AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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Reports

Expanding healthcare quality and patient safety reporting across Queensland's health system: Discussion paper
Queensland Health
Brisbane, State of Queensland (Queensland Health), July 2017. p.32.

URL	https://www.health.qld.gov.au/system-governance/strategic-direction/improving-service/expanding-patient-safety-reporting
Notes	The Queensland Government has produced this Discussion paper in an effort to elicit the views of the community about the collection, reporting and use of healthcare quality and patient safety information, particularly how healthcare quality and patient safety reporting may be expanded. The professed vision is to: • further enhance information available to patients; • improve transparency for healthcare professionals; • support the efforts of the stakeholders funding, reporting on and regulating healthcare services; and • continue to drive improvements that maintain Queensland's leading health system. The paper's release coincided with a COAG Health Council meeting at which health ministers discussed standardised patient safety and quality reporting data in all public and private hospitals.

General Surgery: GIRFT Programme National Speciality Report
Abercrombie J
London 2017. p. 58.

URL	http://gettingitrightfirsttime.co.uk/national-general-surgery-report-published-2/
Notes	The UK's Getting It Right First Time (GIRFT) Programme seeks to improve the quality of care by reducing unwarranted variations, bringing efficiencies and improving patient outcomes. The programme has just published its first report (of a planned 30). This report examines variation in general surgery. The report contains 20 recommendations aimed at improving general surgery in order to provide better outcomes for patients, and eliminate unwarranted differences between hospitals in areas such as effective procedures, length of stay, infection rates and procurement costs. The recommendations, spread across five themes, include: Theme 1: Data and performance measurement 1. Improve coding of emergency general surgical activity. 2. Introduce national policy levers to drive case ascertainment (completeness) in national audit programmes to a level approaching 100%. 3. Improve routine data collection quality. 4. Enhance national audit programmes by recording the number of patients with a relevant diagnosis, not just those who underwent a surgical procedure. 5. Design and progress implementation of an optimum care pathway for colorectal patients, and review national cancer targets in light of the resulting evidence. Theme 2: Procurement 6. Instigate pricing transparency in procurement for general surgery, and use the resulting insight to deliver more cost effective procurement. 7. Review options for consolidation of procurement at a national level. 8. Identify centres of good procurement performance, and understand what factors lead to the most favourable procurement prices. Theme 3: Choice, commissioning and care pathways 9. Require reversible risk factors to be addressed prior to non-urgent procedures, using a patient-centred approach utilising shared decision-making. 10. Where not already described, define optimal care pathways in national guidance so they can be implemented locally with minimal, if any, variation. Optimal care pathways already defined in guidance should be implemented locally with minimal, if any, variation. Theme 4: Surgical performance 11. Adopt a "zero-tolerance" approach to known avoidable surgical complications, on which there should be reliable data and national guidance. 12. Strengthen the clinical morbidity and mortality meetings by expanding the current focus on deaths and major complications. 13. Improve understanding of the causes of litigation and take action to reduce common errors that lead to claims. 14. Make available and require at appraisal surgeon-level intelligence on activity and outcomes. 15. Develop a means of identifying the best performing teams and enable others to visit them as part of continuing professional development (CPD). 16. Conduct a national review, assessing the NHS model of clinical autonomy against international comparators, with a view to reducing unwarranted variation in clinical practice. Theme 5: Efficiency and emergency provision 17. Require data to be collected routinely about operation duration to establish a measurable benchmark for different types of procedures.

