

NATIONAL PRIMARY CARE RESEARCH AND DEVELOPMENT CENTRE

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ACCESS TO CARE

Alazri, M. H. et al. UK GPs' and practice nurses' views of continuity of care for patients with type 2 diabetes. Family Practice April 2007 24 (2), 128-137 doi: 10.1093/fampra/cmm003

Background: Continuity of care is widely regarded as a core value of primary care. Type 2 diabetes is a common chronic disease with major health, social and economic impacts. Primary health care professionals in many countries are involved in the management of patients with type 2 diabetes, but their perspectives on continuity remain neglected in research. Objective: To explore UK GPs' and nurses' experiences of continuity of care for patients with type 2 diabetes in primary care settings. METHODS: Semi-structured individual interviews were conducted with 16 GPs and 18 practice nurses who manage patients with type 2 diabetes recruited from 20 practices with various organizational structures in Leeds, UK. results: Three types of continuities were identified: relational continuity from the same health care professional, team continuity from a group of health care professionals and cross-boundary continuity across primary-secondary care settings. Relational continuity was influenced by the quality of the patient-health care professional relationship, policy of the National Health Service (NHS) in the UK (new General Medical Services contract), walk-in centres, the behaviour of receptionists and the structure and systems of the practice. Team and cross-boundary continuities were influenced by the relationship between team members and by effective communication. Relational continuity contributed to more 'personal care', but the usual health care professional might know less about diabetes. Team continuity was important in providing 'physical care', but patients could be confused by conflicting advice from different professionals. Cross-boundary continuity helps to provide 'expert advice', but is dependent upon effective communication. Conclusion: GPs and practice nurses dealing with patients with type 2 diabetes identified three types of continuities, each influenced by several factors. Relational continuity deals better with psychosocial care while team continuity promotes better physical care; therefore, imposing one type of continuity may inhibit good diabetic care. Cross-boundary continuity between primary and secondary care is fundamental to contemporary diabetic services and ways should be found to achieve more effective communication

Derkx H. P, et al Assessing communication skills of clinical call handlers working at an out-of-hours centre: development of the RICE rating scale British Journal of General Practice 2007 57 (538) 383-387

Background: Out-of-hours centres provide telephone support to patients with medical problems. In most of these centres specially-trained nurses handle incoming telephone calls. They assess patients' needs, the degree of urgency, and determine the level of care required. Assessment of the medical problem and the quality of 'care-by-phone' depend on the medical and communication skills of the call handlers. AIM: To develop a valid, reliable, and practical rating scale to evaluate the communication skills of call handlers working at an out-of-hours centre and to improve quality of communication. Design of study: Qualitative study with focus groups followed by validation of the rating scale and measurement of reliability (internal consistency). Setting: out-of-hours centres in the Netherlands. Method: A focus group developed the rating scale. Experts with experience in training and evaluating communication skills of medical students and GPs commented on the scale to ensure content validity. The reliability of the rating scale was tested in a pilot in which ten specially-trained assessors scored six telephone calls each. Results: The scale, known as the RICE rating scale, has 17 items divided over four different phases of the telephone consultation: Reason for calling; Information gathering; Conclusion; and Evaluation (RICE). Content validity of the scale was assessed by two experts. Reliability of the scale tested in the pilot was 0.73 (Cronbach's alpha). Conclusion: Establishing a rating scale to assess the communication skills of call handlers which meets common scientific demands, such as content validity and reliability, proved successful. This instrument can be used to give feedback to call handlers

Giannelli, M et. al. General practitioners' knowledge and practice of complementary/alternative medicine and its relationship with life-styles: a population-based survey in Italy BMC Family Practice 2007 8:30 doi: 10.1186/1471-2296-8-30

Abstract: background: The growing popularity of CAM among the public is coupled with an ongoing debate on its effectiveness, safety, and its implications on the reimbursement system. This issue is critically important for GPs, who have a "gatekeeping" role with respect to health care expenditure. GPs must be aware of medications' uses, limitations and possible adverse effects. Our objective was to explore GPs' knowledge of CAM and patterns of recommendation and practice, as well as the relationship between such patterns and GPs' life-styles. Methods: A cross-sectional study was conducted in Tuscany, a region of central Italy. One hundred percent female GPs (498) and a 60% random sample of male GPs (1310) practising in the region were contacted through a self-administered postal questionnaire followed by a postal reminder and telephone interview. Results: Overall response rate was 82.1%. Most respondents (58%) recommended CAM but a far smaller fraction (13%) practised it; yet 36% of CAM practitioners had no certificated training. Being female, younger age, practising in larger communities, having had some training in CAM as well as following a vegetarian or macrobiotic diet and doing physical activity were independent predictors of CAM recommendation and practice. However, 42% of GPs did not recommend CAM to patients mostly because of the insufficient evidence of its effectiveness. Conclusions: CAM knowledge among GPs is not as widespread as the public demand seems to require, and the scarce evidence of CAM effectiveness hinders its professional use among a considerable number of GPs. Sound research on CAM effectiveness is needed to guide

physicians' behaviour, to safeguard patients' safety, and to assist policy-makers in planning regulations for CAM usage

Grytten, J. and Sorensen, R Primary physician services- list size and primary physicians' service production Journal of Health Economics 2007 26 (4) 721-741 doi: 10.1016/j.jhealeco.2007.01.001

The regular general practitioner scheme was introduced in Norway in 2001. A patient list system in combination with a partial per capita financing system for primary physician services was then introduced. The focus of this research was to study how the patient list system influences patients' accessibility to primary physicians, and how the system influences primary physicians' service production. We studied two possibilities: First, some physicians can have an incentive to acquire a long patient list in order to ensure a high unearned income from per capita payment. This can lead to rationing of consultations. Second, physicians with short lists can have an incentive to increase their service production per consultation in order to compensate for lack of income. This leads to increased costs. The research questions were investigated empirically using two large sets of national data. Two of the main findings were that long lists do not lead to rationing, and short lists do not increase service production per consultation

