AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
Editor: Dr Niall Johnson niall.johnson@safetyandquality.gov.au
Contributors: Niall Johnson, Lilly Crino

Reports

Review of Safety and Quality in the WA health system: A strategy for continuous improvement
Mascie-Taylor H, Hoddinott J
Perth: Government of Western Australia, Department of Health; 2017. p.60.

URL	http://ww2.health.wa.gov.au/Improving-WA-Health/Safety-and-quality-review
Notes	The Western Australian Department of Health commissioned a team led by Professor Hugo Mascie-Taylor to conduct a review of safety and quality in the WA health system. Sometimes such reviews are prompted by major failures or crises. The WA review is positioned as a "pro-active measure focused on the effectiveness of current system-wide arrangements, strategic priorities for safety and quality, and on areas for improvement and future development." The review made 28 recommendations grouped into: • *Roles, responsibilities and accountabilities* — performance reporting, regular state-wide safety and quality appropriate system tension and challenges, and change management. • *Governance structures, groups and committees* — Board oversight, Board and Safety & Quality sub-committees/working groups, clinical risk management, and clinical leadership, professionalism and performance management. • *System policies and standards* — policies and standards, publishing safety and quality performance information, consumer engagement, and clinical audit.

	• *System oversight and assurance* (including governance arrangements, monitoring and benchmarking, licensing and accreditation) — Consistent standards across all providers, assurance requirements, facilitation and support, clear models for intervention, benchmarking performance, collaborative working, system oversight of public private partnerships, system oversight of mental health services, and volume quality assurances. • *Systemwide strategic priorities for safety and quality* including supporting systemwide improvement and innovation — setting improvement goals, clinical incident reporting, and feedback and implementing learning from safety and quality monitoring.

Items which should not routinely be prescribed in primary care: A Consultation on guidance for CCGs
NHS England
London: NHS England; 2017. p. 48.

URL	https://www.england.nhs.uk/2017/07/medicine-consultation/
Notes	NHS England has published detailed plans (drawn up with general practitioners and pharmacists) to **reduce or eliminate prescriptions for ineffective, over-priced and low value treatments**. A formal public consultation is being launched on new national guidelines which state that 18 treatments – including homeopathy and herbal treatments – which together cost taxpayers £141 million a year should generally not be prescribed. The consultation also covers a further 3,200 prescription items, many of which are readily available and sold 'over the counter' in pharmacies, supermarkets, petrol stations, and other retailers, often at a significantly lower price than the cost to the NHS.

New approaches to value in health and care
Redding D
London: Realising the value; 2017. p. 21.

URL	https://www.health.org.uk/publication/new-approaches-value-health-and-care
Notes	The UK's Health Foundation has published this report from the Realising the value programme. The programme sought to consolidate what is known about person- and community-centred approaches for health and wellbeing, and make recommendations on how they can have maximum impact. This particular report includes 'calls to action' to ensure that the approach to understanding, capturing, measuring and assessing value in health and care takes full account of value, as it is experienced and created by people and communities. The paper's calls to action include: • basing core national measures on the health and wellbeing outcomes that are most important to people and communities • prioritising support for commissioners to build skills, knowledge and confidence to commission for the outcomes that people and communities value • developing methods for aggregating personalised and community-level outcomes into population-level data • researching the use of person-centred outcome measures or patient reported outcome measures (PROMs).

Journal articles

New diagnostic tests: more harm than good
Hofmann B, Welch HG
BMJ. 2017;358:j3314.

DOI	https://doi.org/10.1136/bmj.j3314
Notes	Piece taking a somewhat sceptical view of the future of diagnostics. The piece's key messages include anticipating that innovative technologies and venture capital are combining to produce new disease biomarkers and mobile monitoring devices and that these technologically advanced diagnostics does not mean that they will automatically contribute to improvements in clinical care and population health. They may well have the potential to help some people, but may also contribute to as increase in the frequency of false alarms, overdiagnosis, and overtreatment in others. The authors also worry that excessive testing and false alarms may increase healthcare workload and shift clinicians' focus towards the healthy and that clinicians must provide a strong counterbalance: educating patients, respecting baseline risk, thinking downstream, and expecting misleading feedback. The authors' summary finishes "Diagnostic efforts can start a cascade of events that turn well people into ill patients. We must **develop new diagnostic tests to tackle real health problems, not to generate them**."

