How come we can't solve a 40 year old quality problem? We've been leaving surgical sponges in patients for the past 40 years. Why do we keep making the same mistakes?

Theme 1 Fostering continuous improvement and clinical excellence:

- Operational excellence framework would be a good start to supporting health services to be thinking and acting in a way to connect all aspect that are integral to quality and safety.
- Collaboration can be achieved through the clinical networks where the relationship has been established with the sector and engagement
- In most health services the PRISM report is not circulated to senior leaders and is not connected to governance committees. There is a lack of an overarching view that can be drilled down into detail.
- Consumers have been successfully engaged as part of the design process and being involved in governance committees.
- Assessment: the Rush Safety Steps might go a long way to supporting health services to think of the different levels of safety that need to be achieved. This could be used to help them move along the operational excellence framework and strive to be better.
- Motivation: there doesn't seem to be a clear motivator to work towards excellence such as Leap Frog and Baldrige that exist in the US. Being recognised for achievement could encourage health services to be better than the minimum standard of pass/fail accreditation.
- Linkages: to understand the link between risk, assurance, improvement and legal would be beneficial for senior leaders. This could be a simple as an input and output diagram.
- Culture: at the front line staff don't call each other out on non-standard practice. This seems to be for two reasons: a lack of standard work and work standards (even for simple things such as terminal cleaning post infectious patient) don't exist and hence it's a case of 'I learnt this way and you learnt your way. Who is right and who is wrong?'; and who do they tell or report these things too? In a just culture there is a sense of collegiality and the friendly reminder to do the process according to standard. When there is no standard then there is no conversation. There is no Andon cord to pull!
- Culture: stopping the line (Andon): in industry they use this term which means stop and investigate at the place where the incident happened. Like out MET teams however on a much broader scale to help support problem solving and continuously improving practice.
- Culture:
- University staff could look at the appropriate data collection, monitoring and presentation of data and methods for investigating high outliers or the line of enquiry to understand if the outlier requires persuing or if it's skewed data. Analysis skills are lacking.
- Opportunity to support staff through small scale testing for implementing evidence into practice. Staff don't realise how to try and test changes without a big project and resource. A simple PDSA method just tries a new way with one patient, in just one hour on one day. If successful then scale up until it's embedded.

Theme 2 Improving hospital governance:

- I think the department doesn't have a coordinated view of clinical areas and could take more steps to achieve clearer line of sight. For example, if the quality branch found an area that was of concern it is at such a high level of reporting that it's not always possible to see what's going wrong. Then the link to include the Program area is not always made and performance team is brought in to help fix the issue.
- Responsiveness is too slow i.e. 15 months to follow up a mortality data capture issue is far too long.
- Possibility of predictive measures rather than solely reactive monitoring. 'What can go wrong next?'
- Measurement framework and methods for presenting data to support decision making. Quite often data is not in a format that supports governance committees to make the right decisions about where issues are occurring.

Boards and chief executives:

- Often the CEO will provide their version of what's happening rather than what is happening. This is certainly the case when access issues heighten.
- Increasingly the violence associated with mental health and drugs patients has made many staff really concerned and unclear about how best to manage the needs of these patients.
- The principle of ensuring safety in smaller units is the same for larger ones: what doesn't get measured doesn't get managed. Furthermore, when these measures don't link to higher level targets and there's no accountability from all areas to help and support target achievement then silo's will continue (between units within health services and beyond).
- Should part of health service governance be connecting with the community and other units?

Theme 3 Strengthening oversight pf safety and clinical governance:

- There's such an emphasis on flow and not the same emphasis on quality. Yes shorter waiting times result in better quality however with the increase in volume of separations the quality focus has dropped off.
- In the hospital context these are the barriers to quality and safety:
    - The ever changing team (shift by shift and rotation by rotation)
    - Increasing acuity and shrinking post graduate qualifications
    - Lack of easily accessible standards
    - Large scope to make errors (we do not persue error proofing to prevent issues from occurring again)
    - Broken systems and processes – it's hard to do quality and be safe in systems that are designed to allow harm to occur.
    - Siloed patient information (35 different forms to complete and up to 7 different data bases to access per acute inpatient and no overall coordinated view of what's happening)

Theme 4 Advancing transparency:

Create an effective knowledge management system: there is opportunity for greater sharing and collaboration. We need to make this information more accessible. The Department is very rigid about how information is shared that it stifles real time access to problem solving and what other health services have done to solve issues.