From the Editor’s chair


In this edition, we look at a range of issues, from quality and safety in clinical settings, to running cost-effective health systems, evaluating health programs and providing patient-centred care.

Hospital performance and reform, and overtreatment and overdiagnosis, have continued to inspire debate in recent months. We also canvass them here.

In addition to regular features such as Australian and international research and reports, we have introduced some new content to the Bulletin. In this issue we profile the Clinical Excellence Commission’s Patient Safety Manager Bronwyn Shumack, whose work on human behaviour in health systems earned her a HARC Scholarship. We have also added a selection of news, including a wrap-up of the last HARC Forum.

The next Forum is not far away, so save the date for May 13. Dr Mark Graber, an international authority on diagnostic error in medicine, will be keynote speaker. His views on the role of diagnosis in defining quality and safety in health care are featured in this edition’s research highlights.

As always, we welcome your feedback and suggestions, and our contact details can be found at the end of Bulletin.

Jacqui Jones
Editor
HARC e-Bulletin
HARC Forum: A compassionate approach to cultural change

Evidence-based solutions that promote teamwork, accord with patient perceptions, and encourage compassion in clinical practice, are key to helping hospitals improve the patient experience, the 8th HARC Forum heard.

Fred Lee, consultant and author of *If Disney Ran Your Hospital: 9½ Things You Would Do Differently*, told the audience that asking patients about their perceptions, rather than simply attempting to satisfy their physical needs, would move healthcare systems from “good” to “great”.

Improvement had to be evidence based, but it could be as simple as tracking patient feedback, he said.

“This is not about making it more complicated to improve, it’s to make it more scientific in our improvement.

“A person’s emotions also affect healing; don’t leave that out of the clinical discussion.”

More than 120 researchers, health managers, clinicians and policy makers attended the September Forum: Hospital culture: effecting change, held in Sydney and hosted by ABC National Medical Reporter Sophie Scott.

Mr Lee said that hospitals were a service industry and, like Disney, should be concerned with the emotional experience of human beings: in Disney’s case fun and, often for hospitals, tragedy.

Recognising the value of compassion in reducing patient stress and aiding healing was crucial, and could be as simple as a nurse making a comforting gesture to a cancer patient or a phlebotomist using conversation to distract someone having a blood test.

He said improving quality from the bottom ranks up, examining what made the best departments and services good, teamwork and discussion, were important.

Professor Jeffrey Braithwaite, Foundation Director, Australian Institute of Health Innovation, University of New South Wales, also addressed the Forum. While changing culture was not easy, patient need should be the starting point, he said.

*Save the date for the 9th HARC Forum to be held on May 13 at Aerial UTS Function Centre. More details will be sent to members soon.*
Overtreatment and overdiagnosis in the spotlight

Since its launch a year ago, the US Choosing Wisely campaign to eliminate unnecessary medical tests and treatments has gained significant momentum, with 35 specialty societies now signed up compared with the original nine.

In February, 17 societies unveiled new lists of ‘Things Physicians and Patients Should Question’. These are evidence-based recommendations to assist in decision making about most appropriate care. They include advice such as ‘CT scans are unnecessary in the immediate evaluation of minor head injuries’ and ‘don’t perform annual cervical cytology screening for women aged 30 to 65’.

The campaign is run by the American Board of Internal Medicine Foundation.

The British Medical Journal added its voice to the overdiagnosis debate in February, launching a Too Much Medicine campaign to increase awareness of the benefits and harms of treatments and technologies and develop ways to wind back medical excess.

In Australia, the University sector website The Conversation ran a series on overdiagnosis and MJA Insight drew attention to the issue with an article from emergency physician Dr Sue Ieraci.

Writing about experiences of an early management of severe trauma (EMST) protocol, Dr Ieraci said this logical system seemed to be used increasingly for every patient with trauma; a robot-like repetition of tests that bypassed clinical logic. She said a more rational application of EMST principles could save patients from some unnecessary testing.

Breast cancer screening and overdiagnosis has been the subject of intense discussion in the past few months. A New England Journal of Medicine study published in November suggested mammography screening was associated with “substantial overdiagnosis” of breast cancer. In the past 30 years, 1.3million US women may have had breast tumours detected by screening that would never have led to clinical symptoms, the authors estimated. However, the study caused controversy, and was described by some as an unsupported attack on mammography that should never have passed peer review.