	18. Undertake a capacity planning study to enable theatre capacity to be principally organised around emergency care. 19. Provide consultant-delivered emergency general surgery in each trust. 20. Require every trust to identify a consultant lead for emergency general surgery, with allocated time in their job plan. The report noted that not only are there variations in treatment and outcomes but there are also variations in cost/procurement. The report also suggests that a number of changes to practice around surgery could have significant impacts, including reducing costs. One of these also would see a significant reduction in the amount of people unnecessarily admitted for emergency general surgery if more acute hospitals introduced consultant-led surgical assessments at their 'front door'. The report's analysis estimates that could see o up to 30 per cent fewer general surgery emergency admissions a year where no operation is delivered, and could cut the NHS's annual cost for this from £361 million to £253 million. Other opportunities to improve patient care and outcomes, and deliver potential efficiencies of over £160m annually, include: • A reduction in the length of stay for elective colorectal surgery patients from the average of 10.2 days to the 5.5 days in the best performing hospitals, would ensure patients go home sooner and would free up to 84,000 bed days, equivalent to a saving of £23.6m. • A reduction in the length of stay for appendicectomy patients from an average of 3.5 days to 2 days would free up 30,000 bed days, equivalent to a cost reduction of £8.5m. • Reducing some hospitals' high levels of emergency readmission at 30 days for gall bladder surgery to the national average would save £1m in bed days. • If providers with high 30 day emergency readmission rates following appendicectomy reduced their readmission rates to the national average, this would free up £5.8m worth of bed days. • If all patients received gall bladder surgery within 14 days of diagnosis, as opposed to the national average of 23% of patients, more people would be treated in a timely fashion with fewer readmitted for later surgery, and up to £5m saved. • If all trusts reversed surgical stomas following colorectal cancer resection, where appropriate, in the recommended time frame of 6 months rather than 18 months, this would provide a better experience for patients and could save almost £2.4 million annually. • For a basket of surgical supplies, procurement costs varied from £1,467 to £2,336. If all hospitals procured these items at the lowest price, national costs would reduce by 59%.

For information the Commission's work on healthcare variation, see https://www.safetyandquality.gov.au/atlas/

IHI Framework for Improving Joy in Work. IHI White Paper
Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D
Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017.

URL	http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx
Notes	Burnout has been something of a recurring theme recently (for example, see the AHRQ *Physician Burnout* page described below). The [US] Institute for Healthcare

	Improvement (IHI) believes an important part of the solution is to focus on restoring joy to the health care workforce. This white paper is intended to serve as a guide for health care organisations in engaging in a process where leaders ask colleagues at all levels, "What matters to you?" — enabling them to better understand the barriers to joy in work, and co-create meaningful, high-leverage strategies to address these issues. The white paper describes the following: • The importance of joy in work (the "why"); • Four steps leaders can take to improve joy in work (the "how"); • The IHI Framework for Improving Joy in Work: nine critical components of a system for ensuring a joyful, engaged workforce (the "what"); • Key change ideas for improving joy in work, along with examples from organizations that helped test them; and • Measurement and assessment tools for gauging efforts to improve joy in work. Word matter and language is important and care might be needed when introducing topics such as 'joy in work' with burnt out, jaded and/or cynical colleagues.

Journal articles

A qualitative study on the implementation of quality systems in Australian hospitals
Leggat SG, Balding C
Health Services Management Research. 2017;30(3):179-86.

DOI	http://dx.doi.org/10.1177/0951484817715594
Notes	Paper describing a qualitative study of how 'quality' is done in Australian hospitals, largely influenced by the needs of accreditation. This study, based on document review, self-evaluation and qualitative data from interviews and focus groups of 270 board members, managers and staff, examined the implementation of quality systems in eight Australian public hospitals. The authors report finding that "'Quality' was consistently described as an 'extra' set of tasks to do, rather than a means to creating sustained, safe, quality care." While goodwill and positive intent abounded," a lack of understanding of how to effect change in the complexity of hospitals…led …to …a technical, top-down approach based on compliance and reactive risk." Thus the challenge may lie in how systems (and leaders) "supports and encourages meaningful staff engagement with creating safe, quality care".

Performance data and informed consent: a duty to disclose?
McWhirter RE
Medical Journal of Australia. 2017;207(3):100-1.

