



Health Issues Centre
Consumer voices for better healthcare

Health Issues Centre submission to the

National Safety and Quality Health Service Standards

Version 2: Consultation draft

Australian Commission on Safety and Quality in Health Care

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About Health Issues Centre

Health Issues Centre (HIC) welcomes the opportunity to provide input into the review of the *National Safety and Quality Health Service Standards Version 2: Consultation draft*.

HIC works with consumers, carers and citizens to channel their unique insights and experiences as health service users in order to create a better health system for everyone. HIC actively promotes the involvement of consumers and the community in shaping policy and practice.

INTRODUCTION

Health Issues Centre (HIC) brings to this report a perspective informed by conversations conducted with health consumers as well as our own professional experience as consumer representatives.

Those conversations focus on the first three standards (Governance and Safety, Partnering with Consumers and Comprehensive Care) as the standards most directly impacting consumer experience and outcome.

Methodology

During October 2015, HIC conducted consultations with both consumers and health service representatives at a number of Victorian settings. These included:

- HealthWest Network (health service representatives from Western Melbourne)
- Ballarat Health (health service staff)
- West Gippsland Healthcare Network (consumers)
- The Frankston and Mornington area (consumers and volunteers).

The focus of these consultations was the three standards identified as GS, PC and CC. This report is a summary of commonly expressed insights overlaid by the interpretation and analysis of HIC staff.

GENERAL COMMENTS

On the whole, Consumers were very supportive of the intentions of the review and acknowledged that the revised Standards seek to strengthen an emphasis on partnering with consumers. They were particularly pleased that the Standards have provided direction to health services around consumer participation and patient and family centred care.

We applaud the fact that the revised standards are intended to place “greater emphasis on partnerships with consumers as fundamental for ensuring safety and quality”.

We also applaud the desire to “better reflect a consumer’s journey through a service”. This acknowledges that as well as health outcomes the quality of a consumer’s experience as they interact with the health system is important in its own right.

Consumer edition

Consumers requested a consumer guide that would provide an overview of the Standards and their purpose, how they are evaluated for compliance and what changes consumers could expect in settings ranging from those that are clinically specific such as falls prevention through to discharge planning and shared decision making.

Special needs

While the focus on Indigenous health care is welcome the Standards lack the same specificity in relation to other disadvantaged, stigmatized and traumatised consumers and communities. It is not enough to just elaborate about diversity in the glossary.

KEY ISSUES

Notwithstanding the improvements to the Standards consumers identify ongoing shortcomings, ambiguities and limitations. Some of these can be addressed by further refinements (and consumers have provided editorial suggestions in those circumstances). However others may reflect the inherent limitations of attempting to drive system and service change through any compliance regime. We have encapsulated the following three broad areas of concern:

Lack of specificity

Despite the welcome emphasis on participation, Consumers feel that their role remains constrained. The focus is still on consumers informing (eg complaints) and receiving report-backs but not on consumers participating in service review and improvement. They called for more emphasis in the Standards on the opportunity to participate in process improvement and feed-back loops.

A second concern is that in attempting to account for a broader variety of health settings and in avoiding being prescriptive the Standards have compromised specificity for ambiguity. This enables services to provide a minimalist response that falls short of meaningful action. This was characterised as “wriggle-room”.

The Standards are clear in intention but imprecise in road-mapping pathways to change. While it is not the role of the Standards to be an instruction manual on how to operationalise change, it would be useful to provide examples of what constitutes a meaningful outcome.

Obtuse definitions

Much of the concern expressed around minimalism and “wriggle-room” related to the obtuse use of terms both within the document and as defined in the glossary. Perhaps the best example of this is the core Glossary definition of Partnerships.

Partnerships

“Partnerships with consumers” can embrace a variety of relationships. In fact the Glossary definition refers to consumers being “treated with dignity and respect” and the sharing of information and collaboration “to the extent that consumers choose”. It goes on to say that partnerships “at all levels are necessary” but the definition stops short of adopting the co-management principles central to Person Centred Care or the shared decision making of Consumer Engagement.

Similarly, the definition for “Consumer centred care” refers to “mutually beneficial” partnerships without validating the consumer role as a participant in decision making within that relationship.

A definition of Partnership is required that addresses the sharing of power quintessential to any healthy and meaningful partnership.

Culture

This term is used in a range of contexts within the standards (GS 9 – “just culture”, GS 1 – “safety culture”) without any glossary definition of organisational culture. This seems odd given the emphasis placed on the cultural dimensions of effective reform.

In both definitional examples, the document appears to side-step any fundamental acknowledgement of the principle of power sharing. It enables services to claim they have established partnerships on the basis of information sharing and low-level consultation.