Hopp FP and et al The use of telehealth for diabetes management: a qualitative study of telehealth provider perceptions Implementation Science 2007 2 :14 doi: 10.1016/j.jhealeco.2007.01.001

Background Monitoring and Messaging Devices (MMDs) are telehealth systems used by patients in their homes, and are designed to promote patient self-management, patient education, and clinical monitoring and follow-up activities. Although these systems have been widely promoted by health care systems, including the Veterans Health Administration, very little information is available on factors that facilitate use of the MMD system, or on barriers to use. **Methods** We conducted in-depth qualitative interviews with clinicians using MMD-based telehealth programs at two Veterans Affairs Medical Centers in the Midwestern United States. **Results** Findings suggest that MMD program enrollment is limited by both clinical and non-clinical factors, and that patients have varying levels of program participation and system use. Telehealth providers see MMDs as a useful tool for monitoring patients who are interested in working on management of their disease, but are concerned with technical challenges and the time commitment required to use MMDs. **Conclusions** Telehealth includes a rapidly evolving and potentially promising range of technologies for meeting the growing number of patients and clinicians who face the challenges of diabetes care, and future research should explore the most effective means of ensuring successful program implementation

Maheswaran R, et al Impact of NHS walk-in centres on primary care access times: ecological study British Medical Journal 17/5/2007 334 (7598) p. 838- doi:10.1136/bmj.39122.704051.55

Objective To examine whether walk-in centres contribute to shorter waiting times for a general practice appointment. **Design** Ecological study. **Setting** 2509 general practices in 56 primary care trusts in England; 32 walk-in centres within 3 km of one of these practices. **Main outcome measure** Waiting time to next available general practitioner appointment (April 2003 to December 2004), from national monthly primary care access survey. **Results** The percentage of practices achieving the target waiting time of less than 48 hours to see a general practitioner increased from 67% to 87% over the 21 month study period (adjusted odds ratio 1.07 (95% confidence interval 1.06 to 1.08) per increase in month). Achievement of the waiting time target decreased with increasing multiple deprivation (0.57 (0.49 to 0.67) for most versus least deprived third) and increased with increasing practice population size (1.02 (1.00 to 1.04) per 1000 increase). No evidence was found that increasing distance from a walk-in centre was associated with decreasing odds of achieving the waiting time target (1.00 (0.99 to 1.01) per km increase). Increasing "exposure" to a walk-in centre, modelled with a distance decay function based on attendance rates, also showed little evidence of association with achievement of the waiting time target (1.02 (0.97 to 1.08) for interquartile range increase). No evidence existed that the rate of increase in achieving the 48 hour target over time was enhanced by proximity or "exposure" to a walk-in centre. Results were similar when the analysis was rerun with data for 2003 only (done because pressure in 2004 to meet the government's deadline might have led to other changes that could have masked any walk-in centre effect). **Conclusions** No evidence existed that walk-in centres shortened waiting times for access to primary care, and the results do not support the use of walk-in centres for this purpose

Porter A, et al. 'Should I stay or should I go?' Deciding whether to go to hospital after a 999 call Journal of Health Services Research and Policy 2007 12 Suppl 1 32-38 doi: 10.1258/135581907780318392

Objective: In most UK ambulance services, crews attending someone who has phoned the emergency services on '999' will take the patient to hospital, unless the patient makes the decision to stay at home (or wherever they happen to be when the ambulance arrives). Safety concerns have been raised about non-conveyance decisions. We undertook a study of one UK Ambulance Service to examine ambulance crew members' views on how decision-making about non-conveyance works in practice in relation to non-urgent calls. **Methods:** A total of 25 paramedics took part in three focus groups. Focus groups were transcribed and analysed thematically. **Results:** The ambulance service's apparently straightforward guidance on decision-making about non-conveyance proved tricky in the messiness of the real world, for two reasons. The first was to do with the notion of the patient's capacity to make decisions and how this was interpreted. The second was to do with the complexity of the decision-making process, in which the patient, the crew and, in many cases, family or carers often take part in negotiation and de facto joint decision-making. **Conclusions:** There is a mismatch between policy and practice in relation to non-conveyance decisions. Findings should be built into research and service development in

this rapidly changing field of practice in emergency and/or unscheduled care. The commonly accepted perspective on shared decision-making should be extended to include the context of '999' ambulance calls

CHRONIC DISEASE

Birks Y et al Exploring health-related experiences of children and young people with congenital heart disease Health Expectations 2007 10 (1) 16-29 doi: 10.1111/j.1369-7625.2006.00412.x

Objective: To determine the health-related experiences of children with congenital heart disease. Design: Qualitative, semi-structured interviews. Participants: A purposive sample (N = 35) of children and young people, aged between 8 and 19 years, with a variety of congenital heart conditions recruited from one treatment care centre in the north of England. Results: The main themes identified included: physical limitations of their condition; restrictions; attitudes of others; choices about information; coping with life and privacy. Conclusions: This study suggests that while many of this sample of children said that they coped well with their condition some children did experience significant impact on their quality of life in several domains. Children and young people identified a need for improved strategies to help them communicate about their condition with peers, schoolteachers and health-care professionals to allow a better understanding of what they are able to achieve

Dragan A, Akhtar-Danesh N, Relation between body mass index and depression: a structural equation modeling approach BMC Medical Research Methodology 2007 7:17 doi: 10.1186/1471-2288-7-17