DOI	http://dx.doi.org/10.5694/mja16.01195
Notes	This article describes some legal precedents for disclosure of past performance, skill or experience to patients considering surgical services. The author observes: "Hospitals, colleges and other institutions increasingly collect, analyse and disseminate data relating to the performance of individual health practitioners, particularly those undertaking surgical procedures. Arguments have long been made for an ethical duty to disclose information regarding a practitioner's experience or skill to patients as part of the process of informed consent. Significantly, recent developments suggest that practitioners may, in some circumstances, have a legal duty to disclose their performance data to patients." While this article (cautiously) suggests greater use of performance data and more patient-centric care, it would seem that the information asymmetry that characterises health care will remain.

What works in implementation of integrated care programs for older adults with complex needs? A realist review
Kirst M, Im J, Burns T, Baker GR, Goldhar J, O'Campo P, et al
International Journal for Quality in Health Care. 2017.

DOI	https://doi.org/10.1093/intqhc/mzx095
Notes	Integrated care is seen by many as a means for improving care, particularly for those with chronic and/or complex care needs. This article describes a 'realist' review of the evaluative evidence on integrated care (IC) programs for older adults that sought to identify key processes leading to the success or failure of these programs in achieving outcomes such as reduced healthcare utilisation, improved patient health, and improved patient and caregiver experience. From the 65 articles analysed, the review found trusting **multidisciplinary team relationships** and **provider commitment** to and understanding of the model were important, along with contextual factors such as "strong **leadership** that sets clear goals and establishes an organizational **culture** in support of the program, along with joint **governance** structures, supported **team collaboration** and subsequent successful implementation. Furthermore, **time** to build an infrastructure to implement and **flexibility** in implementation, emerged as key processes instrumental to success of these programs."

Sharing the process of diagnostic decision making
Brush JE, Jr, Brophy JM
JAMA Internal Medicine. 2017.

DOI	http://dx.doi.org/10.1001/jamainternmed.2017.1929
Notes	The sharing of decision making has been widely encouraged when it comes to decisions about whether to treat and what treatment options to use. This viewpoint article suggests extending the shared decision making process back to an earlier point in the clinical process to that of diagnosis. The authors believe sharing the diagnosis process with patients will contribute to better diagnoses and "For clinicians, thoroughly understanding each step can help them look critically at their own practice, hone their skills, improve their performance, and involve patients and families in the process." The authors do discuss some of the issues and challenges, one of which is likely to be that of dealing with uncertainty and probabilities.

For information the Commission's work on shared decision making, see
https://www.safetyandquality.gov.au/our-work/shared-decision-making/

End-Of-Life Medical Spending In Last Twelve Months Of Life Is Lower Than Previously Reported
French EB, McCauley J, Aragon M, Bakx P, Chalkley M, Chen SH, et al
Health Affairs. 2017 July 1, 2017;36(7):1211-7.

DOI	http://dx.doi.org/10.1377/hlthaff.2017.0174
Notes	There has been a pervasive belief that health spending in the last year of life represents a large proportion of total health spending. This study examined health spending in nine countries found that "spending in the **last twelve months of life** accounted for **8.5–11.2** percent of overall" whereas "spending in the **last three years of life** accounted for as much as **24.5 percent** of overall costs". The authors argue that this "suggests that the focus should be on reducing the costs of caring for people with chronic conditions—many of whom are approaching death". Consequently, a change of end-of-life care such that "an appropriate mix of long-term care, hospice, and home care would ensure that only those patients who wanted and needed to be in hospitals were treated there. The primary payoff would be better quality care, along with modestly lower costs."

For information the Commission's work on end of life care, including the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*, see https://www.safetyandquality.gov.au/our-work/end-of-life-care-in-acute-hospitals/

Patient safety in dentistry: development of a candidate 'never event' list for primary care
Black I, Bowie P
British Dental Journal. 2017;222(10):782-8.

DOI	http://dx.doi.org/10.1038/sj.bdj.2017.456
Notes	Patient safety can have both universal and domain-specific elements. This paper looks at the domain of dentistry, specifically how it could inform a 'never event' list. Never events are, as they sound, a list of things that should never occur and for which measures to prevent them should be taken. This paper describes an attempt at developing a never list for primary care dentistry that encompassed a literature review, eight workshops with dental practitioners and a modified Delphi with 'expert' groups. 250 dental practitioners suggested 507 never events which were then reduced to 27 types grouped in seven themes. The most frequently occurring themes were: 'checking medical history and prescribing' and 'infection control and decontamination'. 'Experts' endorsed nine candidate never event statements with one graded as 'extreme risk' (failure to check past medical history) and four as 'high risk' (including, extracting wrong tooth).

