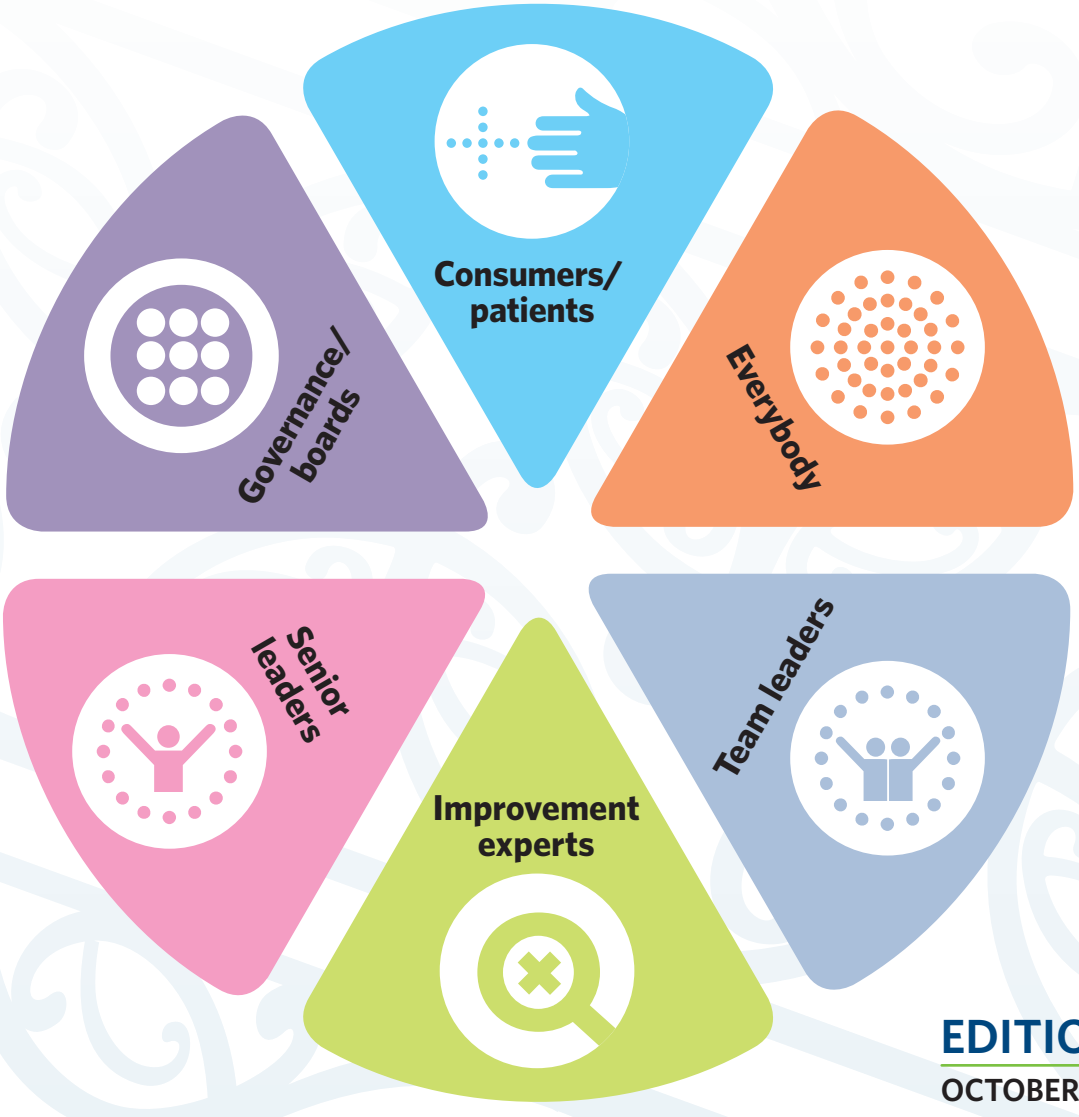
Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

From knowledge to action

A framework for building quality and safety capability in the New Zealand health system



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CONTENTS

Foreword

All people working in health care will have foundation-level knowledge of quality improvement and patient safety. This is our vision.

Enabling all people as consumers/patients to be full participants in the health care team is fundamental to quality improvement and patient safety. This is also our vision and underpins all quality improvement endeavours.

The New Zealand quality and safety capability framework articulates the primary knowledge and understanding that consumers and health care workers need to have, and the actions they need to take, to achieve better quality and safety. It has evolved as a result of a sector request for guidance and direction. This framework is based on international models and has been adapted for the New Zealand environment with input from the sector.

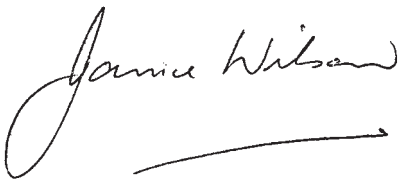
Over the last year there were more than a million inpatient admissions and 7–8 million outpatient visits to hospitals. In addition, there were 12.7 million daytime visits to general practitioners, with similar numbers of visits to general practice nurses,[1] and countless interactions with nongovernmental organisations, community providers and private providers. Everyone working in the health and disability sector comes to work to do their best for the consumers/patients they interact with. They all want to see a safer system and improve the quality of their services.

This framework gives a high-level overview of fundamental capabilities with simple summaries broken down by the various health care groups. Seven broad domains of capabilities are described, each of which further specifies associated knowledge and actions relevant to each health care group.

We acknowledge these capabilities will take time to build and develop. How they are developed and enhanced is up to local organisations and communities. Many organisations already have quality and safety educational and training programmes and experts, and may have already achieved the aim of this framework. Others we have spoken with are looking to use such a framework for self-assessment, professional development or reviewing skills gaps in their teams. We hope to help the wider sector by providing stories about how organisations and communities use this framework and by sharing learnings and resources that can be locally adapted.

In the long term, we envisage this knowledge base will be acquired by health care workers through preregistration or other educational and training programmes. This base can be extended through professional development and other programmes. We plan on working with other key stakeholders such as tertiary educational providers, Health Workforce New Zealand, specialty colleges and others to help achieve the vision for quality and safety capability and leadership within the New Zealand health care sector. This will benefit not only the individual consumer/patient and their family/whānau, but New Zealand as a whole, thus helping to achieve the New Zealand Triple Aim.

This framework will remain a living document and may change as quality improvement and patient safety knowledge progresses. In time we will extend this to be used by the wider disability and home support sector. This document has focused on the health sector in the first instance.

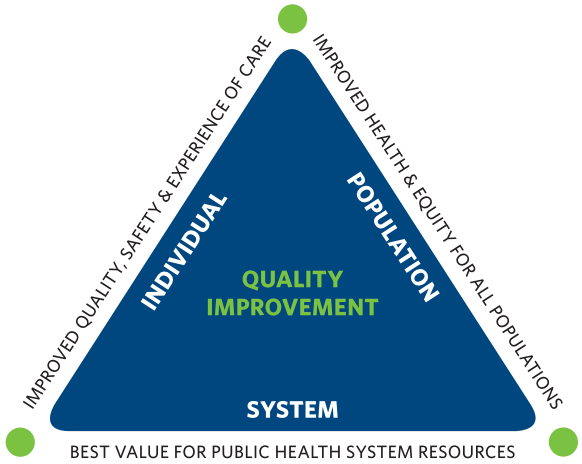


Dr Janice Wilson
Chief Executive, Health Quality & Safety Commission

1 Ministry of Health. 2014. *Health and Independence Report 2014*. Wellington: Ministry of Health. URL: www.health.govt.nz/publication/health-and-independence-report-2014 (accessed 9 June 2016). Also, unpublished Ministry of Health data.

Introduction

Safer and better-quality care occurs when consumers/patients,[2] health care workers, non-clinical staff and those in governance and management work together at all levels of the health and disability system with a common purpose. This common purpose is expressed through the New Zealand Triple Aim.



The Triple Aim identifies three dimensions that together mean:

- providing effective, evidence-informed treatments that meet the values and needs of individuals
- ensuring there is improved health and equity for all populations in New Zealand
- avoiding harm and waste by doing the right thing, and doing it right.

Achieving the Triple Aim requires more than technical knowledge and skills. It requires a capable workforce that can adapt to meet the changing needs of the complex health care environment.[3] This can only occur in a system where consumer/patient safety and experience of care are top priorities. Compassionate care, underpinned by openness and transparency to engender mutual trust and respect, is fundamental to enable consumers and the health care workforce to work effectively together to co-design a more resilient health system.

The Health Quality & Safety Commission (the Commission) has a national mandate to develop and support capability and leadership in quality improvement and patient safety to ensure the delivery of health care is consistent with our overarching framework, the Triple Aim.[4]

The Commission clearly identifies building sector capability as one of our strategic priorities to assist the sector to effect change.[5] This strategy needs to include addressing existing workforce needs, sustainably building the quality improvement capability of the future workforce, developing specialist roles in quality improvement science, supporting consumer/patient participation, ensuring decision-making is based on data and evidence, and supporting boards to provide leadership that encourages a quality improvement and patient safety focus throughout the sector.

This document describes a high-level framework to guide the development of quality and safety capability across all levels in the health and disability sector, including consumers/patients. It has been developed at the request of the sector and informed by international models with input from an expert advisory group.