Background: Obesity and depression are two major diseases which are associated with many other health problems such as hypertension, dyslipidemia, diabetes mellitus, coronary heart disease, stroke, myocardial infarction, heart failure in patients with systolic hypertension, low bone mineral density and increased mortality. Both diseases share common health complications but there are inconsistent findings concerning the relationship between obesity and depression. In this work we used the structural equation modeling (SEM) technique to examine the relation between body mass index (BMI), as a proxy for obesity, and depression using the Canadian Community Health Survey, Cycle 1.2. Methods: In this SEM model we postulate that 1) BMI and depression are directly related, 2) BMI is directly affected by the physical activity and, 3) depression is directly influenced by stress. SEM was also used to assess the relation between BMI and depression separately for males and females. Results: The results indicate that higher BMI is associated with more severe form of depression. On the other hand, the more severe form of depression may result in less weight gain. However, the association between depression and BMI is gender dependent. In males, the higher BMI may result in a more severe form of depression while in females the relation may not be the same.

Also, there was a negative relationship between physical activity and BMI. Conclusion: In general, use of SEM method showed that the two major diseases, obesity and depression, are associated but the form of the relation is different among males and females. More research is necessary to further understand the complexity of the relationship between obesity and depression. It also demonstrated that SEM is a feasible technique for modeling the relation between obesity and depression

Eccles M P, et al A pragmatic cluster randomised controlled trial of a Diabetes REcall And Management system: the DREAM trial Implementation Science 2007 2: 6 doi:10.1186/1748-5908-2-6

Background Following the introduction of a computerised diabetes register in part of the northeast of England, care initially improved but then plateaued. We therefore enhanced the existing diabetes register to address these problems. The aim of the trial was to evaluate the effectiveness and efficiency of an area wide 'extended,' computerised diabetes register incorporating a full structured recall and management system, including individualised patient management prompts to primary care clinicians based on locally-adapted, evidence-based guidelines. **Methods** The study design was a pragmatic, cluster randomised controlled trial, with the general practice as the unit of randomisation. Set in 58 general practices in three Primary Care Trusts in the northeast of England, the study outcomes were the clinical process and outcome variables held on the diabetes register, patient-reported outcomes, and service and patient costs. The effect of the intervention was estimated using generalised linear models with an appropriate error structure. To allow for the clustering of patients within practices, population averaged models were estimated using generalized estimating equations. **Results** Patients in intervention practices were more likely to have at least one diabetes appointment recorded (OR 2.00, 95% CI 1.02, 3.91), to have a recording of a foot check (OR 1.87, 95% CI 1.09, 3.21), have a recording of receiving dietary advice (OR 2.77, 95% CI 1.22, 6.29), and have a recording of blood pressure (BP) (OR 2.14, 95% CI 1.06, 4.36). There was no difference in mean HbA1c or BP levels, but the mean cholesterol level in patients from intervention practices was significantly lower (-0.15 mmol/l, 95% CI -0.25, -0.06). There were no differences in patient-reported outcomes or in patient-reported use of drugs, or uptake of health services. The average cost per patient was not significantly different between the intervention and control groups. Costs incurred in administering the system at the register and in general practice were in addition to these. **Conclusion** This study has shown benefits from an area-wide, computerised diabetes register incorporating a full structured recall and individualised patient management system. However, these benefits were achieved at a cost. In future, these costs may fall as electronic data exchange becomes a reliable reality. Trial registration: International Standard Randomised Controlled Trial Number (ISRCTN) Register, ISRCTN32042030

Elzen H, et al Evaluation of the chronic disease self-management program (CDSMP) among chronically ill older people in the Netherlands Social Science and Medicine 2007 64:9, 1832-1841 doi:10.1016/j.socscimed.2007.02.008

Many chronically ill older patients in the Netherlands have a combination of more than one chronic disease. There is therefore a need for self-management programs that address

general management problems, rather than the problems related to a specific disease. The Chronic Disease Self-Management Program (CDSMP) seems to be very suitable for this purpose. In evaluations of the program that have been carried out in the United States and China, positive effects were found on self-management behaviour and health status. However, the program has not yet been evaluated in the Netherlands. Therefore, the aim of this study was to evaluate the short-term and longer-term effects of the program among chronically ill older people in the Netherlands. One hundred and thirty-nine people aged 59 or older, with a lung disease, a heart disease, diabetes, or arthritis were randomly assigned to an intervention group (CDSMP) or a control group (care-as-usual). Demographic data and data on self-efficacy, self-management behaviour and health status were collected at three measurement moments (baseline, after 6 weeks, and after 6 months). The patients who participated rated the program with a mean of 8.5 points (range 0-10), and only one dropped out. However, our study did not yield any evidence for the effectiveness of the CDSMP on self-efficacy, self-management behaviour or health status of older patients in the Netherlands. Because the patients who participated were very enthusiastic, which was also indicated by very high mean attendance (5.6 out of 6 sessions) and only one dropout, it seems too early to conclude that the program is not beneficial for these patients.