In the UK, The Lancet published findings from an independent panel of British experts highlighting the level of breast cancer overdiagnosis.

The panel, headed by director of the Institute of Health Equity at University College, London, Professor Sir Michael Marmot, examined a range of studies, including 11 randomised trials of breast cancer screening. It said that women needed to be fully informed of the risks and benefits of screening.

And the discussion prompted calls for Australian doctors to better inform women of overdiagnosis risks.

Clicking on to clinical trials

An online information source about clinical trials aims to increase consumer knowledge of medical research and act as a reference guide for industry and researchers.

The Federal Government Australian Clinical Trials website gives patients information on how to become involved in clinical trials, advises industry on advantages of working in Australia, and provides researchers with legal and regulatory guidelines.

The website was a recommendation of a Clinical Trials Action Group report released in March 2011.

The group was established to identify and progress reforms to secure Australia’s competitiveness in the clinical trials sector.
Quality, safety and performance measurement

Workplace aggression a significant professional health issue

A survey of Australian medical practitioners has found 70.6% experienced verbal or written aggression in the workplace and 32.3% experienced physical aggression.

The research, published in the Medical Journal of Australia, is described as the first national study of medical workplace aggression.

It examined the experiences of 3515 GPs and GP registrars, 3875 specialists, 117 hospital non-specialists and 888 specialists in training, over one year.

Female clinicians, international medical graduates and hospital-based clinicians were more likely to experience workplace aggression, the study found.

And hospital-based, younger and less experienced non-specialists and specialists in training were up to twice as likely to experience aggression compared with GPs or specialists.

Patients were the most common source of aggression, followed by patients’ relatives or carers, and co-workers.

The study said that beyond the physical and mental health effects on clinicians, workplace aggression could cause loss of confidence or enthusiasm for treating patients and increase medical errors. It could also affect medical retention and recruitment.

Workplace aggression was a significant professional, occupational safety and public health issue, the authors said. They urged legislators, policy makers, health services and the medical profession to develop strategies to minimise prevalence.


Disruptive doctor behaviour a barrier to effective care

A feature in American Nurse Today highlights how disruptive doctor behaviour, such as inappropriate language or actions, can create barriers to effective care.

It cites a 2011 survey of American physicians in which 70% reported disruptive behaviour occurring at least once a month in their organisation. Ten per cent said it happened daily.

Nurses reported similar findings in a separate survey. Many believed disruptive behaviour contributed to poor postoperative care, incorrect or delayed medication orders and prolonged patient suffering when doctors failed to answer pages or return calls.

Examples of disruptive behaviour included being yelled at for making or witnessing a mistake, or other forms of intimidation, abuse or disrespect.

Suggested advice for addressing disruptive behaviour included: direct confrontation; making use of organisational reporting policies; creating a positive work environment through training; and promoting a culture of respect.

Don’t discount diagnosis, doctors urge

The role of diagnosis is being overlooked in the focus on improving the quality and safety of medical treatment, according to doctors writing in *JAMA*.

In a viewpoint piece, doctors from the research institute RTI International, University of California and the American Board of Internal Medicine, said diagnosis and treatment needed equal emphasis in defining quality and safety in health care.

“Not only is diagnosis critically important to patients, but improving diagnostic skill lies at the heart of efforts to rein in escalating costs of health care,” the authors said.

They said cases of delayed, missed and incorrect diagnosis were common, with an incidence of 10% to 20%, and diagnostic errors accounted for 40,000 to 80,000 deaths a year. The authors cited a survey of more than 6000 physicians, published on medical website QuantiaMD, that found 96% felt diagnostic errors were preventable.

Data collection on errors was needed to improve the diagnostic process, but resources were being devoted to already overrepresented management issues, the authors argued.

A focus on using the most appropriate diagnostic strategies could save billions of dollars, with additional savings to be made in reducing the harm caused by diagnostic errors.

The article said a new emphasis on diagnosis should begin in medical school, and extend to the policy arena and professional societies.