2 The terms 'consumer' and 'patient' are both used in this document. 'Consumer' specifically refers to patients and their families/whānau/aiga that have had personal experiences in the health and disability system. The term also includes all those who might use health and disability services in the future.

3 Bodenheimer T, Sinsky C. 2014. From Triple to Quadruple Aim: Care of the patient requires care of the provider. *Annals of Family Medicine* 12(6): 573–6.

4 Health Quality & Safety Commission. 2014. *Statement of Intent 2014–18.* Wellington: Health Quality & Safety Commission.

5 *Ibid.*

Improving quality and safety in the 21st century

The focus on improving the quality and safety of health care intensified at the turn of the 21st century in response to two seminal reports published by the Institute of Medicine.

The first report revealed the extent of consumer/patient harm caused by health care,[6] and the second report described the extent of the gap between 'the health care we have and the health care we could have'.[7]

Quality defects (the 'gap') were defined in terms of variation in services, including:

- overuse of care for which there is no evidence of effectiveness
- underuse of care for which there is good evidence of effectiveness
- misuse of care, referring to errors that result in consumer/patient harm.

This led to a call for a radical redesign of health systems with a focus on improving quality.[8]

In New Zealand in 2003, the Ministry of Health defined five dimensions of quality (Table 1). These dimensions were underpinned by the foundations of the partnership, participation and protection principles of the Treaty of Waitangi.[9]

Table 1: Dimensions of health care quality

DIMENSION	DEFINITION
Safe	Avoiding harm to patients from the care that is intended to help them.
Effective	Providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
Patient-centred	Providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring patient values guide all clinical decisions.
Efficient	Avoiding waste, including waste of equipment, supplies, ideas and energy.
Accessible	Providing care that does not vary in quality because of personal characteristics such as gender, age, ethnicity, geographic location and socioeconomic status.

Over the past 15 years, approaches to improving the quality and safety of health care have changed. There has been a shift from a 'top-down inspection' model to a more 'bottom-up' continuous improvement model. This 'bottom up' approach requires frontline staff to have knowledge not only of how to 'diagnose and treat' consumers/patients, but how to 'diagnose and treat' quality defects that lead to poor outcomes for consumers/patients and their families/whānau.

The underpinning theories, methods and tools associated with determining the causes of problems and then developing, testing, implementing and spreading changes that yield improvement across the dimensions of quality are referred to as improvement science. These theories, methods and tools have

6 Kohn L, Corrigan J, Donaldson M (eds). 1999. *To Err is Human: Building a Safer Health System*. Washington DC: National Academies Press.
7 Committee on Quality of Health Care in America, Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. URL: www.nap.edu/read/10027/chapter/1 (accessed 9 June 2016).
8 Berwick DM. 2002. A user's manual for the IOM's 'Quality Chasm' report. *Health Affairs* (Millwood) 21(3): 80–90.
9 Minister of Health. 2003. *Improving quality: A systems approach for the New Zealand health and disability sector.* Wellington: Ministry of Health.

been drawn from industrial-quality improvement approaches that arose in the post-war era.[10] Health systems have built on these methods and successfully applied models from industry, such as the Model for Improvement, Lean and Six Sigma.

Everybody participating in the health care sector should understand the principles of improvement science and be able to apply these to the level expected of their role, as part of their everyday work.

While safety is considered a dimension of quality, the inherently hazardous nature of health care and the high numbers of reported adverse events means safety warrants additional consideration.

Vincent et al (2013) define safety as:

> *the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of healthcare.*[11]

As defined above, safety is essentially about avoiding harm caused by the process of health care. To date, there has been a strong emphasis on improving safety by learning from past harm. The causes of consumer/patient harm from health care, however, are seldom simple. In an increasingly complex health system, safety needs to be addressed as a system property.

> *Safety does not reside in a person, device or department. Improving safety depends on learning how safety emerges from the interaction of components.*[12]

Learning how safety 'emerges from the interaction of components' means thinking needs to move beyond simple linear cause-and-effect assumptions. We need to appreciate the health system as a dynamic, adaptive collection of interrelated and interdependent components with a common purpose or aim. We must emphasise the whole with an understanding of the parts and their relationships to each other, the feedback loops and non-linear cause-and-effect relationships.[13]

For safety in health care, we also need to appreciate the role of human factors in the delivery of safe health care. The study of human factors is a discipline that embraces engineering, psychology, anatomy, physiology and medicine.[14] It aims to optimise human performance through the design of tasks, equipment and the environment in which people work in order to minimise the likelihood of errors and unintended consequences. Much has been learned from successful approaches to improving safety used by high-reliability industries such as aviation, nuclear, gas and oil.

Drawing from these approaches, Vincent et al (2013) proposed a framework for health care that identifies five dimensions that should be considered in discussions about what safety means, and how it can be actively managed:

1. Past harm: this encompasses both psychological and physical measures.
2. Reliability: this is defined as 'failure-free operation over time' and applies to measures of behaviour, processes and systems.
3. Sensitivity to operations: the information and capacity to monitor safety on an hourly or daily basis.
4. Anticipation and preparedness: the ability to anticipate, and be prepared for, problems.
5. Integration and learning: the ability to respond to, and improve from, safety information.[15]

10 Scoville R, Little K. 2014. *Comparing Lean and Quality Improvement.* IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement.

11 Vincent C, Burnett S, Carthey J. 2013. *The Measurement and Monitoring of Safety*. London: The Health Foundation.

12 Cooper JB, Gaba DM, Liang B, et al. 2000. The National Patient Safety Foundation agenda for research and development in patient safety. *Medscape General Medicine* 2(3). URL: www.medscape.com/viewarticle/408064 (accessed 9 June 2016).

13 Stepanovich PL. 2004. Using system dynamics to illustrate Deming's system of profound knowledge. *Total Quality Management & Business Excellence* 15(3): 379–89.

14 World Health Organization. 2011. *Patient Safety Curriculum Guide: Multi-professional edition.* Geneva: World Health Organization.

15 Vincent C et al 2013, *op. cit*

Health care is complex. Improving quality and safety in the 21st century is challenging. The one constant, however, is that health is all about people.

> *… the core space of every health system is occupied by the unique encounter between one set of people who need services and another who have been entrusted to deliver them.*[16]

Consumers/patients must also be enabled to manage their health effectively. They require a mindset that equips them with the ability to articulate their needs in order to achieve the quality of life they desire. Consumers/patients also need to work in partnership with health care workers to drive changes that will meet the demands of the changing population and health care environment.

For the health care workforce, the changing health care environment requires not only the requisite knowledge and skills but also 'system thinkers' – people with mindsets that are curious, flexible and adaptable to keep pace with the ever-increasing speed of change. Most importantly, strategies are needed that allow those in the health care workforce to continue to find joy and deep satisfaction in their work.

Finally, cost constraints will drive the need for consumers/patients and health care workers to develop alternative models of care that meet the demands of the changing population and health care environment. There is a move towards developing social models of care that address the broader determinants of health, and that shift the focus from acute care in hospitals to the management of people with long-term conditions in the community. These changes require leadership at all levels to sustain the delivery of safe and effective care and ensure consumers/patients report good experiences of care.

The changing landscape in health care has driven the need to define core enablers for consumers/patients and redefine core capabilities for health care workers.

16 Frenk J, Chen L, Bhutta Z, et al. 2010. Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *The Lancet* 376: 1923–58.

Developing a New Zealand quality and safety capability framework

Developing workforce capability and leadership for quality improvement:

> *offers an important platform for better sector quality and safety outcomes and a more systematic and predictable quality and safety response across the system.*[17]

The New Zealand quality and safety capability framework:

- provides the basis for a common understanding of the knowledge, skills and underpinning values required to achieve better-quality and safer consumer/patient-centred health care
- articulates core enablers for consumers/patients and provides a focus for ensuring there are appropriate opportunities for consumers/patients to develop them
- articulates specific expectations for quality and safety at each level of the health system, from all frontline clinical and non-clinical staff to senior executive teams and board members
- provides overall direction to planning and development for capability building across all levels of the health sector, including consumers/patients
- informs the development of a range of training and education programmes to meet the needs of the sector, so there is a coherent approach to building quality and safety capability in New Zealand.

Sustaining a knowledgeable and skilled workforce in quality and safety can only occur in the context of:

- a culture where quality and patient safety are top priorities across all levels within the health and disability sector
- consumer/patient partnerships occurring across all levels in the health and disability sector to inform quality and safety improvement initiatives
- effective governance and leadership, both clinical and managerial, across all levels within the health and disability sector to improve quality and safety
- an appropriate infrastructure being in place to support, enhance and sustain capability in quality and safety across the sector.

17 Rimmer M. 2012. *Discussion/Scoping Paper: Building quality and safety capability in the New Zealand health and disability sector*. (Unpublished/in-house report for the Health Quality & Safety Commission)

The New Zealand quality and safety capability framework

The New Zealand quality and safety capability framework (the framework) has built on other frameworks previously described by leading health care organisations, including NHS Scotland and Kaiser Permanente.[18]

In selecting the seven domains and grouping knowledge and actions within these, we have taken account of the literature that describes generic capabilities, and drawn on a number of sources of information specifically related to competencies in quality and safety. The methodological stepping stones used to develop the framework are described in Appendix 1.