Fleming S, et al CAM therapies among primary care patients using opioid therapy for chronic pain BMC Complementary and Alternative Medicine 2007 7:15 doi: 10.1186/1472-6882-7-15

Background: Complementary and alternative medicine (CAM) is an increasingly common therapy used to treat chronic pain syndromes. However; there is limited information on the utilization and efficacy of CAM therapy in primary care patients receiving long-term opioid therapy. Method: A survey of CAM therapy was conducted with a systematic sample of 908 primary care patients receiving opioids as a primary treatment method for chronic pain. Subjects completed a questionnaire designed to assess utilization, efficacy and costs of CAM therapies in this population. Results: Patients were treated for a variety of pain problems including low back pain (38.4%), headaches (9.9%), and knee pain (6.5%); the average duration of pain was 16 years. The median morphine equivalent opioid dose was 41 mg/day, and the mean dose was 92 mg/day. Forty-four percent of the sample reported CAM therapy use in the past 12 months. Therapies utilized included massage therapy (27.3%, n=248), chiropractic treatment (17.8%, n=162), acupuncture (7.6%, n= 69), yoga (6.1%, n=55), herbs and supplements (6.8%, n=62), and prolotherapy (5.9%, n=54). CAM utilization was significantly related to age female gender, pain severity income pain diagnosis of neck and upper back pain, and illicit drug use. Medical insurance covered chiropractic treatment (81.8%) and prolotherapy (87.7%), whereas patients primarily paid for other CAM therapies. Over half the sample reported that one or more of the CAM therapies were helpful. Conclusions: This study suggests CAM therapy is widely used by patients receiving opioids for chronic pain. Whether opioids can be reduced by introducing such therapies remains to be studied

Foster J, et al Practice development plans to improve the primary care management of acute asthma: randomised controlled trial BMC Family Practice April 2007 8:1 doi: 10.1186/1471-2296-8-23

Abstract: Background: Our professional development plan aimed to improve the primary care management of acute asthma, which is known to be suboptimal. Methods: We invited 59 general practices in Grampian, Scotland to participate. Consenting practices were randomised to early and delayed intervention groups. Practices undertook audits of their management of all acute attacks (excluding children under 5 years) occurring in the 3 months preceding baseline, 6-months and 12-months study time-points. The educational programme [including feedback of audit results, attendance at a multidisciplinary interactive workshop, and formulation of development plan by practice teams] was delivered to the early group at baseline and to the delayed group at 6 months. Primary outcome measure was recording of peak flow compared to best/predicted at 6 months. Analyses are presented both with, and without adjustment for clustering. Results: 23 consenting practices were randomised: 11 to early intervention. Baseline practice demography was similar. Six early intervention practices withdraw before completing the baseline audit. There was no significant improvement in our primary outcome measure (the proportion with peak flow compared to best/predicted) at either the 6 or 12 month time points after adjustment for baseline and practice effects. However, the between group difference in the adjusted combined assessment score, whilst non-significant at 6 months (Early: 2.48 (SE 0.43) vs. Delayed 2.26 (SE 0.33) $p=0.69$) reached significance at 12m (Early:3.60 (SE 0.35) vs. Delayed 2.30 (SE 0.28) $p=0.02$). Conclusions: We demonstrated no significant benefit at the a priori 6-month assessment point, though improvement in the objective assessment of attacks was shown after 12 months. Our practice development programme, incorporating audit, feedback and a workshop, successfully engaged the healthcare team of participating practices, though future randomised trials of educational interventions need to recognise that effecting change in primary care practices takes time. Monitoring of the assessment of acute attacks proved to be a feasible and responsive indicator of quality care

Griffiths C, et al. Educational outreach to promote screening for tuberculosis in primary care: a cluster randomised controlled trial Lancet 5th May 2007 369:9572, 1528-1534 doi: 10.1016/S0140-6736(07)60707-7

Background: Tuberculosis is re-emerging as an important health problem in industrialised countries. Uncertainty surrounds the effect of public-health control options. We therefore aimed to assess a programme to promote screening for tuberculosis in a UK primary health care district. **MethodS:** In a cluster randomised controlled trial, we randomised 50 of 52 (96%) eligible general practices in Hackney, London, UK, to receive an outreach programme that promoted screening for tuberculosis in people registering in primary care, or to continue with usual care. Screening was verbal, and proceeded to tuberculin skin testing, if appropriate. The primary outcome was the proportion of new cases of active tuberculosis identified in primary care. Analyses were done on an intention-to-treat basis. This study was registered at clinicaltrials.gov, number NCT00214708. **Findings:** Between June 1, 2002, and Oct 1, 2004, 44,986 and 48,984 patients registered with intervention and control practices, respectively. In intervention practices 57% (13,478 of

23,573) of people attending a registration health check were screened for tuberculosis compared with 0.4% (84 of 23 051) in control practices. Intervention practices showed increases in the diagnosis of active tuberculosis cases in primary care compared with control practices (66/141 [47%] vs 54/157 [34%], odds ratio (OR) 1.68, 95% CI 1.05-2.68, $p=0.03$). Intervention practices also had increases in diagnosis of latent tuberculosis (11/59 [19%] vs 5/68 [9%], OR 3.00, 0.98-9.20, $p=0.055$) and BCG coverage (mean BCG rate 26.8/1000 vs 3.8/1000, intervention rate ratio 9.52, 4.0-22.7, $p<0.001$). Interpretation: Our educational intervention for promotion of screening for tuberculosis in primary care improved identification of active and latent tuberculosis, and increased BCG coverage. Yield from screening was low, but was augmented by improved case-finding. Screening programmes in primary care should be considered as part of tuberculosis control initiatives in industrialised countries

Jiwa M, et al Factors influencing the speed of cancer diagnosis in rural Western Australia: a general practice perspective BMC Family Practice 2007 8: 1 doi: 10.1186/1471-2296-8-27

