a culturally-inappropriate manner.

Definitions for the foundations of the partnership, protection and participation principles of the Treaty of Waitangi, and for each of the quality dimensions are provided in Table 2.

Table 2: Definitions of the quality dimensions in the New Zealand health and disability system

| Foundation principles | Quality dimensions |
|---|---|
| <ul style="list-style-type: none"> • Partnership is the principle of working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services. • Participation is the principle of involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services. • Protection is the principle of working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices. | <ul style="list-style-type: none"> • People-centred is the extent to which a service is involving of people, including consumers, and is receptive and responsive to their needs and values. It includes participation, appropriateness, adherence to the Code of the Health and Disability Services Consumers’ Rights 1996¹ and adherence to other consumer protections such as the Health Information Privacy Code 1994. • Equity and access is the extent to which people are able to receive a service on the basis of need and irrespective of factors such as ethnicity, age, impairment or gender. • Safety is the extent to which harm is kept to a minimum. • Efficiency is the extent to which a service gives the greatest possible benefit for the resources used. • Effectiveness is the extent to which a service achieves an expected and measurable benefit. |

¹ The Code of the Health and Disability Consumers’ Rights 1996 is a regulation under the Health and Disability Commissioner Act 1994. When consumers believe that they have not received services in accordance with the Code of Rights, they can complain to the Health and Disability Commissioner.

Balancing the dimensions

For any given situation dimensions of quality will need to be balanced against each other taking into account the values and circumstances of the time. At all times, however, balancing decisions need to recognise that people-centredness is at the heart of quality in service delivery.

Balancing decisions are by their nature judgements informed by the values of the people and organisations making those judgements. Values differ across individuals, populations, cultures and organisations. The approach adopted in this document is intended to enable the application of different value sets when balancing across the dimensions of quality.

Goals have been identified that enable a systems approach to quality improvement. They are the focus of the next chapter.

4 Quality Improvement Goals

Goals

Eleven goals have been identified that support quality improvement in the New Zealand health and disability sector. These are a high-level statement of features of the system that are required to deliver on the quality improvement vision and aims. Development of the goals was informed by the National Health Committee's advice in its *Safe Systems Supporting Safe Care* work and by a working group established to provide advice to the Ministry of Health (members listed in Appendix A).

The goals and their relationship to the vision and aims are outlined in Table 3. Each goal relates to one or more of the system levels and quality dimensions as is outlined in Table 4.

Table 3: Relationship between vision, aims and goals

| Quality improvement approach | | | | |
|--|---|--|---|---|
| Vision | Aims | Goals | | |
| People in the New Zealand health and disability system receive people-centred, safe and quality services that continually improve. | Providing a shared purpose, vision and language to enable enhanced quality improvement in the New Zealand health and disability system. | <ul style="list-style-type: none"> More effective service outcomes for Māori by acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi and applying the principles of participation, partnership and protection. | | <ul style="list-style-type: none"> A shared vision toward safe and high-quality care is engendered through committed leadership at all levels that supports constant maintenance and improvement in service quality. People are encouraged and supported to participate in the planning, delivery and assessment of health and disability services and programmes. |
| | Enabling a systems approach to quality improvement in the New Zealand health and disability system. | | <ul style="list-style-type: none"> The goals in this document and associated actions are reviewed and updated on an ongoing basis. | <ul style="list-style-type: none"> Widespread awareness, understanding and commitment to a quality improvement culture at all levels of the health and disability sector. Evolutionary redesign of systems of care to support delivery of quality services. Unexpected adverse outcomes managed in an open and supportive manner that builds trust and confidence in the system and is fair to all participants. |
| | Enabling improved co-ordination of quality improvement activities in the New Zealand health and disability system. | | | <ul style="list-style-type: none"> Effective and open communication, co-ordination and integration of service activities that recognises the value of teamwork. A supportive and motivating environment that provides the workforce with appropriate tools for continuous learning and ongoing improvement in planning, delivery and assessment of health and disability services. Useful knowledge and information, including clinical evidence, readily available and shared to support a quality-conscious culture. Regulatory protections that assure safe care in place to support people and service providers. |