Graber ML, Wachter RM, Cassel, CK. Bringing Diagnosis Into the Quality and Safety Equations. *JAMA* 2012; 308(12):1211–1212

Telephone triage has minimal impact, research shows

West Australian researchers have sparked debate about the appropriateness of referrals from the federally-funded 24-hour telephone health advice line Healthdirect and the availability of after-hours care. A study published in the *Medical Journal of Australia*, conducted at Royal Perth Hospital emergency department from August 2008 to April 2009, used the phone line’s database to cross check Healthdirect advice with emergency department data.

From July 2008 to June 2009, the phone line answered 573,160 calls, mostly from people concerned about symptoms, though some asked for health information and service locations.

Recommendations to callers included: to attend an emergency department by ambulance or their own transport; attend a general practice within four to 24 hours; attend a general practice within 72 hours to two weeks; provide self-care (with advice given); or use other services.

During the study period there were 42,060 attendances to the Royal Perth Hospital emergency department, of which there were 720 Healthdirect-referred patients, 33,244 self-referred, 3814 GP-referred, and 4282 from other sources.

The Healthdirect-referred patients were significantly younger than patients in the other groups, more likely to be female and more likely to attend the emergency department out of hours.

The researchers found that referrals from GPs were significantly more appropriate than those from the other groups and that the impact of telephone triage was minimal.
More than half the Healthdirect-referred patients attended the emergency department despite a contrary recommendation.

The authors said this highlighted issues with access to after-hours health services.


**Suggestions for making fairer performance comparisons between hospitals**

A study of emergency department waiting time data has highlighted the challenges involved with publicly reporting hospital performance data and making fair comparisons.

The research, published in the *Medical Journal of Australia*¹ used publicly available data from the federal MyHospitals website to examine whether the reported urgency mix of an emergency department’s patients was associated with its waiting time performance.

An analysis of 158 hospitals showed that EDs with a higher proportion of patients assigned to the emergency category had poorer waiting time performance, while EDs with a higher proportion of patients assigned to the non-urgent category performed better.

The authors suggested that EDs with higher proportions of more urgent patients were disadvantaged under the present reporting system.

Adjusting performance scores according to the urgency mix of patients and the size of hospitals would allow fairer comparisons, the paper said.

**Quality measures for surgery**

Hospital rating is also the subject of another paper in *Health Services Research*², which looks at measures of quality for major surgery.

The US study argues the case for fairer comparisons between centres, with use of a composite measure that is a weighted average of all available quality indicators, such as mortality and complication rates for procedures, and hospital characteristics including volume, staffing ratios and teaching status.

“Composite measures of surgical quality are very effective at predicting hospital mortality rates with major procedures,” the authors said.

“Such measures would be more informative than existing quality indicators in helping patients and payers identify high-quality hospitals with specific procedures.”

**Evaluating indicators ‘paramount’**

An Italian research team has assessed hospital performance reporting schemes to evaluate whether they were associated with a change in quality indicators.

The *Health Services Research* study³ compared an evaluation program used in one geographic region, with regions that had no such programs. It focused on the common conditions of heart attack, hip fracture and caesarean birth.

The region with the evaluation program reported an increase in the proportion of hip fracture patients operated on within 48 hours. There was no relevant change for hip fracture in the other regions, suggesting an association between reporting results and improvement in orthopaedic hospital care.
However, treatment of heart attack patients improved in all regions and no progress was made in reducing unnecessary caesarean births.

“Reporting of performance data may have a positive but limited impact on quality improvement,” the authors said.

“The evaluation of quality indicators remains paramount for public accountability.”


Cost-effective health systems

Electronic records can improve diabetes care

US researchers have outlined a cost-effective case for greater use of electronic medical records in clinical decision support.

The researchers used as a basis, a system implemented in a large medical group providing care to about 9000 adults with diabetes. The electronic medical record (EMR)-based clinical decision support (CDS) system was developed to inform clinical care for type 2 diabetes patients aged 18 to 75.

“EMRs can be programmed to include sophisticated algorithms that take advantage of current and past clinical information to provide detailed recommendations at the time of a clinical encounter,” their paper said.

Clinical outcome and cost data from a randomised clinical trial of EMR-based CDS were used as inputs into a diabetes simulation model. The simulation cohort included 1092 diabetes patients with HbA1c above goal at baseline.