Abstract: Background: The speed of diagnosis impacts on prognosis and survival in all types of cancer. In most cases survival and prognosis are significantly worse in rural and remote Australian populations who have less access to diagnostic and therapeutic services than metropolitan communities in this country. Research suggests that in general delays in diagnosis were a factor of misdiagnosis, the confounding effect of existing conditions and delayed or misleading investigation of symptoms. The aim of this study is to further explore the factors that impact on the speed of diagnosis in rural Western Australia with direct reference to General Practitioners (GPs) working in this setting. Methods: The methodology consisted of a structured discussion of specific cases. GPs based in two rural locations in Western Australia were asked to identify up to eight clinical cases for discussion. A diversity of cases was requested encompassing those with timely and delayed diagnosis of cancer. Focus groups were held with the practitioners to identify which factors delayed or facilitated the diagnosis in each case. A structured summary of the discussion was relayed to a wider group of GPs to seek additional views or comments on specific factors that impact on the speed of cancer diagnosis in rural and remote locations in Australia. Results: A number of factors affecting the speed of diagnosis were identified: the demographic shift towards a frailer and older population, presenting with multiple and complex diseases, increases the challenge to identify early cancer symptoms; seasonal and demanding work patterns leading to procrastination in presenting for medical care; unhelpful scheduling of specialist appointments; and the varying impact of informal networks and social relationships. Conclusion: Within the limitations of this study we have generated a number of hypotheses that require formal evaluation: (1) GPs working within informal professional and social networks are better informed about their patients health needs and have an advantage in making early diagnosis; (2) Despite the other differences in the population characteristics decentralising services would improve the prospect for timely diagnosis; and (3) Careful coordination of specialist appointments would improve the speed of diagnosis for rural patients

Jones R , et al. Alarm symptoms in early diagnosis of cancer in primary care: cohort study using General Practice Research Database British Medical Journal 19th May 2007 334: 7602 1040-1044 doi: 10.1136/bmj.39171.637106.AE

Objective: To evaluate the association between alarm symptoms and the subsequent diagnosis of cancer in a large population based study in primary care. DESIGN: Cohort study. Setting: UK General Practice Research Database. Patients 762 325 patients aged 15 years and older, registered with 128 general practices between 1994 and 2000. First occurrences of haematuria, haemoptysis, dysphagia, and rectal bleeding were identified in patients with no previous cancer diagnosis. Main outcome measure: Positive predictive value of first occurrence of haematuria, haemoptysis, dysphagia, or rectal bleeding for diagnoses of neoplasms of the urinary tract, respiratory tract, oesophagus, or colon and rectum during three years after symptom onset. Likelihood ratio and sensitivity were also estimated. Results: 11.108 first occurrences of haematuria were associated with 472 new diagnoses of urinary tract cancers in men and 162 in women, giving overall three year positive predictive values of 7.4% (95% confidence interval 6.8% to 8.1%) in men and 3.4% (2.9% to 4.0%) in women. After 4812 new episodes of haemoptysis, 220 diagnoses of respiratory tract cancer were made in men (positive predictive value 7.5%, 6.6% to 8.5%) and 81 in women (4.3%, 3.4% to 5.3%). After 5999 new diagnoses of dysphagia, 150 diagnoses of oesophageal cancer were made in men (positive predictive value 5.7%, 4.9% to 6.7%) and 81 in women (2.4%, 1.9 to 3.0%). After 15 289 episodes of rectal bleeding, 184 diagnoses of colorectal cancer were made in men (positive predictive value 2.4%, 2.1% to 2.8%) and 154 in women (2.0%, 1.7% to 2.3%). Predictive values increased with age and were strikingly high, for example, in men with haemoptysis aged 75-84 (17.1%, 13.5% to 21.1%) and in men with dysphagia aged 65-74 (9.0%, 6.8% to 11.7%). Conclusion: New onset of alarm symptoms is associated with an increased likelihood of a diagnosis of cancer, especially in men and in people aged over 65. These data provide support for the early evaluation of alarm symptoms in an attempt to identify underlying cancers at an earlier and more amenable stage

Kupersmith J, et al Advancing evidence-based care for diabetes: lessons from the Veterans Health Administration Health Affairs 2007 26 (2) w156-w168

The Veterans Health Administration (VHA) is a unique laboratory for using the electronic health record (EHR) to transform health care and accelerate discovery. This is particularly evident in the care of veterans with diabetes, who constitute a quarter of those served by the VHA. Although EHRs have enabled rapid learning, additional factors were necessary, including the lead participation of clinician-investigators, accountability through performance measurement, a delivery system focused on population health, and favorable economic externalities. "Off-the-shelf" technology is unlikely to generate similar benefits if these attributes are not in place

Le, T. K. Able S. L, and Lage M J, Resource use among patients with diabetes, diabetic neuropathy, or diabetes with depression Cost Effectiveness and Resource Allocation 2006 4:18 doi: 10.1186/1478-7547-4-18

Abstract: Background: Diabetes is often associated with complications and comorbidities. The purpose of this research is to compare medical resources used by patients with the following diagnoses: diabetes mellitus (DM), diabetic neuropathy (DN), and diabetes mellitus combined with comorbid depression (DD). Methods: Adult patients who were diagnosed with DM, DN, or DD were included in the study. There were 55,972 patients in the DM cohort, 2,146 in the DN, and 2,379 in the DD. P values for comparisons between the three mutually exclusive cohorts were conducted using the Tukey-Kramer method. Cost comparisons among the cohorts were conducted using a stepwise multivariate regression that controlled for patient characteristics and comorbid conditions. Results: Individuals in the DM or DN cohorts were generally more likely to use antidiabetic medications than patients in the DD group. Those diagnosed with DN or DD generally used more pain medications than individuals in the DM cohort. The DM cohort had significantly lower diabetes-related total medical costs (\$1,297 v \$5,125, $p < 0.0001$) and lower total medical costs (\$4,819 v \$24,765, $p < 0.0001$) than the DN cohort. The DM cohort also had significantly lower diabetes-related total medical costs (\$1,297 v \$3,264, $p < 0.0001$) as well as significantly lower total medical costs (\$4,819 v \$19,298, $p < 0.0001$) than the DD cohort. Conclusion: Results from this study indicated significant differences in demographic characteristics, comorbidities, and medication use among individuals diagnosed with DM, DN, or DD. These differences translated into significant cost differences. Patients diagnosed with DN or DD had higher diabetes-related costs than patients diagnosed with DM