Association of changing hospital readmission rates with mortality rates after hospital discharge
Dharmarajan K, Wang Y, Lin Z, et al
Journal of the American Medical Association. 2017;318(3):270-8.

DOI	http://dx.doi.org/10.1001/jama.2017.8444
Notes	This American cohort study used the records of more than 5 million [US] Medicare fee-for-service hospitalizations of older patients for heart failure, acute myocardial infarction, and pneumonia from 2008 to 2014 to examine the question of whether hospital readmission reductions associated with the Affordable Care Act (Obamacare) had the unintended consequence of increasing mortality after hospitalisation. The analyses revealed that "reductions in hospital 30-day readmission rates were weakly but significantly correlated with reductions in hospital 30-day mortality rates after discharge. These findings do not support increasing postdischarge mortality related to reducing hospital readmissions."

Risks of using medical record and administrative data for prognostic models
Alexander M, Evans SM, Wolfe R, Ball DL Burbury K.
Medical Journal of Australia. 2017;207(3):126.

DOI	http://dx.doi.org/10.5694/mja16.00919
Notes	This paper compares three different sources of data and their use for health outcome modelling of prognosis – medical records, administrative data discharge coding and a prospective cohort study of thoracic malignancies. While there was good agreement for some aspects of the patient data – such as staging – there was poor concordance on variables such as smoking status (38% vs 83%) and recording of co-morbidity (23% vs 68%) that might be used in modelling and monitoring of long-term health outcomes, with administrative data being the least correct.

Evidence for Health Decision Making — Beyond Randomized, Controlled Trials
Frieden TR
New England Journal of Medicine. 2017;377(5):465-75.

DOI	http://dx.doi.org/10.1056/NEJMra1614394
Notes	Article describing the benefits (and limitations) of various sources of evidence for policy and decision making. Sources addressed include randomised control trials (RCTs), meta analyses, systematic reviews, prospective and retrospective cohort studies, case-control studies, cross-sectional studies, ecological studies, observational studies, program-based evidence, case reports and series, and clinical registries. The author also touches on the question of 'big data'. The piece concludes by reminding us that the "goal must be actionable data — data that are sufficient for clinical and public health action that have been derived openly and objectively and that enable us to say 'Here's what I recommend and why.'"

Use of Cascading A3s to Drive Systemwide Improvement
Winner LE, Burroughs TJ, Cady-Reh JA, Hill R, Hody RE, Powers RL, et al
The Joint Commission Journal on Quality and Patient Safety. 2017 2017/08/01/;43(8):422-8.

DOI	https://doi.org/10.1016/j.jcjq.2017.03.011
Notes	Paper describing elements of the Johns Hopkins Medicine management system. Adopted from Toyota's approach, the A3 method captures the knowledge of frontline experts and "promotes both objectivity through data-driven root cause analysis of poor performance and collective selection and implementation of effective interventions to resolve performance gaps." The authors argue that this is "a disciplined way of collaborative problem solving" and the approach encourages a "workforce of problem solvers" and by using 'cascading A3s"' can also promote strategic alignment up and down the organization".