The findings, published in Health Services Research, included that patients in the intervention group had significantly lower HbA1c (0.26%) relative to patients in the control arm. Intervention costs were $120 per patient in the first year and $76 a patient in the following years. EMR-based CDS increased lifetime quality-adjusted life years (QALYs) by 0.04 and increased lifetime costs by $112, resulting in an incremental cost-effectiveness ratio of $3017 per QALY.

The authors concluded that integrated EMR-based CDS systems had the potential to modestly improve diabetes care for millions of people enrolled in health plans using EMRs. Such systems could be implemented without substantially increasing costs to health care.

The economics of vaccination

UK health economists have examined the case for invasive pneumococcal disease vaccination and found it is only cost-effective in certain high-risk groups.

Their research, published in the BMJ, reviewed the cost effectiveness of using the 13 valent pneumococcal conjugate vaccine in people aged two and older who were at increased risk of invasive pneumococcal disease due to chronic kidney disease, splenic dysfunction, HIV infection, a compromised immune system, chronic heart, liver, or respiratory disease, or diabetes.

They found that vaccinating all high-risk groups would have a large impact on budgets, requiring about 4.1 million vaccine doses at a cost of about £233 million. But they said targeting specific high-risk groups could reduce the costs substantially.

Only vaccination of patients with chronic liver disease was deemed cost effective and the second most favourable at-risk group was people infected with HIV. The authors concluded it was unlikely that a broader pneumococcal vaccination program aimed at risk groups could be considered cost effective.


Geographic-based health spending a blunt instrument: study

A NEJM study has cast doubt on healthcare spending policy that proposes geographic-based payment reform.

The study compared variation in healthcare spending and use of services among 306 hospital referral regions and 3436 hospital service areas, finding substantial local variation.

The work also highlighted that many low-spending hospital service areas were located in high-spending hospital referral regions and many high-spending areas were in low-spending regions.

The authors said many policy proposals suggested targeting high-spending areas for lower Medicare payments or other coverage constraints.

This was in response to evidence of wide geographic variation in health care spending that was not driven by patient characteristics and not associated with quality of care or patient outcomes.

Effectiveness of policies to reduce overuse and maintain access to high-quality care would depend on effective targeting, the researchers said. If there was substantial variation across local areas within hospital referral regions, then focusing on high-cost regions might leave many high-spending locales untouched while inadvertently penalising some low-spending locales.

"...Policies focused exclusively on the HRR [hospital referral region] may be too blunt to promote the best use of health care resources," the authors said.

Evaluating health programs

General health checks “not supported by evidence”

While general health checks have long been common elements of healthcare systems in many countries, Danish researchers say evidence for their effectiveness has been lacking.

Specialists from the Nordic Cochrane Centre reviewed randomised trials comparing health checks with no health checks in adults. Their paper, published in the BMJ, said screening for disease or risk factors had potential benefits, such as reducing morbidity and prolonging life. But possible harms included over-diagnosis, over-treatment and distress for patients. Health checks could also be expensive, the authors said.

In the trials studied, health checks took place in general practice, screening clinics, workplaces and hospitals. The study found that general health checks did not reduce morbidity or mortality, but did increase the number of new diagnoses. Present use of general health checks was not supported by the best available evidence, the paper said.


Structured approach improves blood pressure control

A program of structured care could optimise blood pressure control say Australian specialists writing in the BMJ.

Their study analysed the effectiveness of intensive structured care to optimise blood pressure control based on individual absolute risk targets in primary care.

The structured care program used computer-assisted clinical profiling, risk target setting and drug treatment to manage blood pressure.

The randomised controlled trial involved 2185 patients from 119 general practices.

It found an 8.8% absolute difference in individual blood pressure target achieved at 26 weeks in favour of the intervention group compared with the usual care group.

The authors said that although hypertension was a readily detectable and modifiable condition, it was responsible for more deaths worldwide than any other cardiovascular risk factor, including tobacco use, obesity and lipid disorders.

“... A structured blood pressure management approach (computer assisted) results in higher blood pressure control rates in a primary care setting,” the study said.


