Is the quality and safety agenda stalling?

An *Open Forum* with Professor Mary Dixon-Woods,
The Healthcare Improvement Studies (THIS) Institute, Cambridge, UK

21 August 2019
Renouf Foyer, Michael Fowler Centre, Wellington

DRAFT PROGRAMME

TIME	SESSION
8.30am	**Registration opens**
9.00am	**Mihi whakatau** Peter Jackson, Te Āti Awa
9.10am	**Welcome from the Commission** Professor Alan Merry, chair, Health Quality & Safety Commission
9:20am	**Getting better at getting better: international evidence on improving quality and safety in health care** Professor Mary Dixon-Woods FAcSS FMedSci FRCP Director, THIS Institute The Health Foundation Professor of Healthcare Improvement Studies Professorial Fellow, Homerton College NIHR Senior Investigator Co-editor-in-Chief, BMJ Quality and Safety *Evidence of the effectiveness of many widely-advocated approaches to improving quality and safety in health care has remained very mixed. Sometimes no progress is made; sometimes initiatives have unintended consequences; and sometimes efforts to improve care do the opposite.* *This session will explore some of the reasons for the challenges often encountered by improvement efforts. It will suggest that proportionately too much effort is spent on 'admiring the problems' versus finding solutions. At the same time, too little quality improvement is properly evaluated. Issues of scaling, standardisation and harmonisation have not received the attention they need, not least because too much improvement work is undertaken in isolation at a local level. This results in failure to pool resources and develop collective solutions, introducing new hazards in the process. The session will conclude by identifying what needs to happen to improve improvement.*
10.15am	*Morning tea*

TIME	SESSION
10.45am	**System improvement in the Canterbury DHB** Dr Sue Nightingale, chief medical officer, Canterbury DHB *The Canterbury District Health Board has been successful in transforming healthcare by taking a systems-wide approach using data focussed on patient outcomes to inform clinicians' decision-making.* *This session will provide an overview and some brief examples of what has been achieved as well as some of the challenges.*
11.15am	**The quality and safety agenda from a Māori health perspective** Hector Matthews, executive director, Māori and Pacific health, Canterbury DHB *Challenging inequity as a quality issue. Māori get a lower quality of service and care in the New Zealand health system; fewer referrals, fewer prescriptions, fewer diagnostic tests, less effective treatment plans, offered treatments at substantially different rates, prescribed fewer secondary services such as physiotherapy, chiropractor and rehabilitation.* *This poor quality of care leads to poorer outcomes, greater morbidity and mortality for Māori which is both avoidable and unjust.* *Confronting the cultural monolith of bias at a systemic and individual level may seem terrifying, disturbing and distressing, but it must be done if we are ever going to make meaningful change to the blight of Māori inequity in our health system.*
11.45am	**Q&A with panel of morning speakers**
12.15pm	*Lunch*
	The state of quality and patient safety culture in New Zealand
1.00pm	**Has clinical governance development progressed in New Zealand? Findings from the 2017 national survey** Professor Robin Gauld Pro-vice-chancellor and dean, Otago Business School, and co-director, Centre for Health Systems and Technology, University of Otago *In 2009, district health boards (DHBs) were instructed to implement clinical governance and leadership with a goal of improving care quality and patient safety. DHBs were expected to build partnerships between management and health professionals, support clinical governance development and develop strong clinical leadership.* *Senior doctors have been surveyed since 2010 to gauge perceptions of clinical governance development, with follow-up surveys of the entire professional workforce in 2012 and 2017. Progress appears to have improved in 2012 but since reversed.* *This presentation includes findings from the survey studies and outlines implications, including that clear national policy is demanded with a stronger focus on clinical governance and its coordination across the DHB sector.*

TIME	SESSION
1.30pm	**Moving the culture in operating theatres from check lists to team communication** Mr Ian Civil, safe surgery expert advisory group member, Health Quality & Safety Commission *Culture, or 'the way we do things around here' is particularly strong in surgery. Despite initial scepticism, the Surgical Safety Checklist has been universally introduced throughout the surgical workplace in New Zealand but full engagement with the concepts of communication and teamwork is more challenging to achieve.* *The role and effectiveness of the various measures used in the surgical workplace in New Zealand will be discussed and changes in safety culture reported.*
2.00pm	**A consumer's perspective of quality and safety culture in health care** Jim Edwards, consumer advocate, Taranaki
2.30pm	**Q&A with panel of afternoon speakers**
3.00pm	*Afternoon tea*
3.20pm	**What to do about culture to improve quality and safety** Professor Mary Dixon-Woods *Engineering cultural change is often one of the most stubborn and frustrating challenges for health care organisations. This session will present some of the strategies that are emerging from the research literature as being especially helpful. Emphasising the importance of clear goals at every level of organisations, it will address debates about the accountability of systems versus individuals, show the importance of sound management practices, explain the centrality of collective competence, and offer suggestions on how to encourage voice behaviours.*
4.00pm	**Q&A**
4.15pm	**Wrap-up** **Poroporoaki**
4.30pm	*Forum ends*