**Consumer engagement quality and safety marker webinar**

**Webinar 1**

**Accessible transcript**

**Visual**

**A large speech bubble surrounded by a green border fills a PowerPoint slide. Blue and green text reading ‘Health Quality & Safety Commission New Zealand. Kupu Taurangi Hauora o Aotearoa.’ The blue and green company logo comprises of three thin square blocks with white circles of differing sizes within them. A heading reads ‘Quality and safety marker - consumer engagement.’ Below this in a smaller font, text reads: Kia ora, Talofa lava, Malo e lelei, Fakaalofa lahi atu! We will start at 11:03 to allow participants to complete the registration process. 11 August 2020. A small screen appears in the top right corner of the slide. Deon York, a brunette man wearing a blue shirt and suit jacket, is sitting in a room with white walls with a bright window on the left wall and a pair of bookshelves leaning against the back wall.**

Audio

(Deon): OK, it's 11.03. I'd like to welcome you to this first webinar on the consumer engagement quality and safety marker. I'll be opening with a karakia.

Whakataka te hau ki te uru, whakataka te hau ki te tonga.

Kia mākinakina ki uta, kia mātaratara ki tai.

E hī ake ana te atakura.

He tio, he huka, he hau hū.

Tīhei mauri ora.

As I said, welcome to the first webinar on the consumer engagement quality and safety marker. You'll be hearing from four of us today – Chris Walsh, Richard Hamblin, myself and Ying Li. So we'll get started. But first of all, I just had a few housekeeping things to do with asking a question.

**Visual**

**The slide changes. Text in the large speech bubble reads: ‘How to ask a question.’ Below this is an image taken from the webinar software. Three icons sit in the middle of a dark grey bar – a speech bubble labelled ‘chat’, a hand labelled ‘raise hand’ and two overlapping speech bubbles labelled ‘Q&A’. A red arrow points to the Q&A icon.**

Audio

(Deon): So how do you ask a question on this webinar? You submit your questions using the Q&A feature at the bottom of your screen. So hopefully you can all see it there at the bottom. And you can see where the arrow is just indicating that there. Please note that the chat function has been disabled.

And it would also be helpful, if you have a question for a specific speaker, if you can include the name of the panel member with your question. Of course, like all webinars, this is going to go very quickly, so we apologise in advance if you don't get to ask your question, or we don't get to answer it, rather, live.

But we'll also be compiling all submitted questions, and we'll email these out after the conclusion of this webinar. This will also be recorded, and we will also be having a subsequent follow-up webinar as well. So without further ado, I will pass over to the first speaker on this session, and that is Dr Chris Walsh.

**Visual**

**A new slide appears. Under the blue and green logo for Health Quality & Safety Commission New Zealand, Kupu Taurangi Hauora o Aotearoa, is text in bold: Dr Chris Walsh; Director, Partners in Care.**

Audio

(Deon): Chris is the director of Partners in Care, and Partners in Care is the Health Quality & Safety Commission's consumer engagement programme. Thank you.

**Visual**

**Deon’s video disappears from the corner of the screen. A new slide appears. The word ‘Background’ appears in the top left corner of the large speech bubble. Under this, three words are listed:**

* **Why**
* **How**
* **When**

**Chris Walsh, a woman with short hair and glasses, appears in the top right corner of the screen.**

Audio

(Chris): Kia ora, everyone. I'll just extend my welcome to everybody who's tuned in for this webinar on the quality and safety marker of consumer engagement. So today, at this moment in time, I'm going to be covering the background for the development of the quality and safety marker, so the, kind of, why, the how and the when.

**Visual**

**On the right side of the slide, nine images are placed in a grid. Under each image is a title.**

1. **Image: a woman places a blood pressure cuff on a girl. Title: Co-design Partners in Care.**
2. **Image: a cartoon image of an elderly woman inquiring about medication to woman in a health care uniform. Title: Developing nudges to improve patient experience.**
3. **Image: a white outline of people performing a hongi on a green background. Title: Progressing consumer engagement in primary care.**
4. **Image: a collage of photos of people. Title: Consumer network.**
5. **Image: a title page for a document reading Engaging with Consumers. Title: Engaging with consumers – DHB guide.**
6. **Image: a photo of a man giving a presentation. Title: Consumer stories.**
7. **Image: a document with the acronym PLAN. Title: *Let’s PLAN for better care* resources.**
8. **Image a photo of a man leaning on a chemist’s counter. Title: Health Literacy.**
9. **Image: a photo of three children in sun hats watering a bed of yellow flowers with brightly coloured watering cans. Title: Health equity.**

Audio

(Chris): And I think probably one of the first things I need to say is that we started looking at a quality and safety marker in sort of general terms about... about five years ago here at the Commission. And so we've just— At that time, we're exploring ideas, looking at the evidence internationally, looking at what's been done around New Zealand and trying to think about consumer engagement and how we might try and understand how it contributes to quality in the health services. So the motivation for it was really about, you know, understanding what effective consumer engagement looks like and how services and consumers might know that the engagement that was going on was actually effective and influencing the health outcomes.

So at that time, we were... we were kind of... developing our own resources in the Commission. And one of the themes that ran through all those resources was really about the importance of consumer engagement, not only direct care level, but also at... policy level, service delivery and governance. So that's just a, kind of, little bit of background. 2015 might seem like a long time ago. And indeed, for some of us here, it does feel like a long time ago that we've sort of been tinkering around the edges with this. But we've certainly gained some momentum in the last couple of years, and I'll share with you some of the, kind of... I guess, the signposts along the way.

**Visual**

**The slide containing the nine images rolls upward and is replaced with the word ‘Why?’ in bold in the top left-hand corner.**

* **Established evidence that patient experience, clinical effectiveness and patient safety are all linked.**
* **Engaging with consumers, family, whānau remains a priority in health and disability services.**
* **No ‘QSM’ exists for consumer engagement locally or in other jurisdictions.**
* **Answering the question ‘what does successful consumer engagement look like, and (how) does it improve the quality and safety of services?’**

Audio

(Chris): So let's look at the why. Why have we developed this quality and safety marker?