Table 4: Relationship between goals, system levels and quality dimensions

| Goal | Primary system level focus | Quality dimension/s |
|--|--|--|
| <ul style="list-style-type: none"> • More effective service outcomes for Māori by acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi and applying the principles of participation, partnership and protection. | <ul style="list-style-type: none"> • People • Individual • Team • Organisation • Overall system | <ul style="list-style-type: none"> • Treaty of Waitangi principles of partnership, protection and participation. |
| <ul style="list-style-type: none"> • A shared vision toward safe and quality care engendered through committed leadership at all levels that supports constant maintenance and improvement in service quality. | <ul style="list-style-type: none"> • People • Individual • Team • Organisation • Overall system | <ul style="list-style-type: none"> • Access and equity • Safety • Effectiveness • Efficiency |
| <ul style="list-style-type: none"> • People are encouraged and supported to participate in the planning, delivery and assessment of health and disability services and programmes. | <ul style="list-style-type: none"> • People | <ul style="list-style-type: none"> • Effectiveness |
| <ul style="list-style-type: none"> • Widespread awareness, understanding and commitment to a safety and quality improvement culture at all levels of the health and disability sector. | <ul style="list-style-type: none"> • People • Individual • Team • Organisation • Overall system | <ul style="list-style-type: none"> • Access and equity • Safety • Effectiveness • Efficiency |
| <ul style="list-style-type: none"> • Evolutionary redesign of systems of care to support delivery of high-quality services. | <ul style="list-style-type: none"> • Organisation • Overall system | <ul style="list-style-type: none"> • Effectiveness • Efficiency |
| <ul style="list-style-type: none"> • Unexpected adverse outcomes managed in an open and supportive manner that builds trust and confidence in the system and is fair to all participants. | <ul style="list-style-type: none"> • People • Individual • Team • Organisation • Overall system | <ul style="list-style-type: none"> • Safety • Effectiveness |
| <ul style="list-style-type: none"> • Effective and open communication, co-ordination and integration of service activities that recognises the value of teamwork. | <ul style="list-style-type: none"> • Team • Organisation • Overall system | <ul style="list-style-type: none"> • Access and equity • Safety • Effectiveness • Efficiency |
| <ul style="list-style-type: none"> • A supportive and motivating environment that provides the workforce with appropriate tools for continuous learning and ongoing improvement in planning, delivery and assessment of health and disability services. | <ul style="list-style-type: none"> • Individual • Team | <ul style="list-style-type: none"> • Access and equity • Safety • Effectiveness • Efficiency |
| <ul style="list-style-type: none"> • Useful knowledge and information, including clinical evidence, readily available and shared to support a quality-conscious culture. | <ul style="list-style-type: none"> • Overall system | <ul style="list-style-type: none"> • Safety • Effectiveness • Efficiency |
| <ul style="list-style-type: none"> • Regulatory protections that assure safe care in place to support people and service providers. | <ul style="list-style-type: none"> • People • Individual • Team | <ul style="list-style-type: none"> • Safety |
| <ul style="list-style-type: none"> • The goals in this document and associated actions are reviewed and updated on an ongoing basis. | <ul style="list-style-type: none"> • People • Individual • Team • Organisation • Overall system | <ul style="list-style-type: none"> • Access and equity • Safety • Effectiveness • Efficiency |

Description

To assist the tracking of progress towards the achievement of each goal, a description of how the health and disability system might look when each is achieved has been developed. This description could be translated into selected indicators if required. The goals and their associated descriptions are outlined in Table 5.

Table 5: Goals and descriptions

| Goal | Description |
|--|---|
| More effective service outcomes for Māori by acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi and applying the principles of participation, partnership and protection. | <ul style="list-style-type: none"> • There are mechanisms for ensuring that Māori aspirations and priorities for health are taken into account in the planning and delivery of services. • There is active participation by Māori at all levels of the health and disability sector in decision-making, planning, development and delivery of health services. • DHBs involve Māori in their decision-making and service delivery supports effective Māori development. • DHBs have addressed the access barriers that exist for many Māori in gaining access to appropriate and accessible services. • Māori models of health and traditional healing are recognised and valued. • There is improvement in the effectiveness of mainstream services for Māori. • DHBs, providers and public health agencies have established processes to gather information on Māori consumer/client satisfaction, clinical pathways and decision-making processes, and organisational capacity and capability. • Whānau receive timely, high-quality, effective and culturally-appropriate health and disability services to improve whānau ora and reduce inequalities – effective care includes culturally-competent service delivery. |
| A shared vision toward safe and quality care engendered through committed leadership at all levels that supports constant maintenance and improvement in service quality. | <ul style="list-style-type: none"> • Leadership at all levels of the system supports and promotes a shared quality improvement vision. • Leadership at all levels of the system ensures there is co-ordination of quality improvement activities throughout the system so that gaps and inappropriate duplication in activities are minimised. |
| People are encouraged and supported to participate in the planning, delivery and assessment of health and disability services and programmes. | <ul style="list-style-type: none"> • There is active involvement of consumers/clients and communities to ensure the health and disability system is people-centred. • Decision-making processes at all levels of the health and disability system recognise the importance of people and community participation. • Mechanisms are available to support the participation of people in decision-making. • Disabled people are encouraged to take part in decision-making as service users, as staff in the delivery of services, and in the governance, management, planning and evaluation within all services that disabled people use. |

| Goal | Description |
|--|--|
| There is widespread awareness, understanding and commitment to a safety and quality improvement culture at all levels of the health and disability sector. | <ul style="list-style-type: none"> • There is a widespread ethic of quality improvement and the use of quality improvement practices. • There is widespread understanding of what quality improvement is and it is an integral part of the care and support processes. • There are effective relationships based on mutual trust and respect among all participants in the care process and its ongoing improvement. • Innovation is valued, facilitated and assured throughout the system. • Tensions are dealt with in an open and fair manner. |
| There is evolutionary redesign of systems of care to support delivery of high-quality services. | <ul style="list-style-type: none"> • There are widespread systems for analysing events, learning and promoting the redesign of systems of care. • There is customisation of systems of care based on people's needs and values. • Care and support is provided in the most appropriate place for people's need. • There is easy and timely access to health and disability services. |
| Unexpected adverse outcomes managed in an open and supportive manner that builds trust and confidence in the system and is fair to all participants. | <ul style="list-style-type: none"> • Adverse events are minimised to the greatest extent possible. • When unexpected adverse events occur all participants believe there is appropriate acknowledgement, explanation and demonstration that steps have been taken to reduce the probability of the event happening again. • When injury does occur, systems are in place to make appropriate responses to people's needs. • Individuals are not inappropriately held responsible in instances where the system has led to an adverse event. |
| Effective and open communication, co-ordination and integration of service activities that recognises the value of teamwork. | <ul style="list-style-type: none"> • Communication with people, across teams, within organisations and system-wide is excellent. • Team work is widely valued throughout care systems. |
| A supportive and motivating environment that provides the workforce with appropriate tools for continuous learning and ongoing improvement in planning, delivery and assessment of health and disability services. | <ul style="list-style-type: none"> • There are relationships based on trust and mutually responsible behaviour. • There is ongoing pursuit of competence and education focused on safety and quality across the health and disability support workforce. • Participants are empowered to make positive change rather than feeling helpless and isolated. • Infrastructure is in place to enhance performance, learn from experience and deal fairly with failure. • Management systems support people so that they do not operate in isolation. • Health professionals are supported to be responsive to the needs of disabled people. |
| Useful knowledge and information, including clinical evidence, is readily available and shared to support a quality-conscious culture. | <ul style="list-style-type: none"> • Knowledge and information is shared easily, but appropriately, throughout the sector with people, between health and disability workers, between organisations, and among government agencies to assure optimum monitoring and planning. • Evidence, including appropriate clinical evidence where it exists, is used to inform decision-making at all levels of the system. • Effective reporting systems that enable all participants to report events to facilitate learning and adjustment are in place. |

