The Health Consumer Advocacy Alliance

Experts by Experience

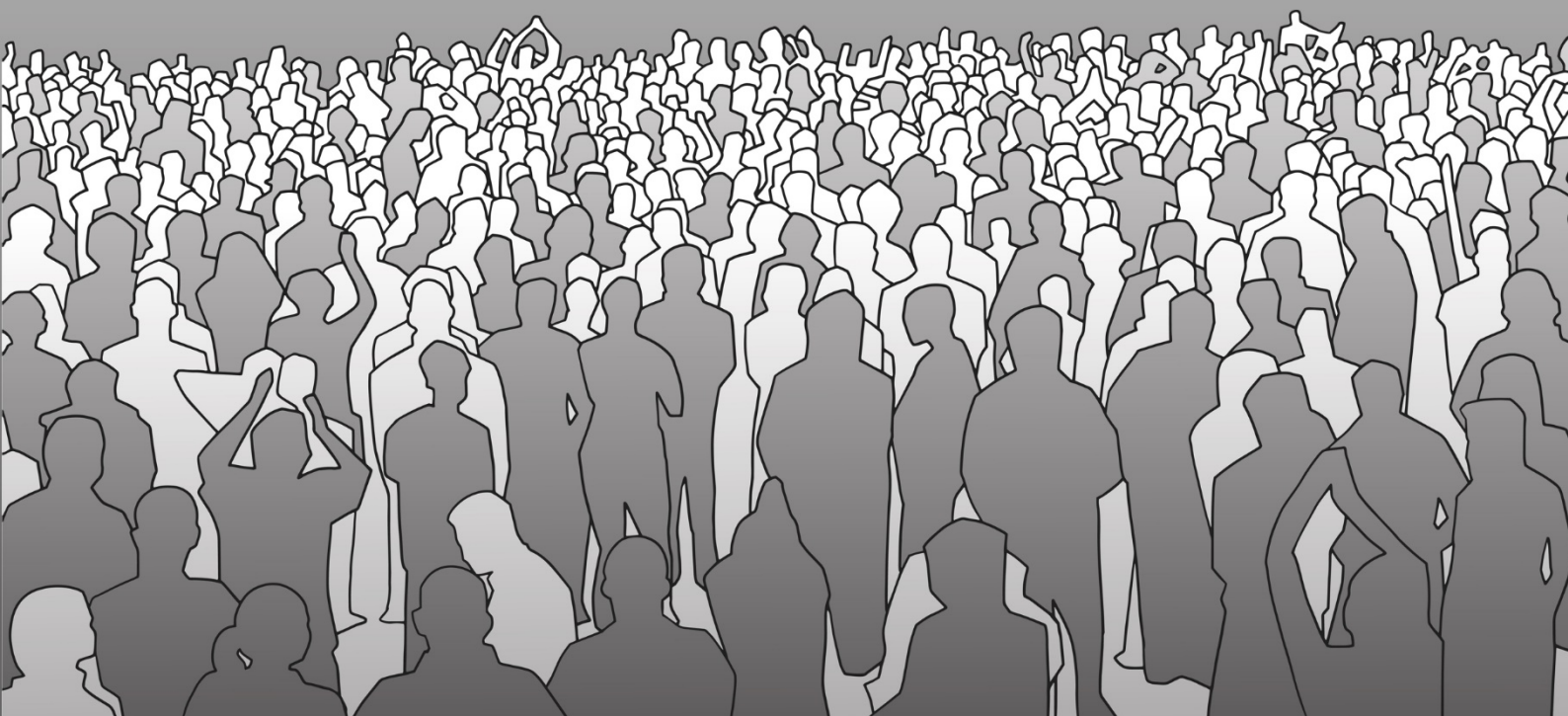
Health Consumer Advocacy Alliance

Supplementary Submission F

11th June 2025

Response to Health Select Committee Hearing with HDC Commissioner, Miss Morag McDowell

HCAA Recommendation to Health Select Committee



A Patient Safety Commissioner: Restoring Trust, Driving Reform, Elevating the Patient Voice

There is a growing argument that New Zealand can achieve safer, more accountable healthcare by simply strengthening existing entities such as the Health and Disability Commissioner (HDC) | Te Toihau Hauora or the Health Quality & Safety Commission (HQSC) | Te Tāhū Hauora Health. This position fundamentally underestimates the scale of the problem and overlooks global best practice.

The message from the New Zealand public is loud and clear, patient safety is not being taken seriously enough. There are increasing concerns about patient safety being raised with little change. The HDC are an extremely important part of our health system, as is the HQSC. The work they do is essential. However, just strengthening their roles is not enough to reassure the public, or make the necessary changes. This will not be as effective as one specific role with the sole focus of patient safety and systemwide improvement.