The evolving story of overlapping surgery
Mello MM, Livingston EH
Journal of the American Medical Association. 2017;318(3):233-4.

DOI	10.1001/jama.2017.8061
Notes	The (literally in this instance) operational aspects of healthcare (and hospitals) is a realm unknown to many consumers and patients. This Viewpoint piece touches on a subject that may well surprise, if not shock, them as it discusses overlapping AND concurrent surgery. Overlapping surgery "refers to operations performed by the same primary surgeon such that the start of one surgery overlaps with the end of another. A qualified practitioner finishes noncritical aspects of the first operation while the primary surgeon moves to the next operation." This is apparently common practice, ranging from having trainees open and close incisions to delegating all aspects of the operation except the critical parts. Concurrent surgery is surgery "in which 'critical parts' of operations for which the primary surgeon is responsible occur during the same time". The authors observe that "There re is general agreement that **concurrent surgery is ethically unacceptable** and is prohibited for teaching hospitals under the [US] Medicare Conditions of Participation." The authors discuss some of the risks and issues around overlapping surgery.

Patients' Hand Washing and Reducing Hospital-Acquired Infection
Haverstick S, Goodrich C, Freeman R, James S, Kullar R, Ahrens M
Critical Care Nurse. 2017 June 1, 2017;37(3):e1-e8.

DOI	https://dx.doi.org/10.4037/ccn2017694
Notes	Further addition to the literature on the value of hand hygiene in health facilities. This study, in a cardiothoracic post-surgical step-down unit looked at the impact of hand hygiene education for patients and greater availability of hand sanitizer. It's recognised that good hand hygiene by patients (and families, carers and visitors) – along with good hygiene by health care workers – can have a major impact on infection rates. Many facilities have made hand hygiene resources widely available and seek to encourage everyone to practice good hand hygiene when they are in a health facility.

For information the Commission's work on healthcare associated infection, including hand hygiene, see https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/

Decommissioning health care: identifying best practice through primary and secondary research a prospective mixed-methods study
Williams I, Harlock J, Robert G, Mannion R, Brearley S, Hall K
Health Services and Delivery Research. 2017;5(22).

DOI	https://dx.doi.org/10.3310/hsdr05220
Notes	The challenge to have things funded under national healthcare systems often seems to pale in comparison with getting things removed or decommissioned. Decommissioning – defined here as "the planned process of removing, reducing or replacing health-care services"– has seen more attention paid to with the greater attention on value and costs. However, it is often a difficult process that can be emotive, fraught with misinformation and vested interests. This UK study sought to derive formulate theoretically grounded, evidence-informed guidance to support best practice in effective decommissioning of services in the English NHS. The authors found that there is a lack of robust evidence to guide decommissioning, but among experts there is a high level of consensus for three good-practice principles: • Establish a strong leadership team • Engage clinical leaders from an early stage • Establish a clear rationale for change.

Public Health Research & Practice
July 2017, Volume 27, Issue 3

URL	http://www.phrp.com.au/issues/july-2017-volume-27-issue-3/
Notes	A new issue of *Public Health Research & Practice* has been published. This issue is a special edition examining the theme of **cancer screening**, and the concerns, controversy and evidence around its benefits and potential harms. Articles in this issue of *Public Health Research & Practice* include: • Editorial: **Cancer screening**: concerns, controversy and evidence (Sarah McGill, Stacy M Carter) • PSA testing for men at average risk of **prostate cancer** (Bruce K Armstrong, Michael J Barry, Mark Frydenberg, Robert A Gardiner, I Haines, S M Carter) • What is **overdiagnosis** and why should we take it seriously in **cancer screening**? (Stacy M Carter, Alexandra Barratt) • Shangri-La and the **integration of mental health care** in Australia (Sebastian Rosenberg) • Why the **public health sector** couldn't create **Pokémon Go** (Becky Freeman, Josephine Chau, Seema Mihrshahi) • History, development and future of **cancer screening** in Australia (Ian N Olver, David Roder) • Clinical consultations and investigations before and after discontinuation of **endocrine therapy** in women with **primary breast cancer** (Derrick Lopez, Anna Kemp-Casey, C Saunders, E Roughead, F Boyle, M Bulsara, D Preen) • Assessing the **efficacy of cancer screening** (Gemma Jacklyn, Katy Bell, Andrew Hayen) • Improving communication about **cancer screening**: moving towards informed **decision making** (Jolyn K Hersch, Brooke L Nickel, Alex Ghanouni, Jesse Jansen, Kirsten J McCaffery)