In the framework, we have chosen to describe capabilities rather than competencies. While both competence and capability are required for the ongoing improvement of the quality and safety of health care, capability reflects a perspective that builds on competence to include the ability to adapt to change and generate new ideas and knowledge. Capability is about staying curious and open-minded – attributes that are essential for a 21st century workforce.[19]

The framework takes a whole-of-system approach as described by Batalden and Davidoff (2007):

> *the combined unceasing efforts of everyone – health care professionals, patients and their families, researchers, payers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning).*[20]

The framework recognises the important role consumers/patients and their families/whānau have with respect to managing their own health and by being actively engaged in the planning and design of care to improve quality and safety. It also recognises that the degree to which they participate will vary. Consumers/patients and their families/whānau therefore must be engaged and empowered to take part to the extent they wish.

Most health care is delivered within the context of teams and within services. Quality and safety capability and leadership within and between multidisciplinary teams and networks are required for the seamless and safe care of consumers/patients, as part of the systems of care within an organisation.

Organisations express capability not only through their systems and structures, but more importantly through their culture, values and behaviours. Exemplary organisations are those where quality and safety practices and values are embedded as part of routine practice, resulting in measurable improvements in the consumer/patient experiences of care and in consumer/patient outcomes.

Ultimately, embedding quality and safety within all roles will result in organisations demonstrating a more mature quality and safety culture, and having in place the requisite systems and structures to encourage the delivery of better consumer/patient outcomes. Making explicit the expected knowledge, skills and behaviours required across broad roles within health care will enhance system capability.

Seven domains have been identified and defined for the framework (Table 2).

18 The Health Foundation. 2014. *Building capability to improve safety*. London: The Health Foundation URL: http://www.health.org.uk/sites/health/files/BuildingCapabilityToImproveSafety.pdf (accessed 9 June 2016).

19 Fraser SW, Greenhalgh T. 2001. Coping with complexity: Educating for capability. *British Medical Journal* 323: 799–803.

20 Batalden PB, Davidoff F. 2007. What is 'quality improvement' and how can it transform healthcare? *Quality & Safety in Health Care* 16: 2–3.

Table 2: Domains of the New Zealand capability framework

DOMAIN	CAPABILITY IN
1. Partnerships with consumers/ patients and their families/ whānau	Empowering consumers/patients and their families/whānau to interact with health care providers to achieve their desired outcomes.
2. Quality and safety culture	Contributing to and modelling a culture where quality and safety are top priorities, and communicating in a way that shows mutual trust and respect.
3. Leadership for improvement and change	Doing what is right and setting an example for others to follow. Knowing and using the principles of change management to support the implementation and sustainability of quality and safety improvements. Those in leadership roles are also responsible for setting the direction for improving quality and safety consistent with organisational and national goals.
4. Systems thinking	Appreciating the health and disability system as a dynamic, adaptive collection of interrelated and interdependent components, including people and processes, with a common purpose or aim. Emphasising the whole with an awareness of the parts and their relationships to each other.
5. Teamwork and communication	Working with others across professional, organisational and cultural boundaries to achieve shared quality and safety goals.
6. Improvement and innovation	Using evidence and data to drive improvement and innovation.
7. Quality improvement and patient safety knowledge and skills	Using appropriate tools, methods and techniques to improve the quality and safety of care.

The framework identifies six health care groups:

- consumers/patients and their families/whānau (section 1)
- everybody participating in the health and disability workforce (section 2)
- operational, clinical and team leaders (section 3)
- quality and safety experts (section 4)
- senior and organisational leaders (section 5)
- governance/boards (section 6).

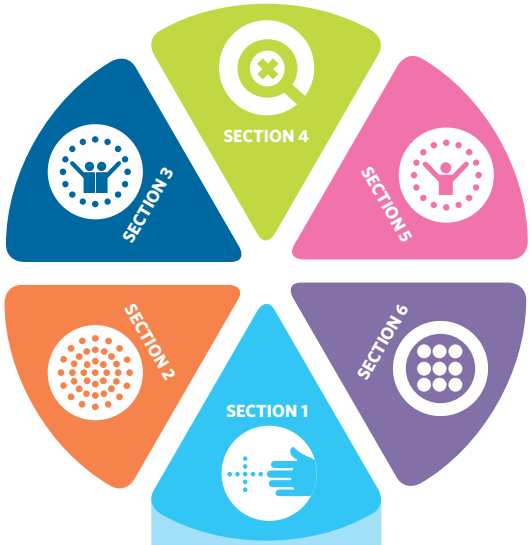
These apply equally across the primary, secondary and aged care sectors.

For each of the groups identified in the framework, the document describes who typically belongs within that broad category, and outlines the associated quality and safety knowledge and actions that could reasonably be expected of a person within the designated grouping.

The section for consumers/patients (see page 13) requires a different approach. For consumers/patients and their families/whānau to engage as active members of the health team, they need knowledge to be able to participate. Whilst recognising that not everyone will actively participate, it is essential we enable and empower those who do. Health care providers should work with consumers/patients and their families/whānau to develop the capabilities described.

SECTION 1

Enabling consumers/patients and their families/whānau as members of the health team



Enabling consumers/ patients and their families/whānau as members of the health team

- Partnerships with consumers/patients & their families/whānau
- Quality & safety culture
- Leadership for improvement & change
- Systems thinking
- Teamwork & communication
- Improvement & innovation
- Quality improvement & patient safety knowledge & skills

SECTION 1: Enabling consumers/patients and their families/whānau as members of the health team

This group includes everyone who accesses the health and disability system, either for their own purposes, or on behalf of another person (for example, as parents or family carers). Enabling consumers/patients to become equal partners in care requires support that builds consumers'/patients' self-efficacy, self-awareness, confidence and coping skills. Consumers/patients may also participate in diverse ways in the health and disability system, including in advocacy, advisory and peer support roles.

For consumers/patients and their families/whānau to engage as active members of the health team, they need knowledge to be able to participate. Whilst recognising not everyone will take an active part in their health care, it is essential we enable those who do. Health care providers should work with consumers/patients and their families/whānau to develop the capabilities described.

The increasing focus on building consumer/patient engagement and partnerships requires a level of health literacy that enables consumers/patients to achieve health outcomes as individuals with their families/whānau.

Consumers/patients and their families/whānau need to feel empowered to ask questions so they can find, interpret and use appropriate information and health services to make effective decisions about their own and/or their family's/whānau's health and wellbeing, in partnership with their health care providers.

Consumers/patients and their families/whānau have the right to receive information any reasonable patient in their circumstances would expect to receive.[21] The information should be communicated in a manner that will enable them to understand it. They should have a clear explanation of their clinical condition, the treatment options available to them, and the expected risks, side effects, benefits and (if applicable) costs of each option. They need advice of the estimated time within which they will receive the treatment/service and the results of tests and procedures.

21 Health and Disability Commissioner. 1996. *The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996.* Wellington: Health and Disability Commissioner. URL: www.hdc.org.nz/the-act--code/the-code-of-rights (accessed 9 June 2016).

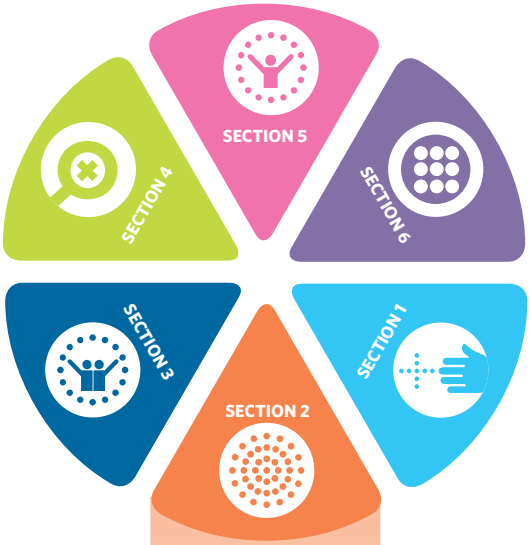
Partnerships with consumers/patients and their families/whānau

Consumers/patients and their families/whānau are enabled to interact with health care providers in ways that empower them to achieve the desired outcomes to the degree they are able or wish to.

KNOWLEDGE OF	ACTIONS
• the importance of consumers/patients and their families/whānau forming partnerships with health care providers • how to ask questions relevant to their needs • where to find information, services and supports relevant to their needs • how to read and interpret the information • how to communicate with their health care provider to express their needs and preferences • potential harms and benefits that may be associated with receiving health care • the importance of expressing concerns to health care providers including feedback of their experience of care • the Code of Health and Disability Services Consumers' Rights and the complaints process.	• understand their right to be involved and participate in their care and treatment by expressing their preferences and asking questions to ensure their needs are met • ask questions and find, interpret and use information, health services and supports to maximise their own health and wellbeing, or that of their families/whānau • communicate concerns about any aspects of quality and safety with the provider, health care organisation or other central agencies; with the support of consumer advocates as needed • participate in advisory roles by sharing their experience and contributing to discussions for improved quality and safety • work with staff to help redesign care, to improve quality, safety and the patient experience.

SECTION 2

Capabilities of everybody participating in the health and disability workforce



Capabilities of everybody participating in the health and disability workforce

- Partnerships with consumers/patients & their families/whānau
- Quality & safety culture
- Leadership for improvement & change
- Systems thinking
- Teamwork & communication
- Improvement & innovation
- Quality improvement & patient safety knowledge & skills

SECTION 2: Capabilities of everybody participating in the health and disability workforce

At this 'foundation' level, everyone needs to understand the importance of improving quality and safety in health care by reducing harm, waste and variation.