Health Affairs
1 August 2017; Vol. 36, No. 8

URL	http://content.healthaffairs.org/content/36/8.toc
Notes	A new issue of *Health Affairs* has been published, with the topics 'Consumerism, Competition, Drug Approval & More'. Articles in this issue of *Health Affairs* include: • **Medicare Competitive Bidding** Program Realized Price Savings For Durable Medical Equipment Purchases (David Newman, Eric Barrette, and Katharine McGraves-Lloyd) • Small Cash Incentives Can Encourage **Primary Care Visits** By **Low-Income People** With New Health Care Coverage (Cathy J Bradley and David Neumark) • Patients Are Not Given **Quality-Of-Care Data** About **Skilled Nursing Facilities** When Discharged From Hospitals (Denise A Tyler, Emily A Gadbois, John P McHugh, Renée R Shield, Ulrika Winblad, and Vincent Mor) • Americans Support **Price Shopping For Health Care**, But Few Actually Seek Out Price Information (Ateev Mehrotra, Katie M Dean, Anna D Sinaiko, and Neeraj Sood) • Offering A **Price Transparency Tool** Did Not Reduce Overall Spending Among California Public Employees And Retirees (Sunita Desai, Laura A Hatfield, Andrew L Hicks, Anna D Sinaiko, Michael E Chernew, David Cowling, Santosh Gautam, Sze-jung Wu, and Ateev Mehrotra) • Drugs Cleared Through The **FDA's Expedited Review** Offer Greater Gains Than Drugs Approved By Conventional Process (James D Chambers, Teja Thorat, Colby L Wilkinson, and Peter J Neumann)

	• HITECH Act Drove Large Gains In **Hospital Electronic Health Record Adoption** (Julia Adler-Milstein and Ashish K Jha) • In Madagascar, Use Of Health Care Services Increased When Fees Were Removed: Lessons For **Universal Health Coverage** (Andres Garchitorena, Ann C Miller, Laura F Cordier, Ranto Ramananjato, Victor R Rabeza, Megan Murray, Amber Cripps, Laura Hall, Paul Farmer, Michael Rich, Arthur Velo Orlan, Alexandre Rabemampionona, Germain Rakotozafy, Damoela Randriantsimaniry, Djordje Gikic, and Matthew H Bonds) • A Voucher System To Speed Review Could Promote A New Generation Of **Insecticides** To Fight **Vector-Borne Diseases** (David B Ridley, Jeffrey L Moe, and Nick Hamon) • Federally Qualified Health Center Clinicians And Staff Increasingly **Dissatisfied** With **Workplace Conditions** (Mark W Friedberg, Rachel O Reid, Justin W Timbie, Claude Setodji, Aaron Kofner, Beverly Weidmer, and Katherine Kahn) • The Population **Health Benefits** Of A **Healthy Lifestyle**: Life Expectancy Increased And Onset Of Disability Delayed (Neil Mehta and Mikko Myrskylä) • The Affordable Care Act Reduced **Socioeconomic Disparities** In Health Care Access (Kevin Griffith, Leigh Evans, and Jacob Bor) • The Battle Of The **Bundle**: Lessons From My Mother's Partial **Hip Replacement** (Timothy Hoff)

BMJ Quality and Safety online first articles

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Determining the optimal place and time for **procedural education** (Martin V Pusic, Marc M Triola) • Getting back on track: a systematic review of the outcomes of **remediation and rehabilitation programmes for healthcare professionals** with performance concerns (Jan-Willem Weenink, Rudolf B Kool, Ronald H Bartels, Gert P Westert) • **Malpractice claims** related to **diagnostic errors** in the hospital (Ashwin Gupta, Ashley Snyder, Allen Kachalia, Scott Flanders, Sanjay Saint, V Chopra) • Identifying patient and practice characteristics associated with **patient-reported experiences of safety problems and harm**: a cross-sectional study using a multilevel modelling approach (Ignacio Ricci-Cabello, David Reeves, Brian G Bell, Jose M Valderas) • Problems with **discharge summaries** produced by **electronic health records**: why are the vendors not named? (Walter Joseph O'Donnell) • Controlled trial to improve **resident sign-out** in a medical **intensive care unit** (Rahul Nanchal, Brian Aebly, Gabrielle Graves, Jonathon Truwit, Gagan Kumar, Amit Taneja, Gaurav Dagar, Jeanette Graf, Erin Hubertz, Vijaya Ramalingam, Kathlyn E Fletcher) • Nursing home **Facebook reviews**: who has them, and how do they relate to other measures of quality and experience? (Jennifer Gaudet Hefele, Yue Li, Lauren Campbell, Adrita Barooah, Joyce Wang)