So as I said just a couple of minutes ago, we were looking for evidence around patient experience, consumer engagement, and we were trying to see what was around in terms of looking at how do we know consumer engagement is working? And so we started to find some stuff, especially internationally. You know, we found a randomised controlled trial, actually, that looked at evidence that patient experience and clinical effectiveness

are all kind of linked. And so, at that time, finding a randomised controlled trial, as you can imagine, was quite significant, because much of the work and much of the evidence around consumer engagement was not at that level of kind of evidence. So we started kind of tinkering around quite a bit more, and we found that the Australian Commission had, I think in 2014, put together a... an audit tool, and one of the... auditing signals was looking at consumer engagement. And so we had a look at that, and we were quite interested in that. And the feedback from the auditing over in Australia was quite interesting, and I guess at that time not so unexpected. And the feedback from the services over in Australia who had been audited really rated the, sort of, consumer engagement quite low and really didn't understand how to engage with consumers. And this came through in the auditing that they were doing around the place. So, you know, other places have really kind of looked at patient-reported outcomes, patient experience surveys and quite a lot of that, sort of, direct care level, but not a lot looking at that, sort of, you know, consumers having an influence over service delivery and over policy and over governance.

So engaging with consumers, family, whānau, remains a priority in health and disability services. Well, this has become more and more important. And I think when we were starting our work in consumer engagement, one of the first things that we did was a guide for DHBs around consumer engagement, which was really looking at a lot of the evidence. And so if you go to that guide, you'll see a lot of international evidence around consumer engagement. And it's on the next slide. You’ll see a whole, kind of, slide of some of the resources that we've got out. But the next, kind of, iteration of this, kind of, guide that we looked out... we put in last year was in primary care. And so it was a different kind of, kinda, guide. And it was different because we had much more awareness and recognition of New Zealand as a society, New Zealand as a place, you know, to receive hospital care and to receive care and primary care. So we looked at...much more around diverse communities and Te Tiriti o Waitangi.

So the Crown's obligations under the treaty has come out a lot more in the health services in New Zealand in the last few years, particularly with poor outcomes for Māori. So this guide in primary care is... much different than the first one that we did and much more located in our, kind of, New Zealand society. And so the diverse communities – I mean, if you think about that as a term, where does that even come from? And we thought to ourselves, 'Oh, is that the right term to use?' And I guess that, you know, brings really a point about the whole kind of way in which we've developed this consumer engagement quality and safety marker with partners and with people in the sector. It's the language that's used. It's a whole different ball game. And with that, sort of, term 'diverse communities', we thought, 'Are people going to be happy with that? What do we do? 'Are Māori going to be happy with a term like that?' And so we sought, initially, advice from Māori in the contacts that we have through the Commission here and talked about it and discussed it, and they were actually OK with it. It may well be that other Māori are not happy with a term like that. And within those diverse communities, of course, we've, in the primary care guide, looked at Pacific communities and the rainbow community and people with disabilities. So, you know, it's a real kind of interesting conundrum when you come to using language with work that we've been doing.

And I think the bottom line for us really is, you know, even the term 'consumer', the term 'engagement', it's really about what suits the communities, what communities identify with and what they feel comfortable with. (COUGHS) So, as I said, we've had no quality and safety marker for consumer engagement locally or in other jurisdictions.

And I think Richard will touch on this in the presentation that he gives next. And I think I remember from the slide that he said 'We really tried. 'We really, really, really tried.' And that, coming from Richard, means that we *really* did try. Answering the question what does successful consumer engagement look like and how does it improve the quality and safety of services? This is what this quality and safety marker is actually about. It's not an audit tool. It's something to help services improve the services that they deliver and work in partnership with consumers.

**Visual**

**A new slide appears. The ‘Why’ remains in the top-left corner. Text under this reads Minister’s LOE 2020/21. This is followed by a block of text which reads: Service user councils. Service user/consumer councils are key mechanisms through which service users can give feedback on how health and disability services are delivered in different communities. The Health Quality & Safety Commission (the Commission) has provided guidance to support an effective approach – *‘Engaging with consumers: A guide for district health boards’* and *‘Progressing consumer engagement in primary care*’. I am aware that many DHBs already have strong user service councils and I want to strengthen this across all districts and regions. The Commission, in partnership with the sector, has developed quality and safety markers for service user engagement and I encourage your DHB to participate in this.**

Audio

(Chris) So that's, kind of, a little bit of the why. So that's kinda like the soft why around it. This might be a little bit of the hard why around it, which is the Minister's letter of expectations for 2020/21. So the minister at that time acknowledged service user councils. So here's another term. We're not using 'consumer'. We're using 'service user councils'. But I think we, kind of, mostly know what that means. Service user and consumer councils are key mechanisms through which service users can give feedback on how health and disability services are delivered in different communities. The Health Quality & Safety Commission has provided guidance to support an effective approach. So here we have the guide for district health boards and the progressing consumer engagement of primary care, which I've just talked about. He goes on to say, 'I'm aware that many DHBs 'already have strong user service councils', 'and I want to strengthen this across all districts and regions,' and, 'The Commission, in partnership with the sector, 'has developed quality and safety markers for service user engagement, and I encourage your DHB to participate in that.' So this is kinda like, you know, something, I guess, coming from the Minister and kinda helps support the work that the sector has been doing around consumer engagement and acknowledging it.

**Visual**

**A new slide appears. The word ‘How’ appears in the top left corner followed by a list of bullet points:**

* **Approach agreed by Commission’s executive leadership team and board**
* **QSM reference group established**
* **Four pilot sites established**
* **Discussions with consumer councils and DHBs**
* **Development of support framework (together)**
* **Piloting undertaken**
* **CEs and others updated (QRMs)**
* **Roll out planned for 2020/21**
* **Incorporated into annual DHB planning**

Audio

(Chris): So I just want to go on a little bit and look at how – how we've gone about developing this quality and safety marker. So we've had the approach agreed by the Commission's executive leadership team and by the board. So I think this happened in 2000 and... Ooh, what were we doing? 2018, I think we had that kind of agreement. And even though we started the work in 2015, there was a lot of, kind of, as I said, tinkering around the edges and looking at the evidence and sussing things out... trying to figure out if this was something that we wanted to do, talking with consumers, talking with providers and just sort of gathering more and more information. So by the time it kinda went to the board and it went to the leadership team here at the Commission, we had quite a lot of information.