To do this, we need to appreciate health care as a process with consumers/patients as the central focus. Berwick (cited in Evans 2014)[22] described 'constant curiosity' as a property of a systems thinker. In this way, individuals bring their own 'lens' to spot ways to make things better and safer for consumers/patients at all levels in an organisation.

All health care workers need to engage in quality and safety improvement efforts appropriate to their role and their sphere of work. Simple quality and safety tools should therefore be part of everyone's skill set in health care. For some, this can be as simple as identifying and reducing waste, standardising an aspect of care, or testing a small change.

Working collaboratively with others in teams is everyday practice in health care. Relationship skills are therefore essential. With the move to more network-based care involving multidisciplinary teams both within and between organisations, effective communication, mutual respect and shared values are basic competencies that enable teams to achieve the best outcomes for consumers/patients.

Managing information is a critical competency for health care workers in the 21st century. This means individuals must be able to integrate, analyse and critically appraise information in real time so they can adapt and respond to changing demands. This may include the need at times to innovate and broaden their scope.

22 Evans M. 2014. *Quality Improvement in Healthcare* [video]. URL: https://www.youtube.com/watch?v=jq52ZjMzqyI (accessed 9 June 2016).

Partnerships with consumers/patients and their families/whānau

Empowering consumers/patients and their families/whānau to interact with health care providers to achieve their desired outcomes.

KNOWLEDGE OF	ACTIONS
• the core concepts and values associated with consumer/patient-centred care including health literacy and cultural safety • the concepts of consumer/patient engagement and consumer/patient partnership across the spectrum of health care as a key strategy for improving health outcomes.[23]	• reflect the values of consumer/patient-centred care as an integral part of their everyday practice • identify the health literacy of the consumer/patient and adapt their communication style to ensure consumers/patients and their families/whānau understand important information and are supported to ask questions • partner with consumers/patients and their families/whānau so their care is tailored to meet their expressed needs and preferences.

Quality and safety culture

Contributing to and modelling a culture where quality and safety are top priorities, and communicating in a way that shows mutual trust and respect.

KNOWLEDGE OF	ACTIONS
• the link with better consumer/patient outcomes and the quality and safety culture of an organisation • the value of openness and transparency in health care and the implications for quality and safety • the importance of identifying, recognising and reporting patient safety incidents and/or adverse events and near misses.	• promote and contribute to a quality and safety culture within their own work environment • be open and transparent in words and actions • recognise and report unsafe acts.

Leadership for improvement and change

Doing what is right and setting an example for others to follow.

Knowing and using the principles of change management to support the implementation and sustainability of quality and safety improvements.

Those in leadership roles are also responsible for setting the direction for improving quality and safety consistent with organisational and national goals.

KNOWLEDGE OF	ACTIONS
• the broad principles of leadership for improvement • the broad principles of change management and the impact of change on self and others • when and how to step up and take action for quality and safety.	• demonstrate leadership appropriate to their role • participate in and support change processes • adapt their own behaviour and attitudes to accommodate change • empower change within the local work team • actively communicate successful change • model doing the right thing in both words and actions • motivate and lead others to do the right thing in words and actions.

23 Ministry of Health. 2015. *A Framework for Health Literacy.* Wellington: Health Quality & Safety Commission. URL: www.health.govt.nz/publication/framework-health-literacy (accessed 9 June 2016).

Systems thinking

Appreciating the health system as a dynamic, adaptive collection of interrelated and interdependent components, including people and processes, with a common purpose or aim.

Emphasising the whole with an awareness of the parts and their relationships to each other.

KNOWLEDGE OF	ACTIONS
• the structure and function of their organisation • the health care system as complex and adaptive • local systems and processes.	• demonstrate an awareness of where their role fits in the context of the wider system • work within their team or department to ensure their actions don't have unintended consequences for others.

Teamwork and communication

Working with others across professional, organisational and cultural boundaries to achieve shared quality and safety goals.

KNOWLEDGE OF	ACTIONS
• how to communicate effectively • how to engage in active listening • how team building contributes to team functioning • how to give and receive constructive feedback.	• ensure written and verbal communications are clear, respectful and logical • engage in active listening • demonstrate understanding of the purpose of the team • demonstrate understanding of their roles, strengths and responsibilities as well as that of each team member • plan and manage time and responsibilities to achieve team objectives • adapt and adjust their own behaviour to meet team objectives • show trust and respect for others in the workplace • give, receive and act on constructive feedback.

Improvement and innovation

Using evidence and data to drive improvement and innovation.

KNOWLEDGE OF	ACTIONS
• how to locate evidence • simple measurement concepts to establish current performance.	• practice is consistent with current knowledge and evidence • use objective evidence and measures to substantiate decisions and identify opportunities for improvement.

Quality improvement and patient safety knowledge and skills

Using appropriate tools, methods and techniques to improve the quality and safety of care.

KNOWLEDGE OF	ACTIONS
• the principles of quality improvement and patient safety • commonly used improvement tools • simple measures to monitor change • human factors that may compromise or impact on quality and safety • the key drivers of poor quality care: harm, waste and variation • how to report and learn from adverse events, incidents and near misses.	• meet their responsibilities for quality and safety • apply tools for improvement • set a goal for improvement • be able to develop a simple measure to evaluate an aspect of care or service delivery and use learnings to improve it • participate in quality improvement and patient safety projects • identify and define problems, especially in relation to harm, waste and variation • anticipate and take steps to minimise risk.

SECTION 3

Capabilities of operational, clinical and team leaders

Capabilities of operational, clinical and team leaders

- Partnerships with consumers/patients & their families/whānau
- Quality & safety culture
- Leadership for improvement & change
- Systems thinking
- Teamwork & communication
- Improvement & innovation
- Quality improvement & patient safety knowledge & skills

SECTION 3: Capabilities of operational, clinical and team leaders

Operational and clinical leaders are in positions that require them to facilitate and lead change within teams and services. This identifies them as champions for quality and safety with a responsibility to foster innovative practices and creativity within team and service areas, in order to bring about changes to improve the quality and safety of care.

As 'middle managers', operational and clinical leaders are the 'bridge' between the senior leadership and the front line. Ensuring organisational objectives are actioned at the front line requires strategic thinking and planning skills and a degree of organisational awareness to create an environment for change.

To effect change, leaders need a sound working knowledge of improvement science and safety science methods, including how to measure improvement to monitor the quality and safety aspects of consumer/patient care and to identify problems. In developing solutions, leaders need to use an evidence-informed approach to inform decision-making and then test, evaluate and refine the impact of selected interventions.

Team leaders also need to be able to lead and work with teams and consumer/patient groups in the co-design and redesign of care. By modelling desirable behaviours and communicating effectively, they should be able to create a culture that has a focus on improving the quality and safety of care for consumers/patients. Leadership and management skills at this level will enable them to execute a number of portfolios effectively.

Change agents and champions of change

Anyone in health care can be a champion of change and advocate change. Some have formal roles in leading service and organisational change to improve the quality and safety of health care. Other change agents in the organisation include those who are not in formal leadership roles but who also lead change in the way things are done or the way ideas are viewed. Clinical educators and intern supervisors may also lead local quality and safety projects at a unit or service level and be a change agent.

Providing learning opportunities for staff on both a formal and informal basis not only improves knowledge and skills, it also creates the momentum that keeps staff engaged and curious about how they can 'take the next step' to improve quality and safety.

Partnerships with consumers/patients and their families/whānau

Empowering consumers/patients and their families/whānau to interact with health care providers to achieve their desired outcomes.

KNOWLEDGE OF	ACTIONS
• the core values associated with consumer/patient-centred care, including health literacy and cultural safety • the concept of consumer/patient engagement and consumer/patient partnership across the spectrum of health care as a key strategy for improving health outcomes • the value of involving consumers/patients and their families/whānau in improving the design and delivery of care.	• mentor and empower staff and colleagues to apply the principles of consumer/patient-centred care as part of their everyday practice • mentor and empower staff and colleagues to adapt their communication style to ensure consumers/patients and their families/whānau understand information and are supported to ask questions • mentor and empower staff and colleagues to partner with consumers/patients and their families/whānau so that care is tailored to meet their expressed needs and preferences • facilitate consumer/patient and their family's/whānau's involvement in improving the design and delivery of care.

Quality and safety culture

Contributing to and modelling a culture where quality and safety are top priorities, and communicating in a way that shows mutual trust and respect.

KNOWLEDGE OF	ACTIONS
• quality and safety culture and the link with better consumer/patient outcomes • how to assess the quality and safety culture • the value of openness and transparency in health care and the implications for quality and safety • the importance of reporting patient safety incidents and/or adverse events and near misses, and the mechanisms for reporting in their own organisation • the difference between system failures and deliberate unsafe acts.	• champion a quality and safety culture within their own work environment • assess the quality and safety culture and use the results to inform improvement • ensure their words and actions model and uphold the values of openness and transparency • receive and act on incidents and/or adverse events and near misses, and use the information for learning and improvement • use appropriate ways to manage system failures and unsafe acts.