| Goal | Description |
|--|--|
| Regulatory protections that assure safe care are in place to support people and service providers. | <ul style="list-style-type: none"> • Effective protections are in place to protect consumers'/clients' rights. • Effective privacy protections are in place. • Effective protections are in place to ensure that health and disability service facilities and the practices undertaken in them are safe. • Effective protections are in place to ensure that those delivering health and disability services are competent to do so. • Effective protections are in place to ensure medicines and therapeutic devices are safe for those who use or receive them. |
| The goals in this document and associated actions are reviewed and updated on an ongoing basis. | <ul style="list-style-type: none"> • There is an annual stocktake by the Ministry of Health of progress in implementing the actions. • The actions are updated at least once every three years involving sector input. • The goals are updated in any given year if updating of them is identified as a key quality improvement action for that year. |

Action plan

While goals are intended to be enduring, the actions needed to support them will change as improvements are made and priorities change. In response to this document, the Ministry of Health has prepared an action plan of activities. These are activities it and some other national agencies are committed to implementing to give effect to the direction in this document. Over time this action plan will be updated and supplemented by the plans and actions of other agencies who are more actively involved in service delivery.

5 Nationally-Consistent Standards and Quality Assurance Programmes

Quality assurance

Quality assurance is about the detection of problems through external or internal investigation, and their correction through systematic activity (National Health Committee 2001). Setting of expectations (standards), their implementation and measurement of performance against them (quality assurance programmes) are integral components of a quality assurance approach.

Part 2 Section 9 of the New Zealand Health and Disability Act 2000 (the Act) focuses on quality assurance. It requires that the Minister of Health determines a strategy for the development and use of:

- a) nationally consistent standards and quality assurance programmes for health services and consumer safety
- b) nationally consistent performance monitoring of health services and consumer safety against those standards and programmes.

A large number of quality assurance mechanisms are in place in the health and disability system. While the focus of this chapter is on key nationwide activities within the Minister of Health's influence given the requirements of the Act, this does not diminish the importance of the other assurance activities that are undertaken in the system. Examples include the various electrical safety standards applying to hospitals and ISO9000 accreditation by a number of agencies including the National Radiation Laboratory.

Legislation and regulations

There is a wide range of legislation and associated regulations that apply to the health and disability system. These are outlined in Table 6. In the broadest sense these can be considered as defining the scope of quality assurance mechanisms in the system.

The health and disability sector is also bound by a range of generic legislation. This includes the Injury Prevention, Rehabilitation and Compensation Act 2001, the Privacy Act 1993 and the Health and Safety in Employment Act 1997.

Table 6: Major health- and disability-related Acts and Regulations

| Acts* | Regulations* |
|--|---|
| <ul style="list-style-type: none"> • Alcoholic Liquor Advisory Council Act 1976 • Alcoholism and Drug Addiction Act 1966 • Burial and Cremation Act 1964 • Cancer Registry Act 1993 • Chiropractors Act 1982* • Dental Act 1988 • Dieticians Act 1950* • Disabled Persons Community Welfare Act 1975 • Health Act 1956 • Health and Disability Commissioner Act 1994 • Health and Disability Services (Safety) Act 2001 • Health Benefits (Reciprocity with Australia) Act 1999 • Health Benefits (Reciprocity with the United Kingdom) Act 1982 • Health Sector (Transfers) Act 1993 • Health Research Council Act 1990 • Hospitals Act 1957 (transitional until repealed on 1 October 2004) • Human Tissue Act 1964 • Medical Auxiliaries Act 1966* • Medical Practitioners Act 1995* • Medicines Act 1981 • Mental Health Commission Act 1998 • Mental Health (Compulsory Assessment and Treatment) Act 1992 • Misuse of Drugs Act 1975 • New Zealand Public Health and Disability Act 2000 • New Zealand Register of Osteopaths Incorporated Act 1978 • Nurses Act 1977* • Occupational Therapy Act 1949* • Optometrists and Dispensing Opticians Act 1976* • Pharmacy Act 1970* • Physiotherapy Act 1949* • Plumbers, Gasfitters and Drainlayers Act 1976 • Psychologists Act 1981* • Radiation Protection Act 1965 • Smoke-free Environments Act 1990 • Tuberculosis Act 1948 | <ul style="list-style-type: none"> • Alcoholic Liquor Advisory Council Regulations 1978 • Alcoholism and Drug Addiction (Forms) Regulations 1968 • Alcoholism and Drug Addiction Institution Order 1975 • Alcoholism and Drug Addiction Institutions Order (various years) • Alcoholism and Drug Addiction (Medical Fees) Regulations 1992 • Anthrax Prevention Regulations 1987 • Asbestos Regulations 1983 • Burial and Cremation (Removal of Monuments and Tablets) Regulations 1967 • Camping Ground Regulations 1985 • Cancer Registry Regulations 1994 • Chiropractors Regulations 1994* • Cremation Regulations 1973 • Dental Regulations 1988* • Dietary Supplements Regulations 1985 • Dieticians Regulations 1987* • Electroplating Regulations 1950 (Amendments 4 and 5 are administered by Labour) • Environmental Health Officers Qualifications Regulations 1993 • Fire Extinguishers Regulations 1958 • Fireguards Regulations 1958 • Fumigation Regulations 1967 • Health (Burial) Regulations 1946 • Health (Bursaries) Regulations 1965 • Health (Cervical Screening (Kaitiaki)) Regulations 1995 • Health (Diseases Communicated by Animals) Regulations 1965 • Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996 • Health Entitlement Cards Regulations 1993 • Health (Hairdressers) Regulations 1980 • Health (Immunisation) Regulations 1995 • Health (Infectious and Notifiable Diseases) Regulations 1966 • Health (Infirm and Neglected Persons) Regulations 1958 • Health Information Privacy Code 1994 (note this is a deemed regulation) • Health (Needles and Syringes) Regulations 1998 • Health (Quarantine) Regulations 1983 • Health (Registration of Premises) Regulations 1966 |