Online tool may reduce chronic disease burden on hospitals

An online program offered to privately insured patients with chronic disease can help decrease hospital admissions, readmissions and average length of hospital stay, a study shows.
The research, published online ahead of print in Population Health Management, looked at HCF’s My Health Guardian (MHG) program, which provides fund members with online tools for a healthy lifestyle and a chronic disease management program. The researchers, from HCF and disease management services provider Healthways, enlisted adult members of the health fund diagnosed with diabetes and heart disease.

The intervention group comprised 5053 members who enrolled in the MHG program. The comparison group comprised 23,077 members who met program eligibility requirements but were not contacted or did not enrol. After 12 and 18 months, treatment members displayed decreases in admissions and readmissions and in average length of hospital stay after 18 months, compared with the comparison group. The magnitude of effect increased over time.

"These results show that MHG successfully reduced the frequency and duration of hospital admissions and presents a promising approach to reduce the burden associated with hospitalisations in populations with chronic disease," the authors said.


### Patient-centred care

#### Managing multimorbidity

The challenge of managing multimorbidity has been addressed in recent editions of the BMJ.

In an editorial, Australian and UK primary care and health services research specialists looked at the challenge of managing patients with mental and physical multimorbidity.

University of Glasgow Professor Stewart Mercer and colleagues said that for patients and health professionals, managing more than one chronic condition was a challenge, particularly when physical and mental health problems were involved.

"When the mix of conditions experienced includes both physical and mental health problems ... the poorly stitched seams of professional care are at their most threadbare," the authors said.

They argued the case for changes in key areas: policy needed to provide greater integration between physical and mental healthcare and tackle the social determinants of health; research required shifts in design, funding and outcomes to produce more and broader studies on patients with multimorbidity; and clinical practice needed to develop new approaches to caring holistically for patients with mental-physical multimorbidity.

#### Adapting guidelines

In a separate analysis, University of Dundee Professor Bruce Guthrie and colleagues said care of patients with multimorbidity could be improved if new technology could bring together guidelines on individual conditions and tailor advice to patient circumstances.

While most people with chronic conditions had multimorbidity, clinical guidelines almost entirely focused on single conditions, they said.

They suggested that more useful guidelines were those that brought together recommendations for different chronic conditions and which identified synergies, cautions and contradictions.
Electronic formats had a major role to play, with an ability to cross reference guidelines – rather than clinicians and patients reading separate documents for every condition – and present the best information on benefits, harms cost and other factors in the most concise way.

**Understanding patient preferences**

Specialists from the US Dartmouth Center for Health Care Delivery Science also wrote in the *Journal* that understanding patient preferences was key to providing good medical treatment but was often ignored.

“Doctors, generalists as well as specialists, cannot recommend the right treatment without understanding how the patient values the trade-offs,” they wrote.

“Regrettably, patients’ preferences are often misdiagnosed.”

The authors cited research on breast reconstruction decisions to illustrate gaps between what patients want and what doctors think they want. Doctors believed that 71% of patients with breast cancer rated keeping their breast as a top priority, but the figure reported by patients was just 7%.

The article outlined a method for making better preference diagnoses. That is, what a patient would choose if he or she were a fully-informed decision maker.

The three-step method involves: adopting a mindset of scientific detachment; using data to formulate a provisional diagnosis; and engaging the patient in conversation and deliberation.

Meanwhile, a *BMJ* essay by former NHS chief executive Nigel Crisp contends that the power of the patient should be central to health reforms in England and elsewhere in the world.

Now a crossbencher in the House of Lords, Lord Crisp said no country had yet been successful in giving its citizens a truly central role in improving health and healthcare, preferring instead to rely on economic and professional levers.

“People are defined in terms of economic and professional frameworks and are reduced to being mere consumers in need of satisfying or passive patients in need of treatment or education,” he said.

“They are not seen as active participants in their own right.”

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4. Crisp N. Patient power needs to be built on strong intellectual foundations: an essay by Nigel Crisp. *BMJ* 2012;345:e61

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**Satisfying patients could improve performance scores**

A telephone survey across 14 US geographical areas has shown that healthcare providers who take action to improve patient satisfaction can improve scores in public reports or pay-for-performance programs.