Nichols L, et al. Diabetes, minor depression and health care utilization and expenditures: a retrospective database study Cost. Effectiveness and Resource Allocation 2007 5 (4) doi: 10.1186/1478-7547-5-4

Abstract: background: To estimate the prevalence of minor depression among US adults with diabetes, health care resource utilization, and expenditures by people with diabetes with and without minor depression. Methods: Among adult 2003 Medical Expenditure Panel Survey respondents, diabetes was identified by diagnosis code and self-report. Depression was identified by diagnosis code plus \geq one antidepressant prescription. Odds of having depression was estimated in people with diabetes and the general population, adjusted for sociodemographic variables (e.g., age, sex, race/ethnicity). Multivariate regressions evaluated factors associated with utilization and log-transformed expenditures for ambulatory care, hospitalizations, emergency visits, and prescriptions. Results: In 2003, 1932 respondents had diabetes, 435/1932 had diabetes and minor depression. Adults with diabetes were more likely than the general population to have

depression (adjusted OR 1.81, 95% CI 1.56, 2.09). People with diabetes with versus without comorbid depression were more likely to be women, have lower incomes and health status, and more diabetes complications (all $p < 0.05$). In unadjusted analyses, ambulatory care visits were higher for those with versus without depression (17.9 vs. 11.4, $p = 0.04$), as were prescriptions (60.7 vs. 38.1, $p = 0.05$). In adjusted analyses, depression was not associated with increased resource use or higher expenditures in any category. Increased number of comorbid conditions was associated with increased resource use in all categories, and increased expenditures for ambulatory care and prescriptions. Conclusion: People with diabetes are twice as likely to have depression as the general population. Screening for and treatment of depression is warranted, as is additional research into a causal relationship between diabetes and depression

Osborne R H, et al The Health Education Impact Questionnaire (heiQ): An outcomes and evaluation measure for patient education and self-management interventions for people with chronic conditions Patient Education and Counseling 2007 66 (2) 192-201 doi:10.1016/j.pec.2006.12.002

Objective This paper describes the development and validation of the Health Education Impact Questionnaire (heiQ). The aim was to develop a user-friendly, relevant, and psychometrically sound instrument for the comprehensive evaluation of patient education programs, which can be applied across a broad range of chronic conditions. **Methods** Item development for the heiQ was guided by a Program Logic Model, Concept Mapping, interviews with stakeholders and psychometric analyses. Construction ($N = 591$) and confirmatory ($N = 598$) samples were drawn from consumers of patient education programs and hospital outpatients. The properties of the heiQ were investigated using item response theory and structural equation modeling. **Results** Over 90 candidate items were generated, with 42 items selected for inclusion in the final scale. Eight independent dimensions were derived: Positive and Active Engagement in Life (five items, Cronbach's alpha (α) = 0.86); Health Directed Behavior (four items, $\alpha = 0.80$); Skill and Technique Acquisition (five items, $\alpha = 0.81$); Constructive Attitudes and Approaches (five items, $\alpha = 0.81$); Self-Monitoring and Insight (seven items, $\alpha = 0.70$); Health Service Navigation (five items, $\alpha = 0.82$); Social Integration and Support (five items, $\alpha = 0.86$); and Emotional Wellbeing (six items, $\alpha = 0.89$). **Conclusion** The heiQ has high construct validity and is a reliable measure of a broad range of patient education program benefits. **Practice Implications** The heiQ will provide valuable information to clinicians, researchers, policymakers and other stakeholders about the value of patient education programs in chronic disease management.

Paterson C. Patients' experiences of Western-style acupuncture: the influence of acupuncture 'dose', self-care strategies and integration Health Services Research and Policy 2007 12 Suppl 1 39-45 doi: 10.1258/135581907780318356

Objectives: To investigate patients' perspectives of the process and outcome of Western-style acupuncture for chronic health problems. To use these results to inform the provision of acupuncture in health services in the UK. **Methods:** A purposive sample of 18 patients who were having Western-style acupuncture, for the first time, for a health problem of at least three months duration, were interviewed twice over a four-month period using semi-structured interviews. Using a constant comparative method, the data were analysed across cases and within cases. **Results:** The interviewees complained of chronic pain and moderate or severe disability which was resistant to conventional treatment. Their experience of acupuncture was diverse and varied according to the 'dosage' of acupuncture received, the inclusion of self-care strategies, and their relationship with the practitioner. These three factors were interlinked and constituted individual styles of practice for each practitioner. The majority of patients benefited in terms of complete or partial relief of pain and disability, and reduction in conventional medication. However, some patients were disappointed by the treatment, distressed about 'wasting people's time', and about the lack of continuity of care. People who benefited most had good general health and a single problem. **Conclusions:** Patients showed discerning judgement regarding the 'dosage' of acupuncture they required, and combined acupuncture with exercises to good effect. Publicly funded health services should provide an acupuncture service that provides the optimal 'dosage' and uses pain relief to promote self-care. Further research to investigate the benefits of a service that combines Western-style and traditional acupuncture is planned.