So, of course, when you're doing anything like this, you've got to sort of establish a reference group, and it didn't take us long to get a reference group together. But what was important in this for us was looking at the make-up of the reference group, and so we wanted to have key people, and it was important for some reason to have an equal number of consumers and an equal number of providers. So we did that. We got, sort of, equal numbers of consumers and providers, and we wanted a kind of... what you might call a representative lens over it as well. So we wanted Māori and Pacific there, and we wanted people with disability, and we wanted providers from across the sector as well. So we did that, and we also had a person from the Ministry of Health sitting on there and an international expert as well, who knows a lot about co-design. So that was kinda like the make-up of the group, plus some of the staff here at the Commission.

Four pilot sites agreed to undertake the work in looking at the development of this quality and safety marker. And so those four pilot sites have provided wonderful material that all the other DHBs and all the other services that will be... developing their own quality and safety marker along these lines will be able to use some really wonderful resources. So the pilot sites that agreed to be involved were Counties Manukau Health, Waitematā, Waikato and Canterbury DHBs. So those four services have really provided, you know, a lot of input into this quality and safety marker.

There were discussions with consumer councils and DHBs, so we went around and we had some community meetings – I know some of the pilot sites had community meetings as well – getting input from all kinds of levels, really. And at the reference group, we developed a support framework. This took a period of time, and Deon will be going through the support framework when he does his presentation, and you'll be able to watch the unfolding of the SURE framework, which is S-U-R-E and stands for supporting, understanding, responding and evaluating. So when someone says we do consumer engagement in our service, we can say, 'Are you SURE?' So sometimes those little things are quite, kind of, interesting and provide a little bit of a hook in.

So the piloting was actually undertaken once people had got a whole lot of, kind of, tools together We've been keeping people updated – the CEs and the quality and risk managers. So we did our last presentation to the quality and risk managers in February this year, and there's another one coming up in a couple of weeks to keep them updated as well. So the rollout is planned for 2020/21, which is now, and as you can see, is supported by the letter of expectation, and it's also incorporated into the annual DHB planning.

**Visual**

**The ‘How’ slide is replaced by a new slide which shows the previous nine images in the grid formation, each with their title in a blue rectangle underneath.**

Audio

(Chris): So I've just got this slide here, which is just some of the resources that have helped us in the thinking about consumer engagement and how to kind of develop it. And there's a couple here that I've already mentioned. You can see on the top right –progressing consumer engagement in primary care, which came out last year. And in 2015, engaging with consumers. And if you look at both of those, they're quite, sort of, different in their approaches, which really—you know, in some way, it kind of reflects the quality and safety marker. It's not something that is set in concrete. It's something that's flexible and should be responsive to communities.

One of the big things that underpins some of the work that we've been doing is the whole approach around co-design. And so, you know, the expectation in this quality and safety marker would be that services would have some indication and would be able to demonstrate that they are using co-design in their service. The other thing, of course, is we've got some stuff around our consumer network, but the DHB consumer councils are really important in the development of this as well. So all the DHBs should have consumer councils or something similar already set up, and I think most of them are kind of there on that.

**Visual**

**A new slide has the word ‘When’ in bold in the upper left corner. Below this in bold, a title reads: DHB plans 2020/21:**

1. **Improving consumer engagement. DHBs are expected to participate in the quality and safety marker for consumer engagement by:**
* **setting up a governance group (or an oversite group) of staff and consumers to guide implementation of the marker**
* **upload data onto the consumer engagement QSM dashboard using the SURE framework as a guide**
* **report against the framework at least annually by Q3.**

Audio

(Chris): So if we just go to this final, kind of, slide here, this is the, sort of, when. And so in the DHB plans, you can see here [CHRIS READS THE SLIDE ALOUD]. So Deon and Ying will be going through that a little bit in a little bit more detail later on in this presentation.

But I just wanted to finish making a few comments about the governance group. We have had some feedback from some of the services that there is a little bit of reticence around setting up a governance group and that the go-to group for something like this is something like the consumer council. I think that's one way to do it, but, you know, this is an important piece of work, and it's something that we can all own. In setting up a governance group, it's important to have the consumers and the providers working in partnership. We have put some terms of reference... just a draft guide for terms of reference for a governance group on the dashboard, so there's a whole lot of information on the dashboard as well. But this governance group is important because there is some work to do. We need to move away from that kind of ad hoc, sort of, you know, 'just have a look at this and see what you think of this' kind of process that we sometimes do. We need something that's much more, kind of, supported and to build a kind of team within that governance group who can look at what needs to be done, who can provide some advice. It may well have a person from the consumer council. It's probably a good idea. But just divvying it over to the consumer council to do and just get them to feed back on things isn't really, kind of, taking the notion of partnership to its full, kind of, level. And from what I understand, a lot of the consumer councils have got a lot of work to do anyway. So having this kind of group set up with good representation from the communities for Māori and Pacific and for other groups in the community, as well as for providers, will be a good way of really getting this, kind of, quality and safety marker up and running. It's a time-limited group. It would be a time-limited sort of group.

So it wouldn't run forever, but, you know, it would be something that would be exciting to be involved in. And hopefully services will see the value of this, rather than just divvying it over to the consumer council on an ad hoc sort of basis. So, I think that's all I have at the moment. Yeah, so thank you for listening, and hopefully you've got some questions that we can, as a panel, discuss at the end.

**Visual**

**A new slide shows the blue and green logo for Health Quality & Safety Commission New Zealand, Kupu Taurangi Hauora o Aotearoa, and under that text which reads: Richard Hamblin, director of health quality intelligence.**

Audio

(Chris): OK, thank you, myself. I can thank myself for that. We'll move on to our second presentation, and this one is Richard Hamblin. Richard is the director for health quality intelligence here at the Commission, and his presentation will look at how measurement and quality improvement fit together. So welcome, Richard.

**Visual**

**A new slide reads ‘How measurement and quality improvement fit together.’ Dr Chris Walsh’s video feed in the upper-right corner is replaced by Richard Hamblin, a dark haired and bearded man in glasses, black jacket and a pink shirt.**

**Audio**

(Richard): Hello, everyone. I'm Richard Hamblin. I'm director of health quality intelligence at the Commission. I'm delighted to be here today to talk a little bit about this concept of how measurement and quality improvement fit together, how they interact. I'll talk about that for a few minutes. And that will, I hope, tee up some of my colleagues to talk a little bit more about the SURE framework and how this works overall to deliver a consumer quality and safety marker.