| Acts* | Regulations* |
|-------|--|
| | <ul style="list-style-type: none"> • Health (Retention of Health Information) Regulations 1996 • Hospitals Regulations 1993 • Housing Improvement Regulations 1947 • Intellectually Handicapped Persons Homes Regulations 1955 • Lead Process Regulations 1950 • Medical Laboratory Technologists Regulations 1989* • Medical Radiation Technologists Regulations 1995* • Medicines (Designated Prescriber: Nurses Practising in Aged Care and Child Family Health) Regulations 2001 • Medicines Regulations 1984 • Medicines (Related Products (Exempted Foods)) Regulations 2000 • Mental Health (Forms) Regulations 1992 • Mental Health (Medical Fees) Regulations 1992 • Mental Hospitals Road Traffic Bylaws 1960 • Microwave Ovens Regulations 1982 • Misuse of Drugs Regulations 1977 • Noxious Substances Regulations 1954 • Nurses Regulations 1986* • Obstetric Regulations 1986 • Occupational Therapy Regulations 1964 • Old People's Homes Regulations 1987 • Optometrists and Dispensing Opticians Regulations 1997* • Pharmacy Registration Regulations 1972* • Pharmacy Regulations 1975 • Physiotherapy Regulations 1979* • Plastic Wrapping Regulations 1979 • Plumbers, Gasfitters, and Drainlayers Regulations 1977 • Podiatrists Regulations 1982* • Porirua Hospital Traffic Bylaws 1969 • Radiation Protection (Appeals) Regulations 1974 • Radiation Protection Regulations 1982 • Smoke-free Environments Regulations 1999 • Spray Coating Regulations 1962 • Tuberculosis Regulations 1951 • Venereal Diseases Regulations 1951 • Water Supplies Protection Regulations 1961 |

* These Acts and Regulations are expected to be replaced by the Health Practitioners Competence Assurance Bill when it is passed.

Strategy for nationally-consistent standards and quality assurance programmes

The strategy for development, use and monitoring of nationally-consistent standards and quality assurance programmes involves:

1. reinforcement of *key* standards, quality assurance mechanisms and requirements: Code of Health and Disability Services Consumers' Rights 1996, the Health Information Privacy Code 1994, the Health and Disability Services (Safety) Act 2001, National Screening Standards, and the Health Practitioners Competence Assurance Bill
2. a focus on the standards and quality assurance expectations of District Health Boards. This is because District Health Boards are responsible for funding most health services for New Zealanders. They are also major providers of health and disability services to New Zealanders
3. the use of advisory committees as a quality assurance and improvement mechanism for the health and disability system. These include the National Health Epidemiology and Quality Assurance Advisory Committee (Epiqual) and Mortality Review Committees
4. use of the *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector* document as it is a quality assurance mechanism for the overall system.

The specific elements that make up each of these components of the strategy and the associated monitoring arrangements are summarised in Table 7. A fuller description of each of the elements is provided in Appendix 2.

Reporting progress

Each year the Minister of Health will report to the House of Representatives on progress in implementing the strategy outlined above. This is to meet the reporting requirements of Part 2 Section 9 of the New Zealand Public Health and Disability Act 2000. The Minister will also present to the House of Representatives copies of any reports from the National Health Epidemiology and Quality Assurance Advisory Committee and Mortality Review Committees that are covered by Part 2 Sections 16(6) and 17(8) of the Act.

The House of Representatives also receives reports on the quality of health and disability services as part of other reporting arrangements. These include annual reporting by the Minister of Health against progress in implementing the *New Zealand Health Strategy* and reporting by the Director-General of Health on the current state of public health.