Proudfoot J, et al Quality of chronic disease care in general practice: the development and validation of a provider interview tool BMC Family Practice 2007 8:21 doi: 10.1186/1471-2296-8-21

Background: This article describes the development and psychometric evaluation of an interview instrument to assess provider-reported quality of general practice care for patients with diabetes, cardiovascular disease and asthma--the Australian General Practice Clinical Care Interview (GPCCI). **Methods:** We administered the GPCCI to 28 general practitioners (family physicians) in 10 general practices. We conducted an item analysis and assessed the internal consistency of the instrument. We next assessed the quality of care recorded in the medical records of 462 of the general practitioners' patients with Type 2 diabetes, ischaemic heart disease/hypertension and/or moderate to severe asthma. This was then compared with results of the GPCCI for each general practice. **Results:** Good internal consistency was found for the overall GPCCI (Cronbach's alpha = 0.75). As far as the separate sub-scales were concerned, diabetes had good internal consistency (0.76) but the internal consistency of the heart disease and asthma subscales was not strong (0.49 and 0.16 respectively). There was high inter-rater reliability of the adjusted scores of data extracted from patients' medical notes for each of the three conditions. Correlations of the overall GPCCI and patients' medical notes audit, combined across the three conditions and aggregated to practice level, showed that a strong relationship ($r = 0.84$, $p = 0.003$) existed between the two indices of clinical care. **Conclusion:** This study suggests that the GPCCI has good internal consistency and

concurrent validity with patients' medical records in Australian general practice and warrants further evaluation of its properties, validity and utility

Ridsdale L, et al How do patients referred to neurologists for headache differ from those managed in primary care? British Journal of General Practice 2007 57 (538) 388-395

Background: Headache is the neurological symptom most frequently presented to GPs and referred to neurologists, but little is known about how referred patients differ from patients managed by GPs. AIM: To describe and compare headache patients managed in primary care with those referred to neurologists. Design of study: Prospective study. Setting: Eighteen general practices in south-east England. Method: this study examined 488 eligible patients consulting GPs with primary headache over 7 weeks and 81 patients referred to neurologists over 1 year. Headache disability was measured by the Migraine Disability Assessment Score, headache impact by the Headache Impact Test, emotional distress by the Hospital Anxiety and Depression Scale and illness perception was assessed using the Illness Perception Questionnaire. Results: Participants were 303 patients who agreed to participate. Both groups reported severe disability and very severe impact on functioning. Referred patients consulted more frequently than those not referred in the 3 months before referral ($P = 0.003$). There was no significant difference between GP-managed and referred groups in mean headache disability, impact, anxiety, depression, or satisfaction with care. The referred group were more likely to link an increased number of symptoms to their headaches ($P = 0.01$), to have stronger emotional representations of their headaches ($P = 0.006$), to worry more ($P = 0.001$), and were made anxious by their headache symptoms ($P = 0.044$). Conclusion: Patients who consult for headache experience severe disability and impact, and up to a third report anxiety and/or depression. Referral is not related to clinical severity of headaches, but is associated with higher consultation frequency and patients' anxiety and concern about their headache symptoms

Sargent P, Pickard S, Shaeff R, Boaden R Patient and carer perception of case management for long term conditions. Health and Social Care in the Community 23/4/2007 OnlineEarly article doi::10.1111/j.1365-2524.2007.00708.x

Nurse-led case management programmes have become increasingly popular over the last 15 years. Countries such as the USA, Canada, Sweden and the Netherlands have long running case management programmes in place for frail elderly people. The Department of Health in England has recently introduced a 'community matron' role to provide case management to patients with highly complex long-term conditions; a group that is predominantly comprised of elderly people. Department of Health policy documents do not define the day-to-day role of community matrons but instead describe the objectives and principles of case management for long-term conditions. The aim of this qualitative study was to describe case management from the perspective of patients and carers in order to develop a clearer understanding of how the model is being delivered for patients with long-term conditions. In-depth interviews were conducted with a purposive sample of 72 patients and 52 carers who had experience of case management. Five categories of case management tasks emerged from the data: clinical care, co-ordination of care,

education, advocacy and psychosocial support. Psychosocial support was emphasised by both patients and carers, and was viewed as equally important to clinical care. Patient and carer perceptions of case management appear to contrast with descriptions contained in Department of Health guidance, suggesting an 'implementation surplus' in relation to the policy. This particularly appears to be the case for psychosocial support activities, which are not described in official policy documents. The provision of significant psychosocial support by community matrons also appears to differentiate the model from most other case management programmes for frail elderly people described in the literature. The findings emphasise the importance of seeking patient and carer input when designing new case management programmes.

Symvoulakis E. K, et al Headache: a 'suitable case' for behavioural treatment in primary care? British Journal of General Practice 2007 57:536, 231-237

Headache is a health problem with considerable impact at personal, social, and financial levels in terms of distress, disability, and cost. In the past, many studies have investigated the use of various behavioural treatment modalities for headache. Literature reviews consistently support the effectiveness of behavioural therapeutic approaches for the treatment of the most common primary headaches, namely migraine and tension-type headache. This article recommends that behavioural headache therapies should be developed, tested, and integrated into primary care practice, where most patients with headache are seen and treated. The large population seen in general practice, most of whom have uncomplicated primary headaches, could represent the ideal target for testing behavioural therapies

Varonen H, et al Implementing guidelines on acute maxillary sinusitis in general practice--a randomized controlled trial Family Practice 2007 24 (2) 201-206 doi: 10.1093/fampra/cml074