**Visual**

**Richard changes the slide to an empty speech bubble on the green background. He leans back in his chair as he speaks.**

Audio

(Richard): I think when we talk about measurement and improvement, probably the first thing to say is that measurement isn't in and of itself improvement.

**Visual**

**Words appear at the top of the empty speech bubble: ‘Measurement of itself is not improvement.’ A bright white circle shrinks on the screen revealing a photo of a grimacing man weighing himself on scales in a gym.**

Audio

(Richard): You know, we'll all recognise the old saying that you don't fatten a pig by weighing it. So I reversed that. This chap here, you know, working very hard and weighing himself is not making a great deal of difference to his perceived goal of weight loss. And I think that's an important point to make. It's sometimes actually used to... (SIGHS) downplay the importance of measurement. And I think measurement actually still does have a role in improvement, even though it isn't in and of itself improvement.

**Visual**

**A new slide appears. A title in bold reads: Why measurement matters. Underneath the title are two quotes in italics: ‘We can only be sure to improve what we can actually measure.’ Raleigh and Foot 2010. ‘Evidence suggests that publicly releasing performance data stimulates quality improvement activity at the hospital level.’ Fung et al 2008.**

Audio

(Richard): I think it matters for two reasons. The first is, quote, that, 'We can only be sure to improve 'that which we can actually measure.' If we are doing things but we don't know if it's having an effect, then actually we need to reconsider and make sure that it does actually lead to the improvements we expect to see. The second element is the Fung quote on this slide. And I suppose it's probably a 20-year old literature now actually looking about how making information about the quality of health services, how about making that transparent actually stimulates improvement inside health services. And this has been reasonably well attested to.

**Visual**

**A new slide appears. It is titled: How is measuring and reporting performance supposed to work? Under this is a flow chart which shows how publicly reported performance data feeds into Selection, Knowledge, Change and Motivation, which feeds into Performance which includes effectiveness of care, safety, patient centeredness and united consequences. This loops back to publicly reported performance data the top of the chart. This diagram is from Berwick, James and Coye 2003.**

Audio

(Richard): There's some debate about why this occurs, and this rather complex model has been suggested as two potential pathways by which this works. The first is that consumers make choices about where they go to in receiving health care or accessing health care or co-producing health. The alternative... is the very fact of making information about quality available stimulates organisations to work better to improve their services. Some may say it probably doesn't matter which of the two is actually correct for our purposes, simply to say by one of these mechanisms, or possibly both, we do see a relationship between making information available and seeing improvements resulting. And that has underpinned the way that the Commission has considered how it uses information. We've pretty much published every measure that we've used and made publicly available, particularly inside the quality and safety markers of which this is a distinct but... latest variant of.

**Visual**

**A new slide contains the title ‘How to measure the unmeasurable...’**

Audio

(Richard): I think we really come down to the issue of what the quality and safety markers are about is trying to measure things that are unmeasurable. So if I was to talk about consumer engagement, there isn't a unit of consumer engagement – a consumer-tron or something – I can just look at what's going on and say, 'You've got 37 of those. Well done.' That's not how it works. Very often, we're looking at quite complex ideas that aren't directly measurable, quality being a very good example of this. What exactly is quality, and how do you measure it? Well, fortunately, somebody has been thinking about this, really, for about the last 60 years, or first thought about it 60 years ago.

**Visual**

**A photo of a bald man with a white beard and square framed glasses appears.**

Audio

(Richard): And it was this rather distinguished-looking chap called Avedis Donabedian, who was a Lebanese paediatrician, actually. But his great insight was to recognise there's, kind of, three elements that you want to understand in judging the quality of something.

**Visual**

**A new slide appears. It is titled: The Donabedian combination of “What?”. Bullet points appear under the title.**

* **Structure is what you put into a system.**
* **Process is what you actually do.**
* **Outcome is what happens as a result.**

**So:**

* **Use of a specific electronic system is not a process.**
* **Clinical actions are not outcomes.**

Audio

It's sometimes known as the Donabedian triad. There's a combination of what you're up to. So he first talked about structures. These are what you put inside your system. So it could be something like the resources that you have, the relationships, the... the governance, the committees, the availability of training – all these sorts of aspects count as structure in the way that he thought of the world. Process is what you actually do. So very often you're leveraging those assets that you have in order to do things. And that could be ways that you communicate, it could be... opportunities to... be involved and give feedback. It's those sorts of actual actions, things that really hit the road. And then, finally, outcome is what happens as a result. And these are, you know, about what happens to people as a result of their care. How does it how does it help them? How does it not help them? So it's important to actually get the distinction between these right. So, for example, using a specific electronic system is not a process; it's a structure. So you've got this electronic system there to help you, for example. Similarly, clinical actions – the doctor did X; the nurse did Y – is not an outcome; it's a process. Very often as people work their way through these, getting the classification is actually the really critical thing to do.

**Visual**

**A new slide is titled: How outcome contextualises process.**

Audio

(Richard): But process and outcome, in particular, have a close relationship. We would expect outcomes to flow from processes. And at the heart of the idea of the quality and safety marker is this relationship – that we would expect to see a way of behaving, a way of operating, and then we would expect to see results, outcomes flowing from that. So I can show this in this little simple diagram here.

**Visual**

**A chart appears. It’s divided into four quadrants. The word ‘Outcome’ runs along the top of the chart and the word ‘Process’ runs along the left side. Each quadrant side is marked with either a plus sign or a minus. Each square in the chart has text inside it. The top left box, representing a positive outcome and a positive process reads: Looks to be working (but keep watch out for confounders!) The top right square, indicating a positive process but a negative outcome reads: ?hitting the target and missing the point. ?Is there a new problem. The bottom left square, indicating a negative process but a positive outcome reads: ?What else is happening. ?Regression to the Mean. The final square on the bottom right corner of the chart indicates a negative process and a negative outcome. It reads: Get on with it!**