Both England and Scotland already have stronger, more robust regulatory and oversight systems than New Zealand. Their health entities, including the Care Quality Commission (CQC), the Health Services Safety Investigation Body (HSSIB) the Department of Health and Social Care (DHSC), and dedicated national investigation bodies have significantly broader statutory powers, clearer mandates, and jurisdiction across the public and private sectors. Despite these existing powers, both countries have still implemented a Patient Safety Commissioner (PSC) role.

Why? Because no existing agency, no matter how well-resourced or well-intentioned, is solely focused on the **proactive** identification of systemic safety risks, the lived experiences of patients, or the enforcement of action when the system fails to learn from harm. NZ is falling behind countries that are making more comprehensive and deliberate investments in safety culture and system-wide improvement. If stronger systems than ours still found it necessary to create an independent PSC, then New Zealand with its fragmented oversight, limited regulatory reach, and ongoing avoidable harm cannot credibly claim that reforming existing bodies is sufficient.

Although ideal, the setup of this position does not necessarily need to be a standalone, new organization. But it does need to be completely independent if aligned with a specific agency like the HQSC. This joint approach could work and the HQSC as our leading patient safety entity, would be a good fit. It would actually strengthen their independence; give more weight to them as an organization.

New legislation would need to be created to give this role the missing ‘teeth’ required to be effective, otherwise we would end up with a role without a strong enough mandate to make a difference. We do not have a body with a legislative mandate over the private sector; this is the perfect solution to ensuring that legislative gap is removed.

A Patient Safety Commissioner (PSC) for New Zealand is not a duplication of effort- it is a structural necessity!

Response to Health Select Committee Hearing with HDC Commissioner, Miss Morag McDowell

21 May 2025 | Health Committee

Refer to Supplementary E for further context in HCAA's response to HDC's written submission on our petition

While the HDC outlined its collaborative efforts with various agencies to address patient safety, significant concerns remain regarding the transparency, accountability, and systemic focus of these efforts. The current model lacks public visibility, proactive advocacy, and the independent oversight needed to address deep-rooted, systemic issues in patient safety across Aotearoa New Zealand's health system.

Key Gaps from Discussion Identified:

1. Lack of Transparency and Public Accountability
HDC cited participation in forums like the National Quality Forum but failed to explain how outcomes from these discussions are shared with the public. There is no centralized, public repository of recommendations or status updates, creating opacity around system-wide failings and corrective action.

2. Systemic Failings Not Actively Addressed
Despite claims to the contrary, HDC's case-based approach limits its ability to detect and act upon broad systemic risks like chronic understaffing that are not complaint-driven but structurally embedded. Acknowledging isolated examples (e.g., the Southern Inquiry) does not equate to an ongoing, visible effort to identify and rectify systemic risks.

3. No Central Oversight Body for Patient Safety
There is no independent entity solely focused on patient safety at a national level with a mandate to proactively investigate, report, and advocate for systemic improvements something the UK's Patient Safety Commissioner model enables by legislation.

4. Insufficient Follow-Up and Clarity on Impact
While HDC reports 90% compliance with its recommendations, there is no public tracking of the remaining 10%, nor any analysis of the impact, enforcement, or categorization (individual vs. systemic) of these recommendations. Without this, it is impossible to assess whether safety issues are being meaningfully addressed. A clear distinction made between HDC recommendations at a district; individual and systemic level is needed urgently. Evidence is needed of the follow up by HDC, outcome, reasons for compliance or non-compliance. It needs to be made clear which of these recommendations are legally binding vs strongly encouraged.

The HCAA welcome Miss McDowells commitment to updating their website to include this information and are pleased with this proactive approach. We feel strongly that HDC need to clarify how they are utilising their 'broad powers' and articulate which of their recommendations are enforceable; which are advisory.

The Health Committee must make our Health Entities more responsible by establishing formal accountability for inaction on systemic failings for **all** Health Entities.

Independent scrutiny = Accountability = Transparency = Trust.

Supporting Evidence

Change Is Essential- What Needs to Change - and Why

A Potential Model - Scotland's Patient Safety Commissioner

During the select committee hearing discussion only England's Patient Safety Commissioner was mentioned. The Scottish Parliament nominated Karen Titchener as its first commissioner on 15 May 2025. This position holds significantly broader legislative powers with the statutory authority to independently investigate systemic issues and compel action from health bodies. The Scottish model prioritises proactive oversight and direct accountability, essential for ensuring genuine scrutiny in the health system, while also strengthening the voice of consumers and health professionals in driving safer, more transparent, and responsive care. Although we can look at adopting a similar model here in New Zealand, we need to first critically examine where our current system falls short, then design the role with the authority, independence, and resources needed to address these gaps, engage meaningfully with consumers and health professionals, and drive transparent, accountable improvements in patient safety..