Table 7: Strategy for development, use and monitoring of nationally-consistent standards and quality assurance programmes

| Strategy | Element | Level of focus | Development and use of standards and quality assurance programmes | Monitoring of standards and quality assurance programmes |
|--|--|-------------------------------|--|--|
| Reinforcement of key nationwide standards, quality assurance mechanisms and requirements. | Code of Health and Disability Services Consumers' Rights 1996 | Individuals and organisations | <ul style="list-style-type: none"> Rights as outlined in the Code of Health and Disability Consumers Rights 1996. | <ul style="list-style-type: none"> Complaints mechanism outlined in the Code. |
| | Health Information Privacy Code 1994 | Individuals and organisations | <ul style="list-style-type: none"> Rules as outlined in the Health Information Privacy Code 1994. | <ul style="list-style-type: none"> Complaints mechanism outlined in the Code. |
| | Health and Disability Services (Safety) Act 2001 | Organisations | <ul style="list-style-type: none"> Provisions of the Act enable additional standards to be developed. From October 2004 all providers must comply with the generic Health and Disability Sector Standards (NZS 8134:2001 – covering consumer rights, organisational management, pre-entry and entry to services, service delivery, managing service delivery, and safe and appropriate environments). Additionally, providers of hospital services, rest homes and residential disability service must meet new infection control (NZS 8142:2000), restraint maintenance and safe practice (NZS 8141:2001), and National Mental Health Sector Standards (NZS 8143:2001) to receive certification under the Act. | <ul style="list-style-type: none"> Audit, monitoring and certification arrangements as outlined in the Act. |
| | Screening Programme Standards | Programmes | <ul style="list-style-type: none"> Performance expectations for the National Cervical Screening programme are set out in an <i>Operational Policy and Quality Standards Manual</i>. National quality standards for the provision of breast-screening services are outlined in a National Operational Manual, in service specifications and in national performance indicators. | <ul style="list-style-type: none"> Quarterly monitoring of the quantitative performance of the National Cervical Screening Programme by an Independent Monitoring Group. Twice-yearly and annual monitoring of the performance of aspects of BreastScreen Aotearoa by an Independent Monitoring Group. |
| | Health Practitioners Competence Assurance Bill | Individuals | <ul style="list-style-type: none"> Outlined in the provisions of the Act when the Act is passed. | <ul style="list-style-type: none"> Outlined in the provisions of the Act when the Act is passed. |
| Focus on the expectations of District Health Boards through the appropriate planning and accountability documentation. | District Health Board Indicator Framework, Service Cover, and Operational Policy Framework documents | Organisations | <ul style="list-style-type: none"> Quality and safety requirements outlined in the Service Cover and Operational Policy Framework documents. | <ul style="list-style-type: none"> Quarterly monitoring by the Ministry of Health of District Health Board performance. Monitoring of provider performance by District Health Boards. |

| Strategy | Element | Level of focus | Development and use of standards and quality assurance programmes | Monitoring of standards and quality assurance programmes |
|--|--|----------------|---|---|
| Use of advisory committees. | National Health and Epidemiology and Quality Assurance Advisory Committee, and Mortality Review Committees | System | <ul style="list-style-type: none"> • Outlined in the terms of reference of the committees. | <ul style="list-style-type: none"> • Reporting requirements outlined in Part 2 Sections 17 and 18 of the New Zealand Public Health and Disability Act 2001. |
| Use of the IQ document as in itself this is a quality assurance mechanism. | Regular updating of the document. | System | <ul style="list-style-type: none"> • Goals are outlined in the document. • . • An updating process for goals outlined in the document • Action plans and quality improvement activities as developed by agencies. | <ul style="list-style-type: none"> • Annual reporting to Parliament against the requirements of Part 2 Section 9 of the New Zealand Public Health and Disability Act 2000. • Updating of the Action Plans |

6 Conclusion

This document has outlined steps to enable people in the New Zealand health and disability system to receive people-centred, safe and high-quality services that continually improve. It has included a vision and goals that aim to:

- provide a shared purpose, vision and language to enable enhanced quality improvement in the New Zealand health and disability system
- enable a systems approach to quality improvement in the New Zealand health and disability system while recognising that a systems approach is not an end in itself, but a means to enhance services for the benefit of people, including consumers
- enable improved co-ordination of quality improvement activities in the New Zealand health and disability system.

The document will be updated using a quality improvement approach. The updating process will involve sector input. The aims, goals and nationally-consistent standards and quality assurance programmes will be updated when required. Progress in giving effect to the approach in the document will be reported annually to the House of Representatives by the Minister of Health.

Improving quality requires constant attention and effort. It is a process that can always be made better even though very good work is already happening. It is the responsibility of all the people, individuals, teams, organisations and systems within the health and disability system. The purpose, vision, aims and goals outlined in this document are intended to enable all the participants to make ongoing improvements to this process.

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Appendix 1: Working Group Members

A working group was formed specifically for the purpose of providing advice to inform development of this document. The working group met on three occasions. The people who participated in one or more of these meetings were:

- Geoff Annals (NZNO)
- Audrey Aumua (Chief Advisor, Pacific, Ministry of Health)
- Deborah Baird (Māori Health Directorate, Ministry of Health)
- Gillian Bohm (Ministry of Health)
- Robin Briant
- Cathy Cooney (DHBNZ Chief Executive Representative)
- Barbara Crawford (Waikato DHB, member of Quality Managers' Group)
- Elaine Elbe (ACC)
- Maureen Gillon (RNZCGP)
- Peter Gow (Counties Manukau DHB)
- Gillian Grew (Ministry of Health)
- Andrew Holmes (Ministry of Health)
- Peter Jansen
- Elizabeth Knopf (Ministry of Health)
- Sally McLean (DHBNZ)
- Sue Merrilees (Disability Issues Directorate, Ministry of Health)
- Simon O'Dowd (Residential Care Association)
- Dale Oliff (Southland DHB)
- Lesley Orr (Disability Consumer Representative)
- David Press (Ministry of Health)
- Simon Robb (Ministry of Health)
- Peter Roberts (Ministry of Health)
- Christine Roseveare (Te Wana Programme / Health Care Aotearoa)
- Alan Shirley (Wairarapa DHB, member of Senior Medical Advisors' Group)
- Judi Stridd (Women's Health Action)
- Chris Tuffnell (Spot On Quality)
- Jim Vause (RNZCGP).