Background: Management of acute maxillary sinusitis (AMS) is not optimal; antibiotics are often prescribed for viral sinusitis, which leads to many problems including those with antimicrobial resistance. Guidelines have been proposed as a means to change the professional practices. Objective: Our aim was to study whether a nationwide guidelines implementation programme has an effect on the management of AMS in primary care. Methods: A multi-centre randomized controlled trial was conducted in 30 health centres (HCs) covering a population of 819 777 people from 1998 to 2002. The participating HCs were randomized to implement guidelines either according to a problem-based learning (PBL) or an academic detailing (AD) method facilitated by local GPs. Data were gathered during 1 week in November in all study years and also from external control HCs in 2002. The main outcome measure was compliance with the key points of AMS management in national Current Care guidelines. Results: Implementation of guidelines produced minor changes towards the recommended practices in the management of AMS. Use of the first-line drug amoxicillin increased slightly (from 39% to 48% in AD centres and from 33% to 45% in PBL centres, controls 40%). Proportion of courses of antibiotics with recommended duration increased in MIKSTRA study centres (from 34% to 40% in AD centres and from 32% to 47% in PBL centres, controls 43%). Conclusions: A nationwide guidelines implementation project produced modest changes in the

management of AMS. There were no significant differences between AD and PBL education methods. Less than half the HCs were able to realize the project as intended, which decreases the internal validity of the study. The guidelines implementation might have benefited of more focussed targets and approaches that took into account the problems and practices of each HC

**Watkins P Evolution of diabetes care over half a century Clinical Medicine
2007 7 (2) 109-112**

Patients with 'big stomachs, skin-and-bone necks, skull-like faces, feeble movements' were beginning to stir in desperate anticipation of the new insulin treatment. Dr Allen arrived as it was growing dark and in just a few words gave them hope: 'I think I have something for you'.1 Soon afterwards, Elizabeth Hughes was to write of her insulin treatment: 'It is simply too wonderful for words, this stuff'.1 That was in 1922, and so it is still today, on every occasion when an acutely ill type 1 diabetic patient starts insulin treatment.

**Welschen L M C, et al The effectiveness of adding cognitive behavioural therapy aimed at changing lifestyle to managed diabetes care for patients with type 2 diabetes: design of a randomized controlled trial BMC Public Health 2007 7:74
doi:10.1186/1471-2458-7-74**

Background In patients with type 2 diabetes, the risk for cardiovascular disease is substantial. To achieve a more favourable risk profile, lifestyle changes on diet, physical activity and smoking status are needed. This will involve changes in behaviour, which is difficult to achieve. Cognitive behavioural therapies focussing on self-management have been shown to be effective. We have developed an intervention combining techniques of Motivational Interviewing (MI) and Problem Solving Treatment (PST). The aim of our study is to investigate if adding a combined behavioural intervention to managed care, is effective in achieving changes in lifestyle and cardiovascular risk profile. **Methods** Patients with type 2 diabetes will be selected from general practices (n=13), who are participating in a managed diabetes care system. Patients will be randomised into an intervention group receiving cognitive behaviour therapy (CBT) in addition to managed care, and a control group that will receive managed care only. The CBT consists of three to six individual sessions of 30 minutes to increase the patients motivation, by using principles of MI, and ability to change their lifestyle, by using PST. The first session will start with a risk assessment of diabetes complications that will be used to focus the intervention. The primary outcome measure is the difference between intervention and control group in change in cardiovascular risk score. For this purpose blood pressure, HbA1c, total and HDL-cholesterol and smoking status will be assessed. Secondary outcome measures are quality of life, patient satisfaction, physical activity, eating behaviour, smoking status, depression and determinants of behaviour change. Differences between changes in the two groups will be analysed according to the intention-to-treat principle, with 95% confidence intervals. The power calculation is based on the risk for cardiovascular disease and we calculated that 97 patients should be included in every group. **Discussion** Cognitive behavioural therapy may improve self-management and thus strengthen managed diabetes care. This should result in changes in lifestyle and

cardiovascular risk profile. In addition, we also expect an improvement of quality of life and patient satisfaction. Trial registration: Current Controlled Trials ISRCTN12666286

COMMISSIONING

Baxter K, Weiss, M, Le Grand, J Collaborative commissioning of secondary care services by primary care trusts Public Money and Management 2007 27 (3) 207-214 doi:10.1111/j.1467-9302.2007.00581.x

This article examines collaborations between primary care trusts in the commissioning of secondary care services in England. It applies principal-agent theory qualitatively to two case studies. The theory suggests that collaboration should take place if organizations share relevant information and agree joint objectives. The study findings show that sharing information is not a major problem for these case studies, but that agreeing joint objectives is.

Lambert M F, Gray J, Resources to develop successful primary care commissioners Quality in Primary Care 2007 15 (2) 119-122

Modern political and economic pressure, combined with changing population needs and expectations, require the NHS to commission new and innovative health services. The success of this policy hinges on NHS managers and professionals rapidly developing the skills and experience essential to commission innovative yet affordable service specifications that meet the needs of patients, the NHS and the public.

Wilson E, et al Prioritizing health technologies in a primary care trust Journal of Health Services Research and Policy 2007 12 (2) 80-85 doi: 10.1258/135581907780279495

Background: In the English National Health Service (NHS), Primary Care Trusts (PCTs) are responsible for commissioning health-care services on behalf of their populations. As resources are finite, decisions are required as to which services best fulfil population needs. Evidence on effectiveness varies in quality and availability. Nevertheless, decisions still have to be made. Methods: We report the development and pilot application of a multi-criteria prioritization mechanism in an English PCT, capable of accommodating a wide variety of evidence to rank six service developments. Results: The mechanism proved valuable in assisting prioritization decisions and feedback was positive. Two community-based interventions were expected to save money in the long term and were ranked at the top of the list. Based on weighted benefit score and cost, two preventive programmes were ranked third and fourth. Finally, two National Institute for Health and Clinical Excellence (NICE)-approved interventions were ranked fifth and

sixth. Sensitivity analysis revealed overlap in benefit scores for some of the interventions, representing diversity of opinion among the scoring panel. Conclusion: The method appears to be a practical approach to prioritization for commissioners of health care, but the