Leadership for improvement and change

Doing what is right and setting an example for others to follow.

Knowing and using the principles of change management to support the implementation and sustainability of quality and safety improvements.

Those in leadership roles are also responsible for setting the direction for improving quality and safety consistent with organisational and national goals.

KNOWLEDGE OF	ACTIONS
• current theory, practice and tools for leadership • current theory, practice and tools for change management • how to ask the right questions to advance learning and development within their team/service • social movement concepts in generating and sustaining commitment over time • principles of and techniques for spread and sustainability.	• set, communicate and lead the strategic direction for quality improvement in collaboration with the senior leaders and governance • assess the readiness and create the imperative for change • build good relationships and use networks across service and organisational boundaries to influence and engage others to bring about change • chair or participate in organisational committees that have a key influence on quality and safety • coach, mentor and empower others to improve capability in quality and safety leadership • actively communicate successful change.

Systems thinking

Appreciating the health system as a dynamic, adaptive collection of interrelated and interdependent components, including people and processes, with a common purpose or aim.

Emphasising the whole with an awareness of the parts and their relationships to each other.

KNOWLEDGE OF	ACTIONS
• the New Zealand health care context including the structure and function of national, regional and local organisations • the New Zealand Triple Aim • the health care system as complex and adaptive • quality and safety as integral system properties • the application of systems theory and operational management in health care • systems and processes across the continuum of care.	• demonstrate an awareness of the various roles they undertake and/or manage in the context of the wider system • facilitate awareness of the complex interplay between consumers/patients, families/whānau, health care workers and the work environment, and the implications for quality and safety • use multidisciplinary input to analyse quality and safety improvement • ensure team or department actions don't have unintended consequences for other areas.

Teamwork and communication

Working with others across professional, organisational and cultural boundaries to achieve shared quality and safety goals.

KNOWLEDGE OF	ACTIONS
• how to communicate effectively for improvement • how to engage in active listening • how team building contributes to team functioning • how to give and receive constructive feedback • conflict management and resolution.	• ensure written and verbal communications are clear, respectful and logical • engage in active listening • demonstrate understanding of the purpose of the team • demonstrate understanding of their roles, strengths and responsibilities • demonstrate and clarify understanding of the roles, strengths and responsibilities of team members • foster a team culture that supports quality and safety • adapt and adjust their own behaviour and strategies to meet service and organisational objectives • give, receive and act on constructive feedback • model effective strategies for conflict management.

Improvement and innovation

Using evidence and data to drive improvement and innovation.

KNOWLEDGE OF	ACTIONS
• evidence-informed practice methods and tools • the role of quantitative and qualitative data for improving system performance • types of data, sampling methodologies, data collection and management • the reliability, validity and limitations of measurements • basic data analysis, interpretation and presentation to inform decision-making • the requirement for a broad range of indicators to understand system performance and reliability • the importance of consumer/patient narratives and feedback.	• access and appraise evidence to inform practice • use evidence and industry benchmarks to set performance standards and inform continuous improvement • use valid and reliable measures to evaluate aspects of service delivery and inform improvement, change and sustainability • use multiple information sources and a broad range of indicators to assess system performance and reliability • support best and innovative practice changes • measure and act on consumer/patient experiences of care and monitor clinical outcomes • curate, publicise and act on consumer/patient and family/whānau narratives and feedback.

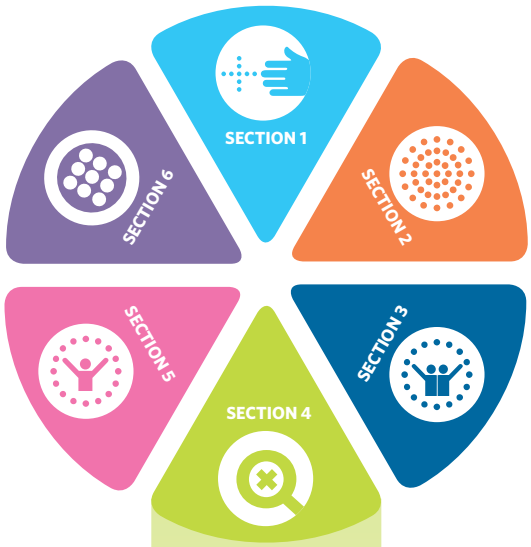
Quality improvement and patient safety knowledge and skills

Using appropriate tools, methods and techniques to improve the quality and safety of care.

KNOWLEDGE OF	ACTIONS
▪ improvement science and patient safety methodologies and tools ▪ current context of health care improvement and patient safety ▪ risk management (clinically and operationally) ▪ the key drivers of poor quality care: harm, waste and variation ▪ a systems approach to learn from failures, including the role of adverse event management and open communication ▪ how other organisations nationally and internationally have successfully improved ▪ how to implement, spread and sustain improvements.	▪ meet their responsibilities for quality and safety ▪ operationalise the organisation's quality and patient safety framework ▪ operationalise the organisation's clinical governance structure ▪ use and model appropriate safety practices to manage risk and increase reliability across the continuum of care ▪ identify and define problems especially in relation to harm, waste and variation ▪ participate in quality improvement and patient safety projects ▪ work with senior leaders to ensure systems and processes are in place to support consumers/patients, families/whānau and staff after adverse events ▪ utilise quality improvement expertise where appropriate ▪ coach and mentor others to build capability in quality improvement and patient safety.

SECTION 4

Capabilities of quality and safety experts



Capabilities of quality and safety experts

- Partnerships with consumers/patients & their families/whānau
- Quality & safety culture
- Leadership for improvement & change
- Systems thinking
- Teamwork & communication
- Improvement & innovation
- Quality improvement & patient safety knowledge & skills

SECTION 4: Capabilities of quality and safety experts

Experts are those who have advanced expertise in the application of quality and safety methodologies and tools. They operate within organisations in a high-level advisory capacity, working both in dedicated quality improvement roles and in other capacities. This means they need to have an overview of the system's capabilities and the ability to critically analyse, design, manage and facilitate quality and safety improvement projects. Their roles may vary depending on the size of the organisation they are working in and the other staff working in this area.

Experts work closely with the executive leadership team to influence strategy and policy. For this they need to ensure the appropriate metrics are in place to provide the information needed to inform and monitor the system.

Experts also work closely with middle managers to enable the translation of organisational goals into actions at the front line. For this they need a sophisticated level of knowledge about the use of data to monitor the reliability of processes, and the safety of systems to identify gaps. An ability to interpret and communicate results at the appropriate level is essential.

Expertise here is often referred to as 'deep' knowledge in the fields of improvement and safety science. Experts also need the skills to mentor and coach others across all levels in the organisation. Experts need to be able to have relationships across the spectrum, from consumers/patients to boards, and be able to communicate effectively at all levels to effect change.

Coming from diverse backgrounds, experts often bring a very strong system perspective and a focus on process that challenges health care thinking and guides it towards new paradigms.

Partnerships with consumers/patients and their families/whānau

Empowering consumers/patients and their families/whānau to interact with health care providers to achieve their desired outcomes.

KNOWLEDGE OF	ACTIONS
• the core values associated with consumer/patient-centred care including health literacy and cultural safety • the concept of consumer/patient engagement and consumer/patient partnership across the spectrum of health care as key strategies for improving health outcomes • the value of involving consumers/patients and their families/whānau in improving the design and delivery of care.	• mentor and empower staff and colleagues in applying the principles of consumer/patient-centred care as part of their everyday practice • mentor and empower staff and colleagues to adapt their communication style to ensure consumers/patients and their families/whānau understand information and are supported to ask questions • mentor and empower staff and colleagues to partner with consumers/patients and their families/whānau so that care is tailored to meet their expressed needs and preferences • work with the organisation, teams and consumers/patients to promote and provide guidance about involving consumers/patients and their families/whānau in improving the design and delivery of care.

Quality and safety culture

Contributing to and modelling a culture where quality and safety are top priorities, and communicating in a way that shows mutual trust and respect.

KNOWLEDGE OF	ACTIONS
• quality and safety culture and the link with better consumer/patient outcomes • the value of openness and transparency in health care and the implications for quality and safety • the importance of reporting patient safety incidents and/or adverse events and near misses and the mechanisms for reporting in their own organisation • the difference between system failures and deliberate unsafe acts • how to analyse the quality and safety culture measurements and apply improvement methods to strengthen the quality and safety culture.	• champion a quality and safety culture across the organisation • ensure their words and actions model and uphold the values of openness and transparency • assist team and senior leaders with identifying, prioritising and responding to quality and safety concerns in a timely manner • use appropriate ways to manage system failures and unsafe acts • provide organisational guidance and support by measuring the quality and safety culture and using the results for improvement.

Leadership for improvement and change

Doing what is right and setting an example for others to follow.

Knowing and using the principles of change management to support the implementation and sustainability of quality and safety improvements.

Those in leadership roles are also responsible for setting the direction for improving quality and safety consistent with organisational and national goals.