Appendix 2: Strategy for Nationally-Consistent Standards and Quality Assurance Programmes

A strategy for development, use and monitoring of nationally-consistent standards and quality assurance programmes was outlined in Chapter 5. It involves:

1. reinforcement of key standards, quality assurance mechanisms and requirements: Code of Health and Disability Services Consumers' Rights 1996, the Health Information Privacy Code 1994, the Health and Disability Services (Safety) Act 2001, National Screening Standards, and the Health Practitioners Competence Assurance Bill
2. a focus on the standards and quality assurance expectations of District Health Boards. This is because District Health Boards are responsible for funding most health services for New Zealanders. They are also major providers of health and disability services to New Zealanders
3. the use of advisory committees as a quality assurance and improvement mechanism for the health and disability system. These include the National Health Epidemiology and Quality Assurance Advisory Committee (Epiqual) and Mortality Review Committees
4. use of the *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector* document as it is a quality assurance mechanism in its own right.

A fuller description of each of these elements is provided below.

Key standards and quality assurance mechanisms and requirements

The key quality assurance mechanisms and requirements in the New Zealand health and disability system are:

i) Code of Health and Disability Services Consumers' Rights 1996

The Code is set out in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. It includes a complaints mechanism.

The rights of consumers and the duties of providers under the Code are as follows:

Right 1 – Right to be treated with respect

- (1) Every consumer has the right to be treated with respect.
- (2) Every consumer has the right to have his or her privacy respected.
- (3) Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori.

Right 2 – Right to freedom from discrimination, coercion, harassment, and exploitation
Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial, or other exploitation.

Right 3 – Right to dignity and independence

Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

Right 4 – Right to services of an appropriate standard

- (1) Every consumer has the right to have services provided with reasonable care and skill.
- (2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
- (3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
- (4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
- (5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Right 5 – Right to effective communication

- (1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.
- (2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

Right 6 – Right to be fully informed

- (1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
 - (a) an explanation of his or her condition
 - (b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option
 - (c) advice of the estimated time within which the services will be provided
 - (d) notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval
 - (e) any other information required by legal, professional, ethical, and other relevant standards
 - (f) the results of tests
 - (g) the results of procedures.
- (2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

- (3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about –
 - (a) the identity and qualifications of the provider
 - (b) the recommendation of the provider
 - (c) how to obtain an opinion from another provider
 - (d) the results of research.
- (4) Every consumer has the right to receive, on request, a written summary of information provided.

Right 7 – Right to make an informed choice and give informed consent

- (1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.
- (2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.
- (3) Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.
- (4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where –
 - (a) it is in the best interests of the consumer
 - (b) reasonable steps have been taken to ascertain the views of the consumer
 - (c) either –
 - (i) if the consumer’s views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or
 - (ii) if the consumer’s views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.
- (5) Every consumer may use an advance directive in accordance with the common law.
- (6) Where informed consent to a health care procedure is required, it must be in writing if –
 - (a) the consumer is to participate in any research; or
 - (b) the procedure is experimental; or
 - (c) the consumer will be under general anaesthetic; or
 - (d) there is a significant risk of adverse effects on the consumer.
- (7) Every consumer has the right to refuse services and to withdraw consent to services.

- (8) Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable.
- (9) Every consumer has the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health care procedure.
- (10) Any body parts or bodily substances removed or obtained in the course of a health care procedure may be stored, preserved, or utilised only with the informed consent of the consumer.

Right 8 – Right to support

Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer’s rights may be unreasonably infringed.

Right 9 – Rights in respect of teaching or research

The rights in this Code extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching or research.

Right 10 – Right to complain

- (1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.
- (2) Every consumer may make a complaint to –
 - (a) the individual or individuals who provided the services complained of
 - (b) any person authorised to receive complaints about that provider
 - (c) any other appropriate person, including –
 - (i) an independent advocate provided under the Health and Disability Commissioner Act 1994
 - (ii) the Health and Disability Commissioner.
- (3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.
- (4) Every provider must inform a consumer about progress on the consumer’s complaint at intervals of not more than one month.
- (5) Every provider must comply with all the other relevant rights in this Code when dealing with complaints.
- (6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that –
 - (a) the complaint is acknowledged in writing within five working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period
 - (b) the consumer is informed of any relevant internal and external complaints procedures, including the availability of –
 - (i) independent advocates provided under the Health and Disability Commissioner Act 1994
 - (ii) the Health and Disability Commissioner

- (c) the consumer's complaint and the actions of the provider regarding that complaint are documented
 - (d) the consumer receives all information held by the provider that is or may be relevant to the complaint.
- (7) Within 10 working days of giving written acknowledgement of a complaint, the provider must –
- (a) decide whether the provider –
 - (i) accepts that the complaint is justified; or
 - (ii) does not accept that the complaint is justified; or
 - (b) if it decides that more time is needed to investigate the complaint –
 - (i) determine how much additional time is needed
 - (ii) if that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.
- (8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of –
- (a) the reasons for the decision
 - (b) any actions the provider proposes to take
 - (c) any appeal procedure the provider has in place.