Audio

So on the side, we've got processes – stuff that you do. Outcomes – results – along the top. Positive and negative. So what if people are doing the right things, and they're getting the right results? Well, probably, whatever you're doing looks to be working. But watch out for confounders, cause there may be some other things going on there. And of course, no result is forever. If you're doing the right process but you're not getting the outcomes, well, there's an idea called hitting the target and missing the point. It's kind of having the right things written down or recording that you're doing things but not really doing them in the way that's anticipated. It's, you know— it’s like doing your homework badly, I guess, in a sense. Could also be because there's a new problem. You're doing the thing that we anticipated, but something’s changed, and it's not having the effect that we anticipated. If somebody's not doing the process and they're not getting the outcomes, it's quite useful to show that, because what it does is removes the sort of excuse that we're different. So there's a 'get on with it' clarion call when you have those two together. Finally, perhaps most interesting – what happens when you're not doing the process but the outcomes improve? Well, it may well be there's something else going on, maybe be a bit of statistical oddity. But typically, actually, there's something that we haven't considered, and actually it's doing that could also, or perhaps more importantly, more firmly have an effect on the outcome that we want. And the quality and safety markers, the way that they've worked, have deliberately brought together processes of outcomes so that we have this broader view of what's going on. And that way, they're quite distinct from, sort of, classical targets, really.

**Visual**

**A new slide is titled in bold: But that doesn’t quite work here.**

* **No one has managed to develop a Donabedian measurement for improvement approach for consumer engagement.**
* **And we know because we looked.**
* **Really, really hard.**

Audio

(Richard): However, the issue that we have is in trying to measure what's going on

in consumer engagement, that approach doesn't quite work. And we know that nobody's ever managed to develop a Donabedian type of measurement structure for consumer engagement. And believe me, we've looked very hard to try and find that. So we actually had to sort of think from first principles about how we could use some of the data that are available to us and other data that can be collected to get to this broader view of what is happening in terms of consumer engagement in DHBs and how this is affecting quality of care. And that really is something that I'll set up for my colleagues to talk a little bit more about the SURE framework. But I hope that's given a grounding in theory, if you like, about what we're trying to do here. Thanks very much for listening.

**Visual**

**A new slide has the blue and green Health Quality & Safety Commission New Zealand logo centred near the top. Below this, a title reads Deon York; programme manager, Partners in Care.**

Audio

(Richard): Well, there we go. Kia ora, everyone. It's good to be with you here today. It's my pleasure now to move on to the next part of the presentation, which is my colleague Deon York, who is programme manager of Partners in Care. He's going to be talking a little bit more about the SURE framework and how you can contribute to it. So I'm happy to hand over to Deon right now.

**Visual**

**Richard’s video feed in the top right corner of the screen is replaced by Deon’s. A new title appears under the logo: Contributing to the consumer engagement quality and safety marker. 11 August 2020.**

**Audio**

(Deon): OK, so now I'll be telling you a little bit more about how to contribute to the quality and safety marker for consumer engagement. You've already heard about some of the background to the consumer engagement, quality and safety marker. And now you'll be wondering, 'Well, how can I contribute to this, and why should I contribute to this?'

**Visual**

**On a new slide, a title in bold reads: In summary.**

1. **What is the background and evidence behind this QSM?**
2. **Why develop such a QSM?**
3. **Who was involved with its development?**
4. **First steps to taking part in QSM.**

Audio

(Deon): So, first of all, what is the background and evidence behind the QSM? Why did we develop such a QSM? Who was involved with its development? So you've heard about those first two, three things. So now I'm going to talk a little bit more about the first steps in taking part in the QSM.

**Visual**

**A new slide is titled DHB plans 2020/21. A subtitle in smaller bold text reads: improving consumer engagement.**

**DHBs are expected to participate in the quality and safety marker for consumer engagement by:**

* **setting up a governance group (or an oversight group) of staff and consumers to guide implementation of the marker**
* **upload data onto the consumer engagement QSM dashboard using the SURE framework as a guide**
* **report against the framework at least annually by Q3.**

Audio

(Deon): So, as you would have seen, Chris talked a bit about setting up of the governance group or an oversight group of staff and consumers to guide implementation of the marker.

I'm going to talk a bit about uploading the data on to the consumer engagement quality and safety marker and a little bit about the SURE framework, cause you're probably wondering, 'Well, what is the framework, and how can I contribute?'

**Visual**

**The next slide reads: What does successful consumer engagement look like, and (how) does it improve the quality and safety of services?**

Audio

(Deon): So, really, what we're trying to answer is – Because over the years, as you know,

there has been a lot of work to look at being more patient-centred or adopting a co-design approach or working more in partnership. And we believe that all of these are positive steps in improving the quality and safety of the health system. But what we're interested to know now is what does it really look like when it's successfully done, and how do we actually know that we're making a difference? And this consumer engagement quality and safety marker is the first step in trying to understand this and seeing how improvements can be made.

**Visual**

**A new slide has bold text in the centre reading ‘What is the ‘SURE’ framework?’**

Audio

(Deon): So the contribution will be to the SURE framework. So you'll be wondering, 'Well, what is the SURE framework, and what does this stand for?'

**Visual**

**On a new slide, four boxes are lined up along the top of the screen. Each box is filled with text. The first box is titled: Supporting. Text under that reads: What is in place to support consumer engagement? The second box is titled Understanding. How do organisations make sense of what consumers are telling them? The third box reads: Responding. What has been done to respond to what consumers have said? The fourth box is titled Evaluating. What has been the impact of these interventions? Under the second box, ‘Understanding’, text in a column reads Response rate: adult inpatient and primary care experience surveys. Representativeness: age ethnicity and gender. Under the fourth box, ‘Evaluating’, text in a column reads: Relevant measures: adult inpatient and primary care experience surveys.**

Audio

(Deon): The SURE framework is about four key areas. The first is supporting. So what is in place to support consumer engagement? The second's about understanding. So how do organisations make sense of what consumers are telling them? The third is around responding. So what is being done to respond to what consumers have said? And lastly, Evaluating. What has been the impact of these evaluations? So that's the SURE framework.

So you can always ask yourself if we're making improvements for the people who access our services, are we SURE that we're doing this? This is a framework to think about when considering that question. There are some data already that the Commission holds about services that will contribute to the SURE framework. These are primarily from the adult inpatient experience survey and the primary care experience survey. So in terms of the adult inpatient and primary care surveys, we can get an understanding what the response rate is for that. We can also look at the representativeness, such as age, ethnicity and gender. So that's one piece of information that we already hold that will contribute to the SURE framework. Then, in terms of evaluating and looking at the impact of the intervention, we already have some relevant measures, again, from these two surveys, so we can track over time how services are going and if improvements are being made. So that will form part of the SURE framework, and as I say, is already routinely collected, and we already hold such information.