KNOWLEDGE OF	ACTIONS
• current theory, practice and tools for leadership • current theory, practice and tools for change management • social movement concepts in generating and sustaining commitment over time • how to ask the right questions to advance learning and development • principles of, and techniques for, spread and sustainability.	• work with senior and organisational leaders to set and lead the organisational strategic direction for quality improvement • provide expertise to facilitate continuous quality improvement with key stakeholders and across professional, organisational and other boundaries • support senior and organisational leaders in bringing a quality and safety focus to organisational meetings • chair or participate in organisational committees that have a key influence on quality and safety • assess and communicate the readiness for organisational change • communicate and support the organisational vision for change • champion and support organisational change processes • build relationships and networks across professional, organisational and agency boundaries to influence and engage others to bring about change • challenge the status quo by asking the right questions • coach, mentor and empower others to improve capability in quality and safety leadership • support and provide guidance to ensure organisational implementation and spread of effective quality and safety initiatives • actively communicate successful change and encourage participants to share their stories.

Systems thinking

Appreciating the health system as a dynamic, adaptive collection of interrelated and interdependent components, including people and processes, with a common purpose or aim.

Emphasising the whole with an awareness of the parts and their relationships to each other.

KNOWLEDGE OF	ACTIONS
• the New Zealand health care context including the structure and function of national, regional and local organisations • the New Zealand Triple Aim • the health care system as complex and adaptive • quality and safety as integral system properties • the application of systems theory and operational management in health care • systems and processes across the continuum of care • tools to analyse the organisation and its systems and processes.	• demonstrate an awareness of the various roles they undertake and/or manage in the context of the wider system • teach about the complex interplay between consumers/patients, families/whānau, health care workers and the work environment; and the implications for quality and safety • ensure human factors knowledge is used to improve the delivery of safe, patient/consumer-centred health care • apply systems thinking to the facilitation and coordination of quality and safety improvement initiatives • work with multidisciplinary teams and leadership to analyse system quality and safety improvement opportunities and prioritise strategies for action • lead capability building to improve organisational quality and safety.

Teamwork and communication

Working with others across professional, organisational and cultural boundaries to achieve shared quality and safety goals.

KNOWLEDGE OF	ACTIONS
• how to communicate effectively for improvement • how to engage in active listening • how team building contributes to team functioning • how to give and receive constructive feedback • conflict management and resolution.	• model communication that is clear, respectful and logical • engage in active listening • demonstrate understanding of the purpose of the team • demonstrate understanding of their roles, strengths and responsibilities • demonstrate and clarify understanding of the roles, strengths and responsibilities of team members for quality and safety • foster a team culture that supports quality and safety • adapt and adjust their own behaviour and strategies to meet service and organisational objectives • give, receive and act on constructive feedback • model effective strategies for conflict management.

Improvement and innovation

Using evidence and data to drive improvement and innovation.

KNOWLEDGE OF	ACTIONS
• evidence-informed practice methods and tools • the role of quantitative and qualitative data for improving system performance, and application of appropriate statistical techniques • the requirement for a broad range of metrics and measurement strategies to understand system performance and reliability • types of data, sampling methodologies, data collection and management • the reliability, validity and limitations of measurements • how to analyse, interpret and present data to communicate results • the importance of consumer/patient narratives and feedback.	• promote the use of evidence-informed practice across the organisation • provide guidance on identifying and using evidence and industry benchmarks to inform organisational performance standards and improvement goals • set up and use a broad range of metrics to measure and monitor system performance and reliability • undertake robust data analyses and communicate the results promptly and effectively • teach measurement methods and recommend tools to build organisational capability in using appropriate measurement strategies to drive improvement • apply relevant statistical methods to support improvement • ensure effective measurement strategies are used across quality improvement and patient safety projects • curate, publicise and act on consumer/patient narratives and feedback • support best, and innovative, practice changes.

Quality improvement and patient safety knowledge and skills

Using appropriate tools, methods and techniques to improve the quality and safety of care.

KNOWLEDGE OF	ACTIONS
• improvement science and patient safety methodologies, techniques and tools • the history and current context of health care improvement and patient safety • approaches to manage safety risks at the individual and organisational levels • the key drivers of poor quality care: harm, waste and variation • a systems approach to learn from failures, including the role of adverse event management and open communication • how other organisations, nationally and internationally, have successfully improved • how to implement, spread and sustain improvements.	• define their roles and meet their responsibilities for quality and safety • teach and support quality improvement and patient safety concepts, theories, skills and use of tools to build quality improvement and patient safety capability and expertise • provide expertise, support and feedback to quality improvement and patient safety initiatives • work with team, senior and organisational leaders to guide and support the application of appropriate safety practices to manage risk and increase the reliability of safe care • model clinical and operational risk awareness and support reporting of safety concerns by staff and consumers/patients and their families/whānau • be proactive in anticipating future system failures and work with staff at all levels, consumers/patients and the families/whānau to identify and take steps to minimise risk • lead/support adverse event reviews to address system vulnerabilities • support a system for sharing learning from failures and successes to improve system performance • work with senior leaders to ensure systems and processes are in place to support consumers/patients, families/whānau and staff after adverse events • facilitate the implementation and sustainability of quality improvement and patient safety initiatives • lead innovative practice in consumer/patient-centred system change.

SECTION 5

Capabilities of senior and organisational leaders

Capabilities of senior and organisational leaders

- Partnerships with consumers/patients & their families/whānau
- Quality & safety culture
- Leadership for improvement & change
- Systems thinking
- Teamwork & communication
- Improvement & innovation
- Quality improvement & patient safety knowledge & skills

SECTION 5: Capabilities of senior and organisational leaders

A commitment to improving quality and safety starts with the board and is put into practice and led by senior and organisational leaders. Together, the board and senior leaders set the organisational strategic quality and safety direction and goals, which are aligned with the national priorities for improvement. Leaders uphold and embody organisational values that enable staff to provide safe, consumer/patient-centred care.

Senior and organisational leaders need to ensure flexible and responsive governance structures that enable and support teams and the organisation to adapt to a constantly changing and challenging health care environment, and ensure effective clinical governance systems are in place.

Clear expectations and a compelling story need to be communicated by senior leaders in a way that supports an organisational culture for learning, and helps create the imperative and leverage for changes that make care safer and more effective. This group doesn't necessarily need to have an in-depth knowledge of quality and safety methodologies, but they do need at least foundation-level knowledge. Understanding the concept of variation and being able to interpret data means they will know what questions to ask to keep the organisation on track to meet its objectives for continuous improvement.

Working collaboratively with quality improvement and patient safety experts, consumers/patients and their families/whānau, senior and organisational leaders will select and prioritise portfolios that align with the organisational quality and safety objectives to ensure a cohesive and systematic approach to quality and safety improvement work.

Partnerships with consumers/patients and their families/whānau

Empowering consumers/patients and their families/whānau to interact with health care providers to achieve their desired outcomes.

KNOWLEDGE OF	ACTIONS
• the core values associated with consumer/patient-centred care including health literacy and cultural safety • the concept of consumer/patient engagement and consumer/patient partnership across the spectrum of health care as a key strategy for improving health outcomes • the value of involving consumers/patients and their families/whānau in improving the design and delivery of care.	• apply the principles of consumer/patient-centred care to organisational decision-making and ensure staff apply these principles as part of their everyday practice • ensure the principles of health literacy and cultural safety are embedded in the organisation's systems and processes • ensure the involvement of consumers/patients and their families/whānau in improving the design and delivery of care.

Quality and safety culture

Contributing to and modelling a culture where quality and safety are top priorities, and communicating in a way that shows mutual trust and respect.

KNOWLEDGE OF	ACTIONS
• quality and safety culture and the link with better consumer/patient outcomes • the importance of measuring the quality and safety culture • the value of openness and transparency in health care and the implications for quality and safety • the importance of a reliable near miss, incident or adverse event reporting system • the difference between system failures and deliberate unsafe acts.	• ensure the organisational strategic plan clearly articulates the quality and safety vision for the organisation • ensure structures and processes are in place to support the strategic vision and direction for quality improvement and patient safety • champion a quality and safety culture across the organisation • ensure the quality and safety culture is measured and the results are used to inform improvement • ensure their words and actions model and uphold the values of openness and transparency • ensure quality and safety are routinely considered as part of core organisational business • receive and act on quality and safety concerns and use the information for learning and improvement • use appropriate ways to manage system failures and unsafe acts.

Leadership for improvement and change

Doing what is right and setting an example for others to follow.

Knowing and using the principles of change management to support the implementation and sustainability of quality and safety improvements.

Those in leadership roles are also responsible for setting the direction for improving quality and safety consistent with organisational and national goals.

KNOWLEDGE OF	ACTIONS
• current theory, practice and tools for leadership • current theory, practice and tools for change management • the application of organisational theory and management in health care (including strategic planning) • how to implement and sustain improvement consistent with the strategic plan • how to ask the right questions to advance learning and development across the organisation • social movement concepts in generating and sustaining commitment over time.	• set and lead the organisational strategic direction for quality and safety improvement in collaboration with governance • communicate the organisational vision for change and create the imperative for change • build good relationships and use networks across service and organisational boundaries to influence and engage others to bring about change • ensure each member of the senior team sponsors, chairs or participates in organisational committees that have a key influence on quality and safety • motivate and enable staff to initiate, implement and spread quality and safety activities • ensure structures and processes are in place to support emerging quality and safety leaders • coach and mentor others to improve capability in quality and safety leadership • acknowledge and celebrate successful improvements.

Systems thinking

Appreciating the health system as a dynamic, adaptive collection of interrelated and interdependent components, including people and processes, with a common purpose or aim.