Findings published in *Health Services Research* said patients with more chronic illnesses reported higher overall satisfaction with medical care received. Better patient-provider interaction and support for patient self-management were associated with higher satisfaction.
Investing in better communication with patients and supporting them in self-management of their illness could improve satisfaction, the paper said.


### Report round-up

**Hospital characteristics influence likelihood of meeting ED targets**

Large variations exist between hospitals in the percentage of patients who leave emergency departments (EDs) within the four-hour timeframe adopted by Australian governments, the National Health Performance Authority’s first report found. *Hospital performance: Time patients spent in emergency departments in 2011–12*, showed that hospital size and location, and whether patients are admitted or discharged, influenced the likelihood of meeting the National Emergency Access Target introduced in 2012. By 2015, 90% of patients presenting to public hospital emergency departments will be required to depart within four hours. Major hospitals recorded the lowest percentage of patients who departed the ED within four hours and large hospitals performed closer to the target. A separate Australian Institute of Health and Welfare report, *Australian hospital statistics: national emergency access and elective surgery targets 2012*, also examines performance against the target.

**Hospital reform failing to deliver: AMA**

Hospital bed numbers remain static and there has been no change in the capacity to move patients through emergency departments or improvement in time spent waiting for elective surgery, according to the *AMA Public Hospital Report Card 2013*. The report analysed public hospital activity data for 2011–12, in light of promised health reform and increased funding from governments. It found no change in the capacity of public hospitals to admit patients to wards from emergency departments more quickly, or to perform more elective surgeries.

**Patients satisfied with hospital experiences**

Most patients admitted to hospital feel doctors and nurses are spending enough time with them, according to an Australian Bureau of Statistics report. The *Patient Experience Survey* summary of findings for 2011–12 said just over four out of five people (81%) who visited an emergency department felt doctors had always or often spent enough time with them, compared with 87% of people who had been admitted to hospital. For ED nurses and hospital nurses, the figures were 85% and 89% respectively. In 2011–12, about 2.3million people aged 15 years and over (13%) had been admitted to hospital in the previous year and 2.5million (14%) had visited an ED.

**NSW healthcare system performs on international stage**

Bureau of Health Information publication *Healthcare in Focus 2012* has found that the NSW healthcare system compares well at an international level, but there is still room for improvement. The report compares NSW with Australia and 10 other countries and shows that in NSW, fewer years of life were lost to heart attack and stroke than most other countries, while acute diabetes complication rates were higher than those recorded in Germany, Sweden, Canada and Norway. Areas highlighted for improvement included reducing diabetic complications, high rates of hospitalisation for medical and surgical care complications, and rates of unplanned readmission for patients with schizophrenia and bipolar disorder.
Profile

Bronwyn Shumack
Clinical Excellence Commission Patient Safety Manager
HARC Scholarship recipient

In the pursuit of improving frontline clinical care and patient safety, health professionals can often overlook an integral consideration: the human factor.

Patient safety specialist Bronwyn Shumack says that as medical technology rapidly evolves in hospitals and healthcare services, attention should also focus on the way the built environment, workplace equipment and staffing limitations influence work behaviours.

Ms Shumack, the Clinical Excellence Commission’s (CEC) Patient Safety Manager, has used her HARC Scholarship to address this issue. In 2012, she attended a conference in France and visited hospitals and health centres in Canada, where she viewed examples of best practice in an area of study known as human factors theory.

“What there really hasn’t been [in NSW is] a concerted approach to how we design environments and set up equipment to make it simple and easy to do the right thing,” she said.

Human factors theory was about people’s abilities, characteristics and limitations, the design of workplace equipment, environments in which staff functioned, jobs they performed and their relationships with other people, Ms Shumack said.

Overseas, she discovered excellent examples of staff training, use of medical devices and built design. An initiative in Canada involved installing medication rooms of exactly the same design in hospitals throughout the health district, so staff working across centres could easily find medication.

Since her study trip, Ms Shumack has met stakeholders and spoken to university students about the role of human factors theory in medical education, highlighting the importance for trainees of communication and having strategies to speak up to senior staff, best use of workplace equipment, and awareness of how to deal with user errors in health systems. She believes an industry training program and online resources would assist health professionals and help improve patient safety.