**Visual**

**On a new slide, the columns of text under the boxes have disappeared and have been replaced with new text. Words placed along the left side of the screen under the boxes read: Engagement, Te Tūhononga. Responsiveness, Te Noho Urupare. Experience, Wheako. Words running along from left to right under the boxes read: Minimal, Te itinga iho. Consultation, Te akoako. Involvement, Te whai wāhi. Partnership & shared leadership, Te Mahi tahi me te kaiārahitanga ngātahi.**

Audio

(Deon): But if we go a little bit further in how you can make a contribution to the SURE framework, we've developed a framework, and as Chris and as Richard mentioned, over time, with many, many stakeholders, and this is it in front of you.

So what this shows on the left-hand side are three categories. One is around engagement, one is around responsiveness, and one is around experience. And then for each of those domains, there are four possible ratings that you can give your service. You can either give minimal, you're in the consultation phase, you're in the involvement phase, or you're in the partnership and shared leadership phase. Now, for each of these, because you'll be wondering about definitions, there is a detailed definition for engagement, a detailed definition for responsiveness, and a detailed definition for experience, which is available on the form page when you enter information into the quality and—for the quality and safety marker. And for each of these categories, whether it be minimal, consultation, involvement or partnership and shared leadership, there is a detailed description for what each one looks like. So the question can be asked if we think we are in the involvement stage for engagement, there are going to be five or six statements that tell you what that looks like or what you would need to do to categorise yourself as in the involvement stage.

However, if you just did this as a tick-box exercise and gave yourself a rating out of four – one for minimal, two for consultation, three for involvement, or four for partnership and shared leadership – then that really wouldn't be enough in and of itself. So there's also the opportunity for you to provide a commentary about why it is that you chose that particular rating for your service overall, and there's an opportunity to upload up to five examples in a range of formats to provide evidence as to why you gave a rating for your service in that way.

So, again, we have... this framework will be available in a lot more detail, and it's available on the QSM page of the Commission's website.

**Visual**

**A new slide is titled: Experience, Wheako. Underneath this are bullet points.**

* **Minimal: these metrics are reported on.**
* **Consultation: these metrics are reported on and shared with relevant stakeholder groups.**
* **Involvement: these metrics are reported on, and shared with relevant stakeholder groups, including consumers involved with the work.**
* **Partnership and shared leadership: these metrics are reported on and shared with relevant stakeholder groups, including consumers involved with the work. Reporting is timely, and feedback loops are closed.**

Audio

(Deon): So to give you one example in a bit more detail – if we look at experience. Under experience, there are actually three statements for each of the ratings, but I've taken just one to show you as an example. So if you were minimal in experience when it comes to consumer engagement, then you would be reporting on experience metrics. So to be minimal – these metrics are reported on. That's fairly straightforward.

To be in the consultation category, you would be looking a little bit further – that not only are these metrics reported on; they're also shared with relevant stakeholder groups. To take that another step further, looking at involvement – not only would these metrics be reported on and shared with relevant stakeholder groups; you would also be involving consumers or your community in this work to be involvement. Under partnership and shared leadership, these metrics would be reported on, shared with relevant stakeholder groups, including the consumers involved with the work.

The reporting would be timely, and crucially to be partnership and shared leadership, the feedback loop would be closed. So, I mean, that's very important, obviously, that information is collected, that it's developed in such a way that it's relevant to everybody involved in that information, but crucially, that that information is used to make improvements. And so that's why that would be considered partnership and shared leadership.

**Visual**

**A new slide has a title centred in the middle of the large speech bubble: More information?**

**Audio**

(Deon): So, if you want more information about how to fill in the consumer engagement quality and safety marker, Ying will be talking more about the practicalities of logging into the website and entering the information. But on top of that as well, we have developed a frequently asked questions on our page. We also have the consumer engagement, quality and safety marker reference group, and many members of that would be happy to be contacted as they've piloted this work and they know the practical aspects of implementing it locally. And finally, you can always contact one of us here at the Commission, and we'd be happy to help you.

**Visual**

**A new slide has the blue and green logo for Health Quality & Safety Commission New Zealand, Kupu Taurangi Hauora o Aotearoa, centred near the top. Under this, text reads Ying Li; senior analyst, health quality intelligence.**

Audio

(Deon): Great, so thank you for listening to that, and I will just keep moving on, in the interest of time, and pass over to Ying Li. As I mentioned, Ying is going to be talking more about how you access the form and how you fill it out. And Ying Li is a senior analyst in the health quality intelligence team here at the Commission. So thank you, Ying.

**Visual**

**Deon’s video feed vanishes and the PowerPoint slides shrink forming a black bar on the right side where Ying’s video appears. Ying has short black hair and wears a black and grey jersey. The slide that takes up the bulk of the screen beside Ying’s video is titled ‘How to submit data.’ Below this title is an image of the website hqsc.govt.nz. The website is themed in the same blue and green colours as the logo which sits near the top of the website. A large blue square bears the message: Kupu Taurangi Hauora o Aotearoa, Health Quality & Safety Commission New Zealand. Working with clinicians, providers and consumers to improve health and disability support services. Next to this is a green bar displaying hyperlinks to the website’s popular pages. As Ying speaks, she moves her mouse cursor over the image.**

Audio

(Ying): Now, let's look at how to submit the data. Here is the screenshot of the home page of HQSC website. So the address is hqsc.govt.nz. So on the top corner, you can see there's a button called 'our programmes', and then clicking the 'our programmes' will bring up a list of all the programmes HQSC is working on.

**Visual**

**She clicks on a link titled ‘Our programmes’ which opens up a new webpage. This webpage contains a list of hyperlinks in blue text. A red arrow points to one titled: Mōhiohio kounga e pā ana ki te hauora, health quality intelligence.**

Audio

(Ying): And in here you see health quality intelligence. And click this link.