ii) Health Information Privacy Code 1994

The Code sets out a number of rules relating to the collection, storage and use of health information. It also includes a complaints mechanism. The rules are:

- Rule 1: Purpose of collection of health information
- Rule 2: Source of health information
- Rule 3: Collection of health information from individual
- Rule 4: Manner of collection of health information
- Rule 5: Storage and security of health information
- Rule 6: Access to personal health information
- Rule 7: Correction of health information
- Rule 8: Accuracy etc of health information to be checked before use
- Rule 9: Retention of health information
- Rule 10: Limits on use of health information
- Rule 11: Limits on disclosure of health information
- Rule 12: Unique identifiers.

iii) The Health and Disability Services (Safety) Act 2001

A new framework for improved safety standards in our hospitals, rest homes and in residential homes for people with disabilities was introduced with the passing of the Health and Disability Services (Safety) Act 2001 (the Safety Act). The objectives of the Safety Act are to:

- promote safe health and disability services

- establish consistent and reasonable standards for health and disability services
- encourage health and disability providers to take responsibility for safely providing services
- encourage health and disability providers to continuously improve service quality.

The Safety Act provides for consistently safe, high-quality services for consumers from more than 3000 health and disability service providers, while also replacing fragmented, outdated legislation. Medical, surgical, paediatric, maternity, age-related services, mental health services, intellectual and disability services (including residential mental health homes and homes for people with disabilities) are all covered by the Safety Act.

From 1 October 2002 there is a two-year transition period to allow existing licensed providers time to meet the Safety Act's requirements and become certified. By 1 October 2004 the new Act will repeal the Hospitals Act 1957, the Hospitals Regulations 1993, the Old People's Homes Regulations 1987, the Obstetric Regulations 1986, and sections of the Disabled Persons Community Welfare Act 1975. Also by 1 October 2004 all providers of hospitals, rest homes and residential disability services must be certified under the Safety Act. From 1 October 2002 all providers will be required to be certified under the Safety Act prior to commencing the provision of services.

Standards

The Health and Disability Sector Standards (NZS 8134:2001) are the generic standard of the new legislation. They set an agreed level for minimum safety and encourage quality improvement in six key areas:

- consumer rights
- organisational management
- pre-entry and entry to services
- service delivery
- managing service delivery
- safe and appropriate environments.

A further set of safety standards has been developed for use with the Safety Act. Providers of hospital services, rest homes and residential disability services must meet these new standards to be certified. The health and disability standards were developed by the sector for the sector, after wide-ranging industry and public consultation. Obtaining sector support and consumer input has been crucial to their development.

The new Safety Standards cover specific aspects of services and include:

- Infection Control (NZS 8142:2000)
- Restraint Minimisation and Safe Practice (NZS 8141:2001)
- National Mental Health Sector Standard (NZS 8143:2001).

The health and disability standards provide a mechanism for continuous development of quality improvement systems and will be reviewed regularly to ensure that they keep up

with changes in service delivery. The Minister of Health will have the power to approve more standards from time to time.

Inputs to outcomes

The Safety Act and health and disability standards move the focus towards monitoring the outcomes of service delivery, and the quality and safety of care provided, rather than inputs. The current licensing and registration system focuses on inputs, or the requirements needed to provide a service. But here and overseas we now recognise that a list of what must be provided (a prescription of inputs) does not necessarily give good results or outcomes.

For example, the Old People's Homes Regulations 1987 prescribe ratios of toilets and baths to residents. This prescription, although important, does not address types of issues such as privacy and independence now included in the standards. Under the new legislation providers must show evidence that services are managed by suitably qualified or experienced people, and that they can safely meet the needs of people in their care.

Auditing

Providers will be audited by independent designated audit agencies, ensuring providers are safe, outcome focused and continuously improving service quality. Providers will receive certification usually for three years, but maybe only for one or two years. Providers who demonstrate safety and continual service improvement may get certification for more than three years, up to a maximum of five years.

Audit agencies will have to demonstrate their competence to the Director-General of Health before they can be designated. They must prove they have the technical expertise to audit, effective systems in place to audit the specified services, effective arrangements to avoid conflicts of interest that may arise, and competent systems and arrangements.

Monitoring

The Ministry of Health, as the regulator in certifying services under the Safety Act, has an obligation to monitor hospitals, rest homes and homes for people with disabilities. The Ministry will collect summaries of audit reports of all relevant services that apply for certification. From 1 October 2004, the Ministry will hold comprehensive audit information on all hospitals, rest homes and homes for people with disabilities. The Ministry of Health will hold this information in an electronic database that will facilitate ready analysis. For example, the data could highlight areas where services are struggling to ensure safety and quality. Alternatively, the data could highlight areas of good practice that can be shared with all service providers. The analysed information will underpin future policy decisions related to the regulation of service safety in hospitals, rest homes and homes for people with disabilities.

iv) Screening standards

Standards

Since the inception of the National Cervical Screening Programme (NCSP) in 1990/91, attempts have focused on meeting the requirements for an effective organised population-based screening programme and providing ongoing systematic monitoring and evaluation of its various parts. Performance expectations for Cervical Screening are set out in *Operational Policy and Quality Standards Manual*. A set of national performance indicators and targets for the programme has also been developed to assist with the monitoring of the NCSP to improve the quality of the programme.