Emphasising the whole with an awareness of the parts and their relationships to each other.

KNOWLEDGE OF	ACTIONS
• the New Zealand health care context including the structure and function of national, regional and local organisations • the New Zealand Triple Aim • the health care system as complex and adaptive • quality and safety as integral system properties • systems theory and operational management in health care • the systems and processes across the continuum of care.	• facilitate awareness about the complex interplay between consumers/patients, families/whānau, health care workers and the work environment, and the implications for quality and safety • use multidisciplinary input including quality improvement experts to analyse system quality and safety improvement opportunities and prioritise strategies for action • ensure quality and safety improvements are coordinated locally and across professional, organisational and other boundaries • build organisational quality and safety capability and capacity.

Teamwork and communication

Working with others across professional, organisational and cultural boundaries to achieve shared quality and safety goals.

KNOWLEDGE OF	ACTIONS
• how to communicate effectively to solve problems • how to engage in active listening • how team building contributes to team functioning • how to give and receive constructive feedback • conflict management and resolution.	• ensure written and verbal communications are clear, respectful and logical • engage in active listening • demonstrate understanding of the purpose of the team • demonstrate understanding of their roles, strengths and responsibilities • demonstrate and clarify understanding of the roles, strengths and responsibilities of team members • adapt and adjust their own behaviour and strategies to meet service and organisational objectives • ensure adequate resources are available to build organisational capability in quality and safety • model effective strategies for conflict management • give, receive and act on constructive feedback.

Improvement and innovation are evidence-informed and data-driven

Using evidence and data to drive improvement and innovation.

KNOWLEDGE OF	ACTIONS
• evidence-informed practice methods and tools • the role of quantitative and qualitative data for improving system performance • types of data, sampling methodologies, data collection and management • the reliability, validity and limitations of measurements • data analysis, interpretation and presentation to inform decision-making and how to communicate results • the requirement for a broad range of indicators to understand system performance and reliability • the importance of consumer/patient narrative and feedback.	• use evidence and industry benchmarks to evaluate organisational performance and inform decision-making • use valid and reliable measures to evaluate aspects of service delivery and inform improvement, change and sustainability • encourage best and innovative practice changes • receive and act on information from multiple sources to drive organisational quality and safety • act on consumer/patient experiences of care and monitor clinical outcomes • publicise and act on consumer/patient and family/whānau narratives and feedback • ensure the quality and safety measure results are disseminated to governance, management, staff and consumer groups.

Quality improvement and patient safety knowledge and skills

Using appropriate tools, methods and techniques to improve the quality and safety of care.

KNOWLEDGE OF	ACTIONS
• improvement science and patient safety methodologies and tools • the current context of health care improvement and patient safety • clinical and operational risk management systems • the key drivers of poor quality care: harm, waste and variation • a systems approach to learn from failures, including the role of adverse event management and open communication • how other organisations, nationally and internationally, have successfully improved • how to implement, spread and sustain improvements.	• define their roles and meet their responsibilities for quality and safety • ensure and put into practice an effective organisational quality and patient safety framework • ensure and resource an effective clinical governance structure • ensure staff use appropriate safety practices to manage risk and increase the reliability of safe care • ensure all consumers/patients and staff report operational and clinical safety concerns • ensure and resource systems to support consumers/patients, families/whānau and staff after adverse events • champion and take part in 'safety walk-arounds' • ensure resources and expertise are appropriately allocated to achieve quality improvement and consumer/patient safety goals, and build capability and capacity.

SECTION 6

Capabilities of governance/boards

Capabilities of governance/ boards

- Partnerships with consumers/patients & their families/whānau
- Quality & safety culture
- Leadership for improvement & change
- Systems thinking
- Teamwork & communication
- Improvement & innovation
- Quality improvement & patient safety knowledge & skills

SECTION 6: Capabilities of governance/boards

Those at a governance level lead the commitment to improving quality and safety by setting the strategic quality direction and goals. Responsibility for the governance of compassionate, consumer/patient-centred, quality clinical care sits with governors/board members.

All governors/board members need to understand the importance of improving quality and safety in health care by reducing harm, waste and variation. They must also understand their legislative requirements in this area.

Governors/board members also need to enable education and training programmes for building capability and leadership within the organisation. This is to ensure all staff have the necessary knowledge, skills and behaviours to meet the quality and safety requirements appropriate to their role.

Partnerships with consumers/patients and their families/whānau

Empowering consumers/patients and their families/whānau to interact with health care providers to achieve their desired outcomes.

KNOWLEDGE OF	ACTIONS
• the core values associated with consumer/patient-centred care including health literacy and cultural safety • the concept of consumer/patient engagement and consumer/patient partnership across the spectrum of health care as key strategies for improving health outcomes • the value of involving consumers/patients and their families/whānau in improving the design and delivery of care.	• apply the principles of consumer/patient-centred care to governance decision-making • apply the principles of health literacy and cultural safety in all governance communications with consumers/patients • champion and resource consumer/patient and their family's/whānau's involvement in improving the design and delivery of care.

Quality and safety culture

Contributing to and modelling a culture where quality and safety are top priorities, and communicating in a way that shows mutual trust and respect.

KNOWLEDGE OF	ACTIONS
• quality and safety culture and the link with better consumer/patient outcomes • the value of measuring the quality and safety culture to inform improvement • the value of openness and transparency in health care and the implications for quality and safety.	• ensure the organisational strategic plan clearly articulates the quality and safety vision for the organisation • ensure structures and processes are in place to support the strategic vision and direction for quality improvement and patient safety • champion and ensure a quality and safety culture within their organisation • review quality and safety culture measurements • uphold the values of openness and transparency • ensure quality and safety are routinely considered as part of core governance business.

Leadership for improvement and change

Doing what is right and setting an example for others to follow.

Knowing and using the principles of change management to support the implementation and sustainability of quality and safety improvements.

Those in leadership roles are also responsible for setting the direction for improving quality and safety consistent with organisational and national goals.

KNOWLEDGE OF	ACTIONS
• current leadership theory and practice • organisational theory and management in health care (including strategic planning) • current change management theory and practice • how change can impact on the organisation.	• ensure structures and processes are in place to support organisational leadership and emerging leaders, including in community health consumer networks • champion and support organisational change processes that target quality and safety improvements • empower change within their organisation • actively communicate successful change that improves patient safety and health care delivery.

Systems thinking

Appreciating the health system as a dynamic, adaptive collection of interrelated and interdependent components, including people and processes, with a common purpose or aim.

Emphasising the whole with an awareness of the parts and their relationships to each other.

KNOWLEDGE OF	ACTIONS
• the New Zealand health care context including the structure and function of national, regional and local organisations • the New Zealand Triple Aim • the health care system as complex and adaptive.	• ensure quality and safety is coordinated across organisational boundaries • ensure the organisation actions the national agenda for quality and safety.

Teamwork and communication

Working with others across professional, organisational and cultural boundaries to achieve shared quality and safety goals.

KNOWLEDGE OF	ACTIONS
• how to communicate effectively to solve problems • how to engage in active listening • how team building contributes to team functioning.	• model communication that is clear, respectful and logical • engage in active listening • give, receive and act on constructive feedback.

Improvement and innovation

Using evidence and data to drive improvement and innovation.

KNOWLEDGE OF	ACTIONS
• the principles of evidence-informed practice methods and tools • the role of quantitative and qualitative data for improving system performance • types of data, sampling methodologies, data collection and management • the reliability, validity and limitations of measurements • data analysis, interpretation and presentation to inform decision-making • the requirement for a broad range of indicators to understand system performance and reliability • the importance of consumer/patient and family/whānau narratives and feedback.	• use evidence and industry benchmarks to evaluate organisational performance and inform decision-making • use multiple information sources and a broad range of indicators to assess system performance and reliability • act on consumer/patient experiences of care and monitor clinical outcomes • publicise and act on consumer/patient and family/whānau narratives and feedback.

Quality improvement and patient safety knowledge and skills

Using appropriate tools, methods and techniques to improve the quality and safety of care.

KNOWLEDGE OF	ACTIONS
• the current context of health care improvement and patient safety • clinical and operational risk management systems • the importance of a patient safety reporting system • the key drivers of poor quality care: harm, waste and variation • a systems approach to learn from failures, including the role of adverse event management and open communication • how to implement, spread and sustain improvements.	• define their roles and meet their responsibilities for quality and safety • ensure and support management in building quality and safety capability and capacity • ensure resources and expertise are appropriately allocated to achieve quality and consumer/patient safety goals • ensure and resource the organisation to have a coherent and effective quality and safety framework • champion and take part in 'safety walk-arounds' with senior leaders • meet with community health consumer networks to report on quality and safety improvements • build board capability in quality and safety.

Appendix 1: Methods

The New Zealand quality and safety capability framework has been developed by the Commission in response to a request from the sector for direction and guidance.

An extensive review of similar frameworks was undertaken which informed the development of this document.[24]

We also drew on the current literature to inform our understanding of what it means to be 'capable' with respect to quality and safety at the individual, team, organisational and system levels for the 21st century.