**Visual**

**Ying clicks that link, changing to a new slide which shows the Mōhiohio kounga e pā ana ki te hauora, health quality intelligence page. This page has a grid of nine images with blue titles underneath. A map of New Zealand shaded in different hues of blue; green, yellow and blue human shapes with an arrow traveling in an upward diagonal through them; a cartoon of a group of buildings including a wharenui; a group of three overlapping coloured speech bubbles; a target coloured red, yellow, green and blue; a pair of overlapping graphs; the white outline of a light bulb on a green background; a pair of stick figures on a see-saw; a clip art picture of a document. A red arrow points to the document icon which is titled Data submission platform.**

Audio

(Ying): You will be able to go to this page. That is the projects of health quality intelligence. At the bottom of the page, you see a data submission platform. Click here.

**Visual**

**Ying clicks this link and the data submission page appears. The website address appears in blue at the top of the screen.** [**https://www.hqsc.govt.nz/our-programmes/health-quality-evlauation/projects/data-submission/**](https://www.hqsc.govt.nz/our-programmes/health-quality-evlauation/projects/data-submission/)

**In a green banner, the title of the webpage is written in white text: Data Submission. A large table takes up most of this web page. Each of the table’s four columns has a title: Adverse events, Consumer engagement, Mental health and addiction, Quality and safety measures. Each row of the table represents a different area’s DHB. A red arrow points to a box in the Consumer engagement column and the Auckland DHB row which is labelled ‘All district health boards.’**

Audio

(Ying): Then you get into this page of the data submission. If you want to save all the clicks, then you can just follow this link to go to this page directly. On this page are several areas data submitted. One of them is consumer engagement. Click the 'all district health boards'. Then you will get to the login page.

**Visual**

**Ying clicks the ‘all district health boards link’ in the table which takes her to a login page requiring an email and password.**

Audio

(Ying): Use the email address and password we provided, and then you can log in.

**Visual**

**She clicks through to a new slide which shows the consumer engagement webpage. This page has an area titled ‘Submit your data’ and another area for users’ information including name, organisation, phone number and email address.**

Audio

(Ying): Once you log in, you see this page. That's the first page of consumer engagement data submission. On this page, it's mainly about your information, so your name, your organisation, phone number and email address. Under that is... some links for further information about this consumer engagement QSM. Once you fill all the information, you just click 'next', then you go to the page two of the data submission.

**Visual**

**Clicking a ‘next’ button takes Ying to a second page. A bar halfway down the page indicates that Ying is at step two of a four-step process. This page is titled Engagement, Te Tūhononga, and asks users to give a rating for this domain from 1-4; 1 being minimal and 4 representing partnership and shared leadership. There are options to upload any supporting documentation and a box where users can describe how their uploaded documents support their chosen rating. As Ying explains the process, her mouse cursor hovers over the link to page three, then moves to hover over the link for page four.**

Audio

(Ying): This page two is about engagement domain. For this domain, you first need to give a self-rating. So from one, two, three, four, choose one as your self-rating score and then upload your supporting document. So under this upload button there is a box for you to fill in a short description of that supporting document, then another upload button and another box for another document. So the maximum number of documents you can upload is five for each domain. If you have more than five documents you want to send to us, then you can talk to us. We'll see how you're going to submit other documents. So, for page three is responsiveness, and for page four is the domain of experience.

**Visual**

**A new slide shows the final website of the process. Small text under the green banner reads ‘Thanks! Your submission has been received.’**

Audio

(Ying): So once you finish all the four-page data submission, you click 'submit' button. Then you will see this page pop up, tell you your submission has been received. So that's the final page of the data submission. Once you see this, which means your submission's done, and once we received your data and document, we're going to do some background tidy-up and reshape the data, reformatting those data and put it through a system to fit into the dashboard.

**Visual**

**A new slide appears titled ‘home page’. A blue banner across the top of the home page reads consumer engagement QSM. Under this are four green boxes in a row, labelled Supporting, Understanding, Responding and Evaluating. Below this is the title ‘A framework for measuring consumer engagement’ followed by paragraphs of text and bullet points. As she talks though the website, Ying’s mouse cursor travels over each of the green boxes.**

Audio

(Ying): So this is the consumer engagement QSM dashboard. This is an interactive dashboard. So we use this dashboard to report the consumer engagement QSM. Here is the screenshot of the front page of the dashboard. You see the four tiles on the top which lay out the framework of the consumer engagement QSM. And below that is a description about the framework. So the tiles are all clickable. So if you click one of them, you will be linked to that specific area. For example, if we click 'supporting', then here is the self-rating page of the Supporting area.

**Visual**

**A new slide is titled ‘Supporting’. A blue banner along the top of the webpage has white text inside reading: Self-assessment results of Supporting. Below this is a stacked bar graph is different shades of green with percentages running along the bottom. A red indicator on this graph marks engagement at 70 percent. A colour key below the graph indicates that this shade of green at 70 percent is a score of 2. Further down this website is a table titled DHB story. The rows of this table are labelled Engagement, Responsiveness and Experience. There is a space in the next column for users to write their experiences of each of these.**

**As Ying discusses this page, her mouse cursor travels along the stacked bar graph, highlighting the different coloured sections one by one. A dialogue box pops up to explain the percentage and engagement score.**

Audio

(Ying): On the top are three filters. You can choose which DHB you want to look at. At the moment, for example, we choose Waitematā DHB. In the domain, we can choose from engagement and responsiveness and experience, and also we can choose which reporting time period of the result we look at by moving the time bar. Once you set up those three filters, then you set up the whole page for the bar chart, for the box of positioning statement and also for the DHB stories. So all the contents will reflect to the filters you just set up. Now, let's look at the bar chart first. This is a horizontal bar with different shades of green. In the light green is one, which means minimum, and the different shade of green means different self-rating scores. So... Hover over the mouse one of the area, for example, the light green, you see this is engagement, and one is minimum, and 60 percent of 20 DHBs gave themselves one for this time period for this engagement domain. If you move mouse to another shade of green, for example, here, then you see this is two – this means consultation. And 20 percent of 20 DHBs gave themselves... as two for this engagement score. That's one information we want you to receive from this bar chart, which is the distribution of the scores. And the other information you can see is from the small person icon. So this represents how the selected DHB scores themselves. For example, here is Waitematā DHB. They score themselves for engagement as two consultation. Please note all this data in this bar chart is mock-up data for this presentation. So this is the horizontal chart.

