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On the Radar

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On the Radar
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Reports

Quality at a glance: using aggregate measures to assess the quality of NHS hospitals
MHP Health Mandate
London. MHP Health Mandate, 2013.

Notes	MHP Mandate has published the first overall assessment of NHS hospital quality in England. Among the findings published are that many of the lowest performing hospital trusts (using the quality index developed) are already subject to regulatory intervention; 'foundation trust' status is a good indicator of high performance on the quality index; **patient experience and waiting times matter most to members of the public** who responded to the poll; and that condition-specific ratings are deemed more useful to patients than general ratings when making informed decisions about their care. The report also seeks to contribute to the ongoing debate about how best to measure quality (in the NHS).
URL	http://mhpccom.wpengine.netdna-cdn.com/health/files/2013/03/Quality-at-a-glance.pdf http://www.mhpc.com/health/revealed-the-best-nhs-hospitals-according-to-the-publics-priorities/

Journal articles

Prescribing trends before and after implementation of an antimicrobial stewardship program
Cairns KA, Jenney AWJ, Abbott IJ, Skinner MJ, Doyle JS, Dooley M, et al
Medical Journal of Australia 2013;198(5):262-266.

Notes	A substantial portion of the 18 March 2013 issue of the *Medical Journal of Australia* is given over to issues around infection, infection control, antimicrobial resistance, surveillance, etc. This piece reports on the implementation and impact of an antimicrobial stewardship program. Such programs are recommended for their role in promoting appropriate use of antimicrobials and thus not further exacerbating the development of resistance. The study used a baseline period of 30 months immediately followed by an 18-month intervention period commencing January 2011 and measured the number and type of interventions made by the antimicrobial stewardship team and the monthly rate of use of broad-spectrum antimicrobial agents. The antimicrobial stewardship team made 1104 recommendations in 779 patients during the 18-month intervention period. In 64% of cases, the recommendation was made to cease or de-escalate the antimicrobial therapy, or to change from intravenous to oral therapy. The introduction of the intervention resulted in an immediate 17% reduction in broad-spectrum antimicrobial use in the intensive care unit and a 10% reduction in broad-spectrum antimicrobial use outside the intensive care unit. Reductions were particularly seen in cephalosporin and glycopeptide use, although these were partially offset by increases in the use of β-lactam–β-lactamase inhibitors. The authors conclude that the "antimicrobial stewardship program, including post-prescription review, resulted in an immediate reduction in broad-spectrum antimicrobial use in a tertiary referral centre." They do note however, that the effect of this intervention apparently reduced over time, which points to the issue of sustainability.
DOI	http://dx.doi.org/10.5694/mja12.11683

For more information about the Commission's work on healthcare associated infections, including antimicrobial stewardship, surveillance, infection control and hand hygiene, see http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality And Cost Issues
Kozhimannil KB, Law MR, Virnig BA
Health Affairs 2013;32(3):527-535.

Notes	The question of variation in health care and how much is appropriate or justifiable (or as the memorable title of a recent: the good, the bad and the inexplicable) is attracting increasing attention. One area of contention about variation has been that of caesarean sections. This US paper reveals that when they examined data for 2009 data from 593 US hospitals they found that c-section rates "**varied tenfold across hospitals, from 7.1 percent to 69.9 percent**". They note that "Even for women with lower-risk pregnancies, in which more limited variation might be expected, cesarean rates varied fifteenfold, from 2.4 percent to 36.5 percent." The authors suggest a number of approaches for addressing these variations, including better coordinating maternity care, collecting and measuring more data, tying Medicaid payment to quality improvement, and enhancing patient-centred

	decision making through public reporting. The OECD is coordinating a study on 'medical practice variation' with a report due later this year. Australia is participating in this study.
DOI / URL	http://dx.doi.org/10.1377/hlthaff.2012.1030 http://content.healthaffairs.org/content/32/3/527.abstract OECD project: http://www.oecd.org/els/health-systems/medicalpracticevariations.htm

Redesigning Primary Care: A Strategic Vision To Improve Value By Organizing Around Patients' Needs
Porter ME, Pabo EA, Lee TH
Health Affairs 2013;32(3):516-525.

Notes	Recognising that the primary care sector in the USA is not quite the same as that in Australia and thus this paper may not be directly applicable, this discussion of a framework for refreshing primary care may still have some value. The authors suggest that US primary care lacks a "robust overall strategy" and to address this "offer a framework based on value for patients to sustain and improve primary care practice. First, primary care should be **organized around subgroups of patients** with similar needs. Second, **team-based services** should be provided **to each patient subgroup** over its full care cycle. Third, each **patient's outcomes and true costs should be measured** by subgroup as a routine part of care. Fourth, **payment** should be **modified to bundle reimbursement** for each subgroup and **reward value improvement**. Finally, primary care patient subgroup **teams** should be **integrated with relevant specialty providers**. We believe that redesigning primary care using this framework can improve the ability of primary care to play its essential role in the health care system."
DOI / URL	http://dx.doi.org/10.1377/hlthaff.2012.0961 http://content.healthaffairs.org/content/32/3/516.abstract

Unlocking information for coordination of care in Australia: a qualitative study of information continuity in four primary health care models
Banfield M, Gardner K, McRae I, Gillespie J, Wells R, Yen L
BMC Family Practice 2013;14(1):34.