National quality standards for the provision of breast-screening services are outlined in a National Operational Manual, service specifications and national performance indicators. The indicators relate to key parameters in the screening pathway. The pathway is from registration of eligible women, testing and assessment, to diagnosis and treatment. The parameters have been chosen because they can be used as indicators of the safety, acceptability, effectiveness and efficiency of BreastScreen Aotearoa (the national breast-screening programme).

Monitoring

Quantitative performance of the NCSP is monitored by an Independent Monitoring Group. The group collates and analyses data against national indicators and targets. The analysis is provided in quarterly reports that include quality improvement recommendations. The National Screening Unit of the Ministry of Health co-ordinates information flow to assure feedback to providers and undertakes analysis and follow-up of the recommendations to ensure delivery of consistent quality in the NCSP.

Aspects of the performance of BreastScreen Aotearoa (BSA) are monitored by an Independent Monitoring Group against an agreed list of measures of performance, and are included in twice-yearly and annual monitoring reports to the Ministry of Health. The National Screening Unit of the Ministry of Health co-ordinates information flow to assure feedback to providers and undertakes analysis and follow-up of the recommendations with providers to ensure delivery of consistent quality in the BSA. A generic audit tool template has been developed for ensuring routine compliance by Lead Providers against National Quality Standards. A component of this audit tool is a survey that assesses the acceptability of screening service for women.

These monitoring mechanisms will continue to be used and developed further for cervical and breast screening.

v) Health Practitioners Competence Assurance Bill

The Bill² puts in place a new framework to ensure that the delivery of services by health practitioners is safe. There will be consistent processes for the registration and ongoing competence of practitioners who are currently regulated and a process for the inclusion of new health professions if appropriate. Registration authorities will certify that practitioners are qualified and competent to practise within a certain scope specifying conditions and time. The key features of the bill regulating health practitioners are outlined below.

Registration authorities

The Minister of Health will appoint the members of each registration authority with provision for elected members to be appointed under regulations. The authorities will have at least two lay members. The registration authority will be separate from the association which represents a particular profession. The Minister of Health may instigate an audit of an authority's policies and procedures if there is concern about its process.

Scopes of practice

Each registration authority will develop scopes of practice describing the activities practitioners are qualified to perform, the conditions under which the activities may be performed and a date for review.

Restricted activities

Some activities, where there is a risk of serious or permanent harm, will be restricted to those who are competent to perform the activity according to their scope of practice.

Ongoing competence

Registration authorities will be required to put processes in place to ensure that practitioners maintain their competence throughout their careers.

Protected quality assurance activities (QAAs)

QAAs facilitate practitioners learning from patient outcomes, improving their competence and reducing adverse outcomes. By declaring a QAA the Minister of Health provides both confidentiality to information that becomes known as a result of the activity and immunity from civil liability to people who engage in the activity in good faith.

Complaints

All complaints about the services of a health practitioner go, in the first instance, to the Health and Disability Commissioner. The Commissioner will have discretion to refer the complaint to the appropriate registration authority if the Commissioner considers that the authority is the appropriate body to deal with it.

² The contents of the final Act are subject to the Parliamentary process.

Each authority will set up a complaints investigation committee to investigate complaints referred to it for action. A range of options will be available to the authority for dealing with the complaint, for example, review competence, counselling, conciliation, or taking no further action.

The Health Practitioners Disciplinary Tribunal

A single disciplinary tribunal will be established to hear complaints against all health practitioners that warrant significant disciplinary action.

Medicines Act

Amendments will put in place a regulatory environment for the safe distribution of medicines.

Quality assurance expectations of District Health Boards

There are a number of documents relating to the Minister of Health's relationship with District Health Boards. These documents establish quality, and safety-related expectations of District Health Boards. The key documents are:

- District Health Board Indicator Framework – this is a monitoring instrument developed for accountability purposes. It contains performance indicators.
- Service Coverage – this defines the range of services that District Health Boards (DHBs) are expected to fund access to for their populations. Specification of service coverage includes quality and safety expectations.
- Operational Policy Framework – this sets out the quasi-regulatory rules that all District Health Boards must comply with. It includes a requirement for DHBs to use standard service specifications (including quality requirements) when providing services.

The requirements in these accountability documents will be the mechanism for identifying nationally-consistent standards and quality assurance programmes for publicly-funded health and disability services.

DHBs' progress in meeting the quality assurance expectations will be monitored against the performance indicators and reporting arrangements between the Minister and Ministry of Health for reporting and assessing DHB performance.

Consistent with a quality improvement approach, the quality assurance related expectations of DHBs in the above documents will be reviewed and refined from time to time.

Advisory committees

The New Zealand Public Health and Disability Act 2000 enables the Minister of Health to appoint members to:

- National Health and Epidemiology and Quality Assurance Advisory Committee (Epiqual)
- Mortality Review Committees (Ministerial committees can be established to review and report on specified classes of deaths, or deaths of specified persons. A Child and Youth Mortality Review Committee has been established).

These committees have roles that support quality improvement through the analysis and identification of various mortality and morbidity issues, with a view to informing improved sector performance.

The provisions in Part 2 Sections 17 and 18 of the New Zealand Public Health and Disability Act 2001 outline monitoring arrangements for reporting of advice from the National Health Epidemiology and Quality Assurance Advisory Committee and Mortality Review Committees.

The IQ Approach

The *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector* document is the mechanism by which the Minister of Health will communicate the specific actions of national focus for ensuring that New Zealand health services are of a high quality. This will include identifying initiatives to develop nationally-consistent standards, quality assurance programmes and monitoring programmes in the New Zealand health and disability system.