**Visual**

**The mouse cursor then travels down to the DHB story table. As the mouse hovers over the chart, a dialogue box appears with a hyperlink that will take the user to supporting documents.**

Audio

(Ying): Next, we can see this is the DHB story box, which lists all the documents... supporting documents DHB submit to us. Click one of the cells. You will see the short description pop up for this supporting document, and there is a link below. So click this link. You will be able to go to the actual document to have a look. So the form of the document can be different. Like, people can submit to us PDF document or Word document or videos and so on. So click the link. You can see the actual document. In the left-hand side is the positioning statement.

**Visual**

**A new slide is titled in bold text: Understanding. This webpage has a blue banner running along the top that reads: Adult inpatient survey response and representativeness. This page is made up of different graphs. A line graph and bar graph represent the response rate and number across different quarters of different years. Below this is a pair of tables containing bar graphs. One shows representativeness by ethnicity percentage point and the other representativeness by age group percentage point.**

Audio

(Ying): So above is the self-assessment result. This presents the percentage of the consumer engagement QSM. We used the patient experience survey data to show the outcome of the consumer engagement QSM. To make a good understanding of the survey result, we have this page. We call it Understanding.

On that page, first, you can choose which DHB to look at. For example, we look at Auckland DHB. Then this chart gives you the information about the response rate and response number. The black line is the response rate over time, how it's changed, and the bar chart is the response numbers over time for the patient experience survey. And below that chart is two figures. One is the representativeness by ethnicity. The other one is by age group. We used orange to indicate there is over-representativeness and used grey to indicate this is under-representative.

So when we look at it by ethnicity, we see Māori, Pacific and Asian. Most of the bar is grey, which indicated most of the survey period for those three ethnicity groups, they are under-representative. But for European and other, the orange colour indicates they're over-representative. If by age group, we look at this chart. For younger age group and older age group, most of them are under-representative, but for the middle age group, many of them are... over-representative. So this is the chart for the Understanding page of the dashboard. It will help you to understand the representativeness of the patient experience result. At the moment, we only show the adult inpatient experience results. In the future, we're going to include the primary care as well.

**Visual**

**A new slide is titled Evaluating. This slide shows a webpage with a blue banner across its top which reads: Adult inpatient experience survey domain scores. This page has drop-down boxes for users to select their domain and DHB. Beside these is a map of New Zealand divided up into different regions and coloured blue. The map is titled Comparison with the first survey. Below this are four line graphs titled Time series of domain scores. The graph tracks scores across different yearly quarters in four categories: Communication, Coordination, Partnership and Physical and emotional needs.**

Audio

(Ying): So, now is the evaluation page. In this page, we show the outcome of the consumer engagement QSM. So, first, choose the domain to look at. We have four domains – communication, coordination, partnership and special needs. So, for example, we choose communication, then we choose the time bar, and then we choose a DHB.

So the result below will show the filters you just set up, and the map over here

is to show the compare... comparison result for the select... for the selected time period

to compare with the first survey result for 20 DHBs. The light blue is this... current selected survey round. The result actually is about the same as the first survey round.

In the green, it means it is better than the first survey result, and the grey means this is no comparison because of low response. Let's back to the bottom chart, which shows the four domains and the score over time. The black line is the score for each of the survey round, and the pink line is the baseline median. We used the first four quarters' median

as a baseline median to compare with the... survey result – each one over time. So, for this page, you will see the outcome of the consumer engagement QSM. So that's all from this dashboard.

**Visual**

**A new slide is titled further questions? In the centre of this slide is an email address in blue:** **qsm@hqsc.govt.nz****.**

Audio

(Ying): So if you have further questions, please just email us at this address. We're happy to discuss further with you. Thank you.

**Visual**

**Ying’s video feed disappears, and the slide once more fills the entirety of the screen. A new slide has the logo for Health Quality & Safety Commission New Zealand centred near the top and the word ‘Questions?’ in bold beneath it. Deon’s video feed appears as a small screen in the top left corner. His feed quickly changes to Richard who sits up straighter in his chair. Richard looks to his right, checking a computer monitor and smiles. His feed is replaced by Chris’.**

Audio

(Chris): So, thank you, Ying. Thank you, Richard. Thank you, Deon. We do have a little bit of time left for questions. We have been responding to them throughout the webinar,

and there's... I can't see any more questions on there. But notably, there's a couple that we've had about the terms of reference and people wanting a copy of those. And, Deon, did you say you sent something around or...?

**Visual**

**Deon’s video feed replaces Chris’.**

Audio

(Deon): We have a terms of reference, and we're happy to send that around and also add it to the frequently asked questions so that you can see it. It's just a template, and feel free to use it however you want. It's just to give you a bit of guidance. And also too... there's been some questions around how you rate services if you've got, sort of, four out of five categories, you've got it, but you don't have the six one. So, you know, the general rule that the QSM group has been adhering to is you'd probably rate yourself one back from that. There's also been questions about how you collate everything around the DHB to then ultimately answer. So I put in the chat there that actually our reference group's been fantastic in developing templates they've been using locally to collate everything. So I'm sure that they'd be happy to share them, and we can share them with all of you and also include them on the website so you've got some examples of how to do that.

**Visual**

**Deon’s video feed changes back to Chris and a new slide appears titled ‘Further questions?’ In the centre of this slide is an email address in blue:** **qsm@hqsc.govt.nz**

Audio

(Chris): Thank you, Deon. Yes, there are plenty... will be plenty of templates available. So, I can't see any other questions there. The only other one that I can recall was about

when this will become available. And we will send you out the link when this webinar becomes available. So I'm sure that will be pretty soon. Any further questions, qsm@hqsc.govt.nz.

So before we finish, I'd just like to thank you all for participating in this webinar and reminding you that hopefully within about four or five weeks we will have another webinar which will be focused on the four pilot sites. So they'll be sharing a lot more information with you. So keep an eye out for that, and we'll send you a message out when that webinar will take place. In the meantime, I'd just like to thank the panellists for their contribution today and close with a karakia.

He aroha whakatō,

he aroha puta mai.

If kindness is sown,

then kindness you will receive.

Thank you very much, everybody.

**Visual**

**Chris’ video feed fills the screen as she starts to remove her glasses. The feed changes to Ying who gives a brief wave goodbye.**

Audio

(Ying): Thank you.

Accessible transcript by Able.
www.able.co.nz