ACC - Missed Opportunity to Drive Effective Patient Safety Improvements

New Zealand is uniquely positioned to lead the world on patient safety and harm prevention because of its Accident Compensation Corporation (ACC) no-fault system, which sets it apart from many other countries. New Zealand's ACC no-fault system removes the fear of litigation creating ideal conditions for a transparent, learning-focused healthcare system. But without strong national direction and a deliberate culture shift toward using this system to drive improvement, the country risks missing a unique opportunity to set the international standard for harm prevention.

How we respond to harm is as important as preventing it in the first place!

The value of including qualified Human Factors and Ergonomics professionals (HFE) professionals (as opposed to those with an interest) alongside clinicians and patient voices in patient safety work is backed by increasing research. Unlike in England the National Health Service (NHS) and HSSIB who employ qualified professionals, we lack a coordinated approach, consistent national training standards, and workforce capacity. An ACC-backed HFE programme was cut short by COVID, despite its potential. The HCAA are extremely disappointed to hear this. If ACC won't invest in this to align with best practice and international standards, who will! Someone should.

An independent Parliamentary Patient Safety Commissioner could champion these evidence-based approaches and drive investment in prevention.

Safety and Quality Top HSSIB Agenda - Aotearoa Must Follow

The Health Consumer Advocacy Alliance recently facilitated a meeting with HSSIB, HDC and HQSC. Chief Executive of HSSIB, Dr Rose Benneyworth and team spoke about how the Human Factors approach is embedded nationally across England. This is certainly something that New Zealand could, and should aim for.

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Dr Benneyworth talked about how critical it is to explore and reconcile 'work-as-imagined' and 'work-as-done' and how improvement should focus on systemic change rather than on individual performance. Dr Andrew Murphy- Pittock spoke about how the HSSIB have developed a competency framework, the first of its kind for healthcare safety investigations globally. The HSSIB "aims to drive radical change in how patient safety is managed across healthcare with a strong and independent voice". The work they are doing is impressive!

The HCAA agree with HSSIB, there are issues and areas in health that do not get the spotlight and it is these issues that are the most concerning. New Zealand should adopt this same principle- "No investigation topic will be 'off-limits' if it impacts patients.

"The problems faced by health services at the moment are complex and do not have simple solutions, but any solutions that will succeed must have safety at their core." HSSIB officially launches

Aotearoa Must Commit to Patient Safety and Align with Global Standards

In April the HCAA formally requested that NZ sign the Mandaluyong Patient Safety Declaration - a critical international commitment to patient safety. We await to hear the outcome of our request from Health Officials.

New Zealand should sign the Mandaluyong Patient Safety Declaration to demonstrate a strong commitment to safer, more accountable healthcare. Endorsing the Declaration aligns New Zealand with global best practice, reinforces the importance of independent oversight, and ensures the voices of patients and health professionals are central to improving care. It supports system-wide learning from harm, embeds patient safety into health leadership and policy, and would help restore public trust following repeated safety failures. The HCAA believes this is a vital commitment and an ideal opportunity for New Zealand to align with global patient safety standards.

Why a Patient Safety Commissioner Guided by Te Tiriti and Partnership with Māori is Essential

Establishing an independent role guided by Te Tiriti principles, operating independently from existing government structures, prioritising patient safety without external pressures or competing priorities, is essential.

Māori, together with Pasifika, other minority groups, and those living with disabilities are disproportionately impacted by preventable harm in our health system. The PSC would be committed to working alongside Māori as equal partners in the health sector, fostering a relationship built on mutual respect, shared decision-making, and collaboration to achieve equitable health outcomes for all.

The HCAA strongly recommends that the PSC embody the principles of Te Tiriti o Waitangi from its inception. A PSC would prioritise the well-being of patients by focusing on prevention, accountability, and cultural responsiveness, while honouring Te Tiriti principles of partnership (Kawenata), protection (Whakaruruhau), and participation (Whai Wāhi). In doing so, the PSC would not only address patient harm effectively but also uphold the values that define Aotearoa's commitment to equitable, culturally safe healthcare for all.

By consulting and collaborating with Māori health providers, community leaders, and patients, the PSC would gather diverse insights to inform a safety framework that is both inclusive and equitable. Presently, patient safety issues are reported inconsistently, and many safety concerns, particularly those affecting Māori are disproportionately affected by health inequities that include delayed or denied access to care, and systematic discrimination. Māori patients experience disproportionate rates of harm due to cultural insensitivity and lack of understanding within the healthcare work-force. By addressing the underlying causes of patient harm, such as inadequate resourcing and structural racism, the PSC could work to dismantle these barriers and improve outcomes for all.