Notes	The greater provision and access to information that electronic health records should offer are frequently cited as a means by which patients can have better coordination and continuity of care. This study suggests that simple provision of information is not in itself sufficient. From the paper's abstract: "Coordination of care is considered a key component of patient-centered health care systems, but is rarely defined or operationalised in health care policy. **Continuity**, an aspect of coordination, **is the patient's experience of care over time**, and is often described in terms of three dimensions: information, relational and management continuity… Four diverse Australian primary health care initiatives were… selected… Each has improved coordination as an aim or fundamental principle. … [the study] explored four questions covering the scope and use of information, the influence of

	governance, data ownership and confidentiality and the influence of financial incentives and quality improvement on information continuity and coordination. Results The overall picture that emerged across all four cases was that whilst accessibility and continuity of information underpin effective care, they are not sufficient for coordination of care for complex conditions. Shared information reduced unnecessary repetition and provided health professionals with the opportunity to access records of care from other providers, but participants described their role in coordination in terms of the active involvement of a person in care rather than the passive availability of information. Complex issues regarding data ownership and confidentiality often hampered information sharing. Successful coordination in each case was associated with responsiveness to local rather than system level factors. Conclusions **The availability of information is not sufficient to ensure continuity for the patient or coordination from the systems perspective**. Policy directed at information continuity must give consideration to the broader 'fit' with management and relational continuity and provide a broad base that allows for local responsiveness in order for coordination of care to be achieved.
DOI	http://dx.doi.org/10.1186/1471-2296-14-34

BMJ Quality and Safety
April 2013, Vol 22, Issue 4

Notes	A new issue of *BMJ Quality and Safety* has been published. Many of the papers in this issue have been referred to in previous editions of *On the Radar* (when they were released online). Articles in this issue of *BMJ Quality and Safety* include: • Editorial: **Trends in adverse events** over time: why are we not improving? (Kaveh G Shojania, Eric J Thomas) • Methodological variations and their effects on reported **medication administration error rates** (Monsey C McLeod, N Barber, B D Franklin) • Changes in **adverse event rates** in hospitals over time: a longitudinal retrospective patient record review study (Rebecca J Baines, Maaike Langelaan, Martine C de Bruijne, Henk Asscheman, Peter Spreeuwenberg, L van de Steeg, K M Siemerink, F van Rosse, M Broekens, C Wagner) • A novel approach to improving **emergency department consultant response times** (Christine Soong, Sasha High, M W Morgan, H Ovens) • Usability of a computerised drug monitoring programme to detect **adverse drug events** and non-compliance in outpatient ambulatory care (Claudine Auger, Alan J Forster, Natalie Oake, Robyn Tamblyn) • Competition in collaborative clothing: a qualitative case study of influences on **collaborative quality improvement** in the ICU (Katie N Dainty, Damon C Scales, Tasnim Sinuff, Merrick Zwarenstein) • Home-care nurses' perceptions of unmet information needs and communication difficulties of older patients in the immediate **post-hospital discharge** period (Katrina M Romagnoli, Steven M Handler, Frank M Ligons, Harry Hochheiser) • Do you have to re-examine to reconsider your diagnosis? **Checklists and cardiac exam** (Matthew Sibbald, Anique B H de Bruin, Rodrigo B Cavalcanti, Jeroen J G van Merrienboer)

	• **Treatment quality indicators** predict short-term outcomes in patients with diabetes: a prospective cohort study using the GIANTT database (Grigory Sidorenkov, Jaco Voorham, D de Zeeuw, F M Haaijer-Ruskamp, P Denig) • Women's **safety alerts in maternity care**: is speaking up enough? (Susanna Rance, Christine McCourt, Juliet Rayment, Nicola Mackintosh, Wendy Carter, Kylie Watson, Jane Sandall) • Estimated nursing workload for the implementation of **ventilator bundles** (Westyn Branch-Elliman, Sharon B Wright, Jean M Gillis, M D Howell) • **Statistical process control charts** for attribute data involving very large sample sizes: a review of problems and solutions (Mohammed A Mohammed, Jagdeep S Panesar, David B Laney, Richard Wilson)
URL	http://qualitysafety.bmj.com/content/vol22/issue4/

BMJ Quality and Safety online first articles

Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Co-ACT—a framework for **observing coordination behaviour** in acute care teams (Michaela Kolbe, Michael Josef Burtscher, Tanja Manser)
URL	http://qualitysafety.bmj.com/onlinefirst.dtl

Online resources

[NSW] State Cardiac Reperfusion Program
http://www.archi.net.au/resources/safety/clinical/cardiac-reperfusion
Description of the NSW State Cardiac Reperfusion Program (SCRP) that sought to enhance care for high acuity patients by providing early diagnosis and treatment, including pre-hospital. The program is "a collaborative initiative providing equitable and early access to cardiac reperfusion to metropolitan and rural communities for patients with ST segment Elevation Myocardial Infarction (STEMI). These high acuity patients receive early diagnosis and treatment aimed at restoring coronary artery blood flow as close to symptom onset as possible."

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