HARC Scholarships of up to $10,000 are available to employees of partner organisations the CEC, ACI and the Sax Institute, to investigate challenges facing their agency. Applications have closed for the latest round of offers, with recipients to be announced soon. For more information, contact Carmen Huckel Schneider carmen.huckel-schneider@saxinstitute.org.au (02) 9514 5938.
Forthcoming events

7th Annual Alfred Medical Research & Education Precinct World Health Day Forum: April 11, Melbourne

“Reducing the Global Impact of High Blood Pressure: Current status and future challenges” is the theme for this year’s forum. Speakers include specialists from Australia, India and China. The event is aimed at people from the research, government and non-government sectors, students and health service providers. See the VicHealth website for more information.

AHRDMA 22nd Annual Scientific Meeting: April 11–12, Adelaide

This Australasian Health & Research Data Managers Association meeting aims to illustrate how academia, industry, government and different scientific disciplines can collaborate to develop new medicines enhance clinical research and medical-scientific understanding. Topics range from the latest in clinical collaborations to data registries and data management to operational aspects of clinical research. Visit the AHRDMA website for more details.

PHAA National Social inclusion and Complex Needs Conference: April 15–16, Canberra

This Public Health Association of Australia event will explore delivering services and programs to people with complex needs, taking the social determinants of health into account. The conference will seek to identify and showcase successful collaborative efforts in service delivery, with a view to informing whole-of-government approaches to policy and program development. Experts from government and non-government sectors will present their work. For information, visit the PHAA website.

Australian Institute of Health Innovation Seminar Series: April 16, Sydney

This seminar is part of The University of New South Wales Australian Institute of Health Innovation series. It features David Dean, General Manager of The Health Roundtable, an organisation that promotes best practice, collaboration and networking among health executives. Mr Dean will present on the theme “Comparing the impact of hospital-acquired patient harm across Australian hospitals”. Visit the AIHI website for more details.

Big Data 2013: April 18–19, Melbourne

Addressing the challenges of the data deluge in health is the aim of this conference, organised by the Health Informatics Society of Australia. It is designed to introduce clinicians, healthcare executives, managers, data and information professionals, health and bio informaticians, health policy makers, and academics to the world of Big Data. More information is available on the conference website.

Evidence-Based Practice Workshop: May 2, Gold Coast

The Centre for Research in Evidence-Based Practice at Bond University is conducting a one-day workshop. Designed for clinicians, health administrators and information managers interested in advancing evidence-based practice in their clinical area, it will involve small group work with professionals in the same field. For information, visit the centre's website.
9th Australasian Redesigning Healthcare Summit: May 7–9, Brisbane
With a theme of “Safer Care – Better Flow” the summit will bring together participants interested in the practice of redesigning hospital and health service care to improve the patient experience. Keynote speakers for this Australasian Lean Healthcare Network event include specialists from Canada, the US, UK and New Zealand. See the Lean Healthcare network website for more details.

9th HARC Forum: May 13, Sydney
Keynote speaker Mark Graber is the recently-retired Chief of Medical Service at the Veterans Affairs Medical Center, Northport, New York and Principal Investigator of the National Patient Safety Foundation. He will be speaking about the causes of diagnostic errors in medicine. More details on the HARC Forum will be sent to members soon.

7th ACHS Annual Executive Masterclass Series: May 20–28, Sydney, Adelaide, Melbourne
This year’s topic is “Patient-based care: the challenge of a new paradigm”. The Australian Council on Healthcare Standards masterclasses will apply knowledge and ideas on re-orienting services, drawing on research and industry experience in patient-based care to explore how to optimise systems performance. Professor Jeffrey Braithwaite, Foundation Director, Australian Institute of Health Innovation, University of New South Wales, and Professor Cliff Hughes, CEO, Clinical Excellence Commission, will lead the masterclasses. For information, visit the ACHS website.

NSW Institute of Psychiatry Clinical Supervision Conference: June 4–6, Sydney
This inaugural event will be an opportunity for mental health clinicians to explore the practice, evaluation and teaching of clinical supervision. It aims to encourage health professionals and educators to examine current issues in clinical supervision research and practice. Further information is available on the institute’s website.