What Aotearoa, Needs Now!

Urgent Need to Rebuild Public Confidence and Trust!

The HCAA reaffirms the urgent need to restore public confidence and echoes the concerns of outgoing New Zealand Auditor-General John Ryan:

"It's a serious problem when people lose trust in the public sector and the government. Trust is essential for the public sector to function effectively and efficiently. This trust must be mutual we need to share information with the public and trust them in return. Building relationships not just with agencies but with people is crucial.

Tikanga, doing things the right way is key to building trust and acknowledging the significant power imbalance between public officials and the communities they serve."
John Ryan, Auditor-General, Q+A 2025

Trust, once lost, is incredibly hard to regain. A Parliamentary Patient Safety Commissioner- independent, proactive, and publicly visible is crucial to restoring New Zealanders' confidence by driving patient safety and preventing avoidable harm!

HCAA Recommendations:

1. **Establish an Independent Parliamentary Patient Safety Commissioner (PSC) role:**

Create this position and empower this role by legislation to monitor, investigate, and publicly report on systemic patient safety issues. Ensure it is fully independent from health providers, HDC, HQSC and all other Health Entitles. You don't need a huge office that costs lots of money to influence real change, we don't need to duplicate what we already have!

2. **Create a Central Public Repository:**

We need a central repository where recommendations and actions taken by all Health Entities to address entrenched systemic failings are visible to the public. Invest properly in our Health Entities so they can do their job effectively.

3. **Mandate Transparency and Follow-Up:**

Require all agencies (including HDC) to publicly report not only recommendations, but their enforcement, compliance barriers, and resolution timelines.

4. **Make Patient Safety a Key Health Target:**

Embed "prevention of avoidable harm" as a core health system target. Evaluation is essential- clearly determine if formal recommendations made enabled long-lasting meaningful and effective change, at a systemic level and individual level for those who been harmed in our system.

5. **Strengthen Quality of Recommendations:**

Ensure continuous improvement by requiring all publicly funded Health Entities to systematically measure and report on actions taken to improve health outcomes in the public domain on a more regular basis, not just in Annual Reports.

6. **Link Evaluation to Patient Safety:**

Recognise that the regular evaluation of both outcomes and recommendations is essential to improving patient safety and reducing system inefficiencies. Mandate that Health Entities evaluate the

evidence base, effectiveness, and impact of their recommendations. This ensures advice is aligned with high-quality outcomes and promotes consistency in care delivery.

7. **Safety Not a System Priority: Change the message!**

'Timely access to care' dominates policy discourse, while the quality and **safety** of care are deprioritized. Quality care does not necessarily equate to safe care. The HCAA recommend to use the words **Patient Safety** when speaking about our health system in the public domain!

8. **Invest in Proven Patient Safety Initiatives that Work:**

Prioritise investment in proven harm mitigation systems that support our health staff to mitigate avoidable harm and respond appropriately when it occurs. Ensure patients and whānau are genuinely heard, respected, and safe within the health system, this must take priority. Why would you not invest in something that is proven to work! (Refer to Supplementary G).

Safety needs to be at the top of the agenda!

Conclusion

New Zealand's healthcare system stands at a critical crossroads. Systemic failings continue to enable avoidable harm, while polished narratives obscure the stark reality faced by patients and health workers alike. Our health system must transform from one that reacts after harm occurs to one that actively prevents it. It is no longer acceptable for our system to merely respond after harm has occurred. We need **bold**, structural change - not superficial fixes!

The establishment of an independent Patient Safety Commissioner (PSC), underpinned by Te Tiriti o Waitangi, represents a vital safeguard for Aotearoa. This role would focus on systemic risks, ensure early identification of medical harm, drive improvements in safety standards, and amplify the voices of patients, staff, and whānau, especially in decisions that impact them directly. The PSC would not duplicate existing roles, nor require extensive funding, but would fill a critical gap in oversight, especially in the private sector, where scrutiny is lacking.

This is a rare opportunity to take meaningful action: to stop avoidable harm, restore public confidence, and create a culturally safe and resilient health system for future generations. By prioritising safety now, the government can reduce harm, save costs, and build a resilient health system for future generations.

We urge the Committee to act decisively and recommend the creation of an independent Patient Safety Commissioner for Aotearoa New Zealand. Patient safety is not a luxury. It is a basic human right. Prioritising it is not optional it is imperative.