International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-access?papetoc
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Dutch surgeons' views on the **volume–outcome mechanism in surgery**: A qualitative interview study (R Mesman; M J Faber; G P Westert; H J J M Berden) • What works in implementation of **integrated care** programs for older adults with **complex needs**? A realist review (Maritt Kirst; Jennifer Im; Tim Burns; G. Ross Baker; Jodeme Goldhar; Patricia O'Campo; Anne Wojtak; Walter P Wodchis) • **Attitudes towards accreditation** among hospital employees in Denmark: a cross-sectional survey (Lars Holger Ehlers; Morten Berg Jensen; Katherina Beltoft Simonsen; Gitte Sand Rasmussen ; Jeffrey Braithwaite) • The **patient-centered medical home**: a reality for HIV care in Nigeria (Aima A. Ahonkhai ; Ifeyinwa Onwuatuelo; Susan Regan; Abdulkabir Adegoke; Elena Losina; Bolanle Banigbe; Juliet Adeola; Timothy G Ferris; Prosper Okonkwo; Kenneth A Freedberg)

Online resources

Choose Physio
https://choose.physio/
This site is part of a campaign from the Australian Physiotherapy Association to increase consumer awareness of what physiotherapy encompasses and why physiotherapy could be chosen ahead of other treatment options.

[UK] NICE Guidelines and Quality Standards
https://www.nice.org.uk
The UK's National Institute for Health and Care Excellence (NICE) has published new (or updated) guidelines and quality standards. The latest reviews or updates are:

- NICE Guideline NG72 ***Developmental follow-up*** *of children and young people* ***born preterm***
  https://www.nice.org.uk/guidance/ng72
- Clinical Guideline CG160 ***Fever in under 5s:*** *assessment and initial management*
  https://www.nice.org.uk/guidance/cg160
- Clinical Guideline CG32 ***Nutrition support*** *for adults: oral nutrition support, enteral tube feeding and parenteral nutrition* https://www.nice.org.uk/guidance/cg32

[UK] A journey to improved staff engagement
http://www.nhsemployers.org/case-studies-and-resources/2017/08/in-your-shoes-imperial-case-study
Case study from London's Imperial College Healthcare NHS Trust describing how they significantly improved their staff engagement levels. This change was driven by engaging with staff to understand more about how they are feeling at work including through the Our Voice, Our Trust survey, the In Our Shoes initiative and the You Said, We Did feedback video. The case study also includes the key 'top tips' from the Trust's perspective.

[USA] Physician Burnout
https://www.ahrq.gov/professionals/clinicians-providers/ahrq-works/burnout/index.html
The Agency for Healthcare Research and Quality (AHRQ) has produced this page summarising what is known about burnout, what are some of the cause and some interventions that can assist. "Burnout is a long-term stress reaction marked by emotional exhaustion, depersonalization, and a lack of sense of personal accomplishment. … Burned-out doctors are more likely to leave practice, which reduces patients' access to and continuity of care. Burnout can also threaten patient safety and care quality when depersonalization leads to poor interactions with patients and when burned-out physicians suffer from impaired attention, memory, and executive function."

[USA] Effective Health Care Program reports
https://effectivehealthcare.ahrq.gov/
The US Agency for Healthcare Research and Quality (AHRQ) has an Effective Health Care (EHC) Program. The EHC has released the following final reports and updates:

- **Omega-3 Fatty Acids and Cardiovascular Disease**
  Clinician summary:
  Omega-3 Fatty Acids and Cardiovascular Disease: Current State of the Evidence
  http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=2491
  Consumer summary:
  Omega-3 Fatty Acids and Cardiovascular Disease: A Review of the Research for Adults
  http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=2490

- **Insomnia Disorder**
  Clinician summary:
  Management of Insomnia Disorder in Adults: Current State of the Evidence
  http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=2493
  Consumer summary:
  Managing Insomnia Disorder: A Review of the Research for Adults
  http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=2492