Barriers to change

The preamble to the Standards acknowledges that there are systemic and cultural barriers to change yet the Standards provide no guidance as to how to identify and overcome these barriers. (We would also add resource allocation as a significant barrier.) We believe that defining and addressing barriers is an essential prerequisite to successful system change and should be the subject of guidance and recommended actions.

These three inhibiting factors combine to create an ambiguity that could enable services to meet the black letter of the Standards without delivering their intended outcome. The remainder of this report deals with comments regarding specific actions.

STANDARD GS: Governance for safety and quality

“Leaders of a health service organisation communicate the importance of partnering with consumers and ongoing quality improvement.”

“Communicat(ing) the importance of partnering” is in itself not a substantive measure. Leaders need to lead with action not sentiment. A more useful statement would be:

“Leaders of a health service demonstrate the importance of partnering with consumers and ongoing quality improvement by embedding consumer partnerships as normative practice within the service.”

GS1 Governance and strategic leadership

GS1.1

GS1 acknowledges the importance of organisational culture but fails to make the direct link between culture change and consumer partnerships:

- b. provides leadership to promote a safety culture in the organisation
- c. provides leadership on partnering with consumers
- d. receives reports and monitors progress on safety and quality performance and culture

We propose the following amendments:

- b. provides leadership to promote a safety culture in the organisation
- c. provides leadership **to promote a culture of** partnering with consumers
- d. receives reports and monitors progress on safety and quality performance and culture
- e. **receives reports and monitors progress on consumer partnerships**

GS1.2

Specific reference to ATSI people is welcomed. It was suggested that similar, specific reference to other examples of “diversity” (disadvantaged, remote, GLBTI etc) is also warranted here and at other reference points throughout the Standards.

GS 5 Quality improvement systems

GS 5.1 and **GS 5.2** engage with consumers in the “review of safety and quality systems” and reporting on these systems. This could be strengthened by explicit reference to consumers being involved in a feedback loop to improve those systems.

GS8 Understanding diversity

“The health service organisation understands the diversity of the consumers who use its services...”

“Understanding” diversity does not of itself lead to meaningful consequence. It would be stronger to say: *“understands the diversity and adjusts its services to ensure they are culturally appropriate”*

GS9 Incident management systems

GS9.1

It is unclear what is meant by “just culture”.

While we commend that consumers will be involved in “analysis of incidents and near misses” and will receive “timely feedback on the analysis” they are not referred to as participants in the use of that analysis “to inform improvements”.

GS10 Feedback systems

GS10.1 “regular feedback” could be limited to passive opportunities such as patient surveys.

“use this information” does not integrate consumers into the process of review.

Feedback should include consumer and community organisations, not just individual consumers.

GS10.2

Once again, consumers are recognised as part of the process of complaint lodgement, analysis and feedback but not as part of the process of improvement and monitoring.

GS13 Performance management

We believe there needs to be a mechanism that incorporates the experience of end-users in performance evaluation.

GS17 Safe environment for the delivery of care

GS17.2

Signage and direction need to be culturally and linguistically appropriate.

STANDARD PC: Partnering with consumers

PC 3 Partnerships in planning, design, delivery, measurement and evaluation

PC3.4

There will be health services with ATSI patients who do not have an ATSI community to draw upon. Or the ATSI patient may well not be part of that local community but part of a different language/cultural group. This action is not appropriate as stated at the moment.

PC4 Information that is easy to understand or use

Overall it is good to see health literacy being specifically referred to. But there is no requirement for the service to assess its own health literacy or that of its staff as a starting point nor to develop the appropriate systems and resource to improve this.

PC4.3

This should also provide consumers with information about sources of evidence for the care being provided.

PC5 Healthcare rights and informed consent

PC5.1

The Australian Charter of Healthcare rights should be standard in all settings. There is no need for variation.

PC5.3 and 5.4

How well equipped will health services be to do this? The consumer's capacity may be only temporarily diminished in cases of ill health so the co-option of decision-making authority needs to be reversible.

PC6 Working together to share decisions and plan care

PC6.2

The sweeping reference to mental illness lacks nuance to guide the circumstances in which this may be appropriate.

STANDARD CC: Comprehensive care

CC4 Collaboration and teamwork

CC4.1

We recommend a broader meaning to encompass consumers: "will work collaboratively" with each other *and with the consumer*.

CC5.2

The same should apply to other consumers drawn from CALD communities

CC6 Comprehensive care planning

CC6.1

- a. "...and information from carers or substitute decision maker."

CC7.1

Extend the definition as per: Clinicians work in partnership with the consumer, and their family, carers *or substitute decision maker* to.