	• Developing an alternative **alcohol advertising** complaint review system: lessons from a world-first public health advocacy initiative (Hannah L Pierce, Julia M Stafford, Mike Daube)

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: • Editorial: The personal and the organisational perspective on **iatrogenic harm**: bridging the gap through **reconciliation** processes (Graham P Martin, Sarah Chew, Thomas R Palser) • Simple example of a practical solution to make **patient feedback** more useful (L Marjon Dijkema, Lisa W Dummer, Jasmijn D Generaal, Merel B Klunder, Anna Bouwknegt, Frederik Keus, Iwan C C van der Horst) • **Measurement** with a wink (Marleen Kunneman, V M Montori, N D Shah) • Reliable adherence to a **COPD care bundle** mitigates system-level failures and reduces COPD readmissions: a system redesign using improvement science (Muhammad Ahsan Zafar, Ralph J Panos, Jonathan Ko, Lisa C Otten, Anthony Gentene, M Guido, K Clark, C Lee, J Robertson, E A Alessandrini) • Editorial: Speaking up against **unsafe unprofessional behaviours**: the difficulty in knowing when and how (Brian M Wong, Shiphra Ginsburg) • **Keep calm**… and prepare (Tobias Gauss, Fabrice Cook)

Online resources

Improving your organisation's health literacy environment
https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/tools-and-resources-for-health-service-organisations/
The Australian Commission on Safety and Quality in Health has developed five fact sheets to support health service organisation's improve their health literacy environment. The next version of the National Safety and Quality Health Service (NSQHS) Standards has a greater emphasis on partnerships with consumers and embedding health literacy into your organisation's systems. These fact sheets link staff working in quality improvement to a range of tools and examples to help you plan how to improve your organisation's health literacy environment.

- *An introduction to improving health literacy in your organisation*
- *Making health literacy part of your policies and processes*
- *Making way-finding easier*
- *Writing health information for consumers*
- *Supporting staff to meet health literacy needs.*

[UK] Measuring and monitoring of safety framework e-guide: better questions, safer care
http://www.haelo.org.uk/patientsafetyguide
This guide has been produced in the UK in conjunction with Advancing Quality Alliance, UK Improvement Alliance, Health Improvement Scotland and the Improvement Academy. The guide is a tool to help organisation use the Measuring and Monitoring of Safety Framework (MMSF) to review their safety of care. The guide has a number of resources to assist health and care professionals to take a more holistic approach when looking at the safety of care. It also offers detailed case studies and templates spanning roles from board to ward, and across ambulance, acute, mental health and primary care settings.

[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 NG12 ***Suspected cancer****: recognition and referral*
  https://www.nice.org.uk/guidance/ng12
- Quality Standard QS5 ***Chronic kidney disease*** *in adults*
  https://www.nice.org.uk/guidance/qs5
- Quality Standard QS155 ***Low back pain*** *and* ***sciatica*** *in over 16s*
  https://www.nice.org.uk/guidance/qs155

[UK] Obsessive Compulsive Disorder
http://www.dc.nihr.ac.uk/highlights/ocd/
The UK's National Institute for Health Research (NIHR) have produced this Highlight review of NIHR research into the management and treatment of Obsessive Compulsive Disorder (OCD). The Highlight features research into psychological and pharmacological treatment options and new research on using self-help materials, combined with modest levels of support from mental health practitioners.