Specifically, these include:

- domains of knowledge[25]
- quality improvement domains[26]
- leadership for quality[27]
- team competencies[28]
- competencies for individuals[29]
- quality improvement and patient safety skills[30]
- Canadian patient safety competencies.[31]

In contrast to other frameworks, the New Zealand framework describes capabilities rather than competencies. The complexity of health care in the 21st century calls for more than knowledge and skills. It requires practitioners to have a high degree of self-efficacy and to adapt and respond to changing environments through ongoing learning and development.[32] The New Zealand framework also takes a whole-of-system approach, reflecting the definition of quality improvement suggested by Batalden and Davidoff (2007):[33]

> *the combined unceasing efforts of everyone – health care professionals, patients and their families, researchers, payers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning).*

In addition to describing the capabilities that would be expected of health care practitioners in their various roles, the New Zealand framework specifically recognises the need to include consumers/patients and those in governance roles.

In arriving at a final set of quality and safety capabilities, our aim was to meet the following criteria:[34]

1. Unique to quality and safety
2. Feasible within a proposed structure of training programmes
3. Endorsed and adopted by key stakeholders
4. Constitutes a uniform expectation
5. Build on/be compatible with other types of defined competencies
6. Be assessable.

24 The Health Foundation 2014, *op. cit.*

25 Batalden PB, Berwick DM, Bisognano M, et al. 1998. *Knowledge domains for health professional students seeking competency in the continual improvement and innovation of health care.* Boston: Institute for Healthcare Improvement

26 The Health Foundation. 2012. *Quality Improvement training for Healthcare Professionals. Evidence Scan.* London: The Health Foundation.

27 Garman A. 2011. Leading for Quality in Healthcare: Development and Validation of a Competency Model. *Journal of Healthcare Quality* 56: 373–82.

28 Baker DP, Day R, Salas E. 2006. Teamwork as an Essential Component of High-Reliability Organizations. *Health Research and Educational Trust* 41: 1576–98.

29 National Advisory Group on the Safety of Patients in England. 2013. *A promise to learn, a commitment to act: Improving the safety of patients in England.* London: The National Advisory Group on the Safety of Patients in England.

30 The Health Foundation 2014, *op. cit.*

31 Canadian Patient Safety Institute. Safety Competencies Steering Committee. 2009. *The Safety Competencies: Enhancing Patient Safety Across the Health Professions.* Ottawa: Canadian Patient Safety Institute.

32 Fraser SW. Greenhalgh T.2001. Coping with complexity: Educating for capability. *BMJ* 323: 799–803.

33 Batalden and Davidoff 2007, *op. cit.*

34 Williams BC, Warshaw G, Fabiny AR, et al. 2010. Medicine in the 21st Century: Recommended Essential Geriatrics Competencies for Internal Medicine and Family Medicine Residents. *Journal of Graduate Medical Education* 2(3): 373–83.

Appendix 2: Glossary of key concepts and definitions – creating a common language

Adverse event	An adverse event is an incident which results in harm to a consumer/patient (see 'Incident' and 'Near miss incident'). [35]
Board	Boards 'govern' the organisation. Sitting at the core of governance is the idea of defining what success means for an organisation and utilising resources, inclusive of people, money and time, to steer it towards that success. Governance encompasses the systems, processes and relationships through which an entity is directed or controlled.[36]
Capability	The extent to which individuals can adapt to change, generate new knowledge and continue to improve their performance.[37]
Coaching	A relationship between two or more people in which one person finds ways to enable and empower the other(s) to perform at higher levels.[38]
Consumer(/Patient)	A person who has accessed or is currently using a health or disability service or is likely to do so in the future.[39]
Consumer engagement	Patients/consumers, families/whānau, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organisational design and governance, and policy-making – to improve health and health care.[40]
Culture	Culture is a system of 'Shared values (what is important) and beliefs (how things work) that interact with an organization's structures and control systems to produce behavioural norms (the way we do things around here)'.[41]
Domain	An area of knowledge or activity.[42]
Evidence	The available body of facts or information that indicates whether a belief or proposition is true or valid.[43]
Human factors	Human factors is an established science that uses many disciplines (such as anatomy, physiology, physics, psychology, engineering and biomechanics) to understand the interrelationships between humans, the tools they use and the environment in which they live and work. It aims to 'optimise human performance through the design of tasks, equipment and the environment in which people work in order to minimise the likelihood of errors and unintended consequences'.[44]

35 Health Quality & Safety Commission. 2012. *New Zealand Health and Disability Services – National Reportable Events Policy* 2012. URL: https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reportable-Events-Policy-Final-Jan-2013.pdf (accessed 9 June 2016).

36 Institute of Directors. (nd). *Governance*. URL: https://www.iod.org.nz/Governance-Resources/Resource-library/Governance (accessed 9 June 2016).

37 Fraser SW, Greenhalgh T. 2001. Coping with complexity: Educating for capability. *BMJ* 323: 799–803.

38 West L, Milan M. 2001. *The Reflecting Glass: Professional Coaching for Leadership Development*. London: Palgrave.

39 Health Quality & Safety Commission. 2015. *Engaging with consumers: A guide for district health boards.* URL: www.hqsc.govt.nz/assets/Consumer-Engagement/Publications/DHB-guide/engaging-with-consumers-3-Jul-2015.pdf (accessed 9 June 2016).

40 Carman KL, Dardess P, Maurer M et al. 2013. Patient and Family Engagement: A Framework for Understanding The Elements and Developing Interventions and Policies. *Health Affairs* 32: 223–31.

41 Reason J. 1998. Achieving a safe culture: theory and practice. *Work and Stress* 12: 293–306.

42 Merriam-Webster.com. URL: www.merriam-webster.com/dictionary/domain (accessed 9 June 2016).

43 Oxford Dictionaries. URL: www.oxforddictionaries.com/definition/english/evidence?q=Evidence (accessed 9 June 2016).

44 Kohn LT, Corrigan JM, Donaldson MS (eds.). 2000. *To Err is Human: Building a Safer Health System.* Washington DC: National Academies Press.

Health care innovation	Health care innovation can be defined as the introduction of a new concept, idea, service, process or product aimed at improving treatment, diagnosis, education, outreach, prevention and research, and with the long-term goals of improving quality, safety, outcomes, efficiency and costs.[45]
Incident	An incident is any event that could have or did cause harm to a consumer/patient (see 'Adverse event' and 'Near miss incident').[46]
Leadership	In health, leadership has been described as 'a mechanism for effecting change and enhancing quality… it requires a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where it would benefit patients'.[47]
Mentoring	A relationship of trust where a more knowledgeable and experienced person gives advice or counsel to a less experienced person.[48]
Multidisciplinary	Professionals from a range of disciplines with different but complementary skills, knowledge and experience working together to deliver comprehensive health care aimed at providing the best possible outcome for the physical and psychosocial needs of a consumer/patient and their carers.[49]
Near miss incident	An incident which under different circumstances could have caused harm to a consumer/patient but did not, and which is indistinguishable from an adverse event in all but outcome.[50]
Open communication	The timely and transparent approach to communicating with, engaging with, and supporting consumers/patients and their families/whānau when things go wrong.[51]
Openness and transparency	Being honest, easy to understand and completely free from concealment.[52]
Patient	See 'Consumer'.
Patient safety	The management of risk over time in order to maximise benefit and minimise harm to consumers/patients in the health care system.[53]
Reliability	In health care, reliability is defined as failure-free operation over time. In this context, failure refers to a breakdown in operations or functions.[54]
Risk	In the context of risk management, risk is defined as the chance of something happening that will have an impact upon objectives. Risk may have a positive or negative effect.[55]
Social movement	'Bottom up' or 'grassroots' change driven by informal and unstructured systems where people change themselves and each other, peer to peer.[56]

45 Omachonu VK. 2010. Innovation in Healthcare Delivery Systems: A Conceptual Framework. *The Innovation Journal: The Public Sector Innovation Journal* 15(1): Article 2.

46 Health Quality & Safety Commission. 2012. *New Zealand Health and Disability Services – National Reportable Events Policy 2012*. URL: https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reportable-Events-Policy-Final-Jan-2013.pdf (accessed 9 June 2016).

47 Department of Health. 2008. *High Quality Care for All. NHS Next Stage Review Final Report*. URL: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf (accessed 9 June 2016).

48 Merriam-Webster.com. URL: www.merriam-webster.com/dictionary/mentor (accessed 9 June 2016).

49 Royal Australian College of General Practitioners (RACGP). 2016. *The RACGP Curriculum for Australian General Practice 2016*. URL: http://curriculum.racgp.org.au/statements/multidisciplinary-care/ (accessed 9 June 2016).

50 Health Quality & Safety Commission. 2012. *New Zealand Health and Disability Services – National Reportable Events Policy 2012*. URL:. https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reportable-Events-Policy-Final-Jan-2013.pdf (accessed 9 June 2016).

51 *Ibid.*

52 Merriam-Webster.com. URL: www.merriam-webster.com/dictionary/openness (accessed 9 June 2016).

53 Vincent C, Amalberti R. 2016. *Safer Healthcare: Strategies for the real world*. New York: Springer.

54 Nolan T, Resar R, Haraden C, et al. 2004. *Improving the Reliability of Health Care*. IHI Innovation Series White Paper. Boston: Institute for Healthcare Improvement.

55 See www.praxiom.com/iso-31000-terms.htm.

56 Bate P, Robert G, Bevan H. 2004. The next phase of healthcare improvement: what can we learn from social movements? *Quality and Safety in Health Care* 13(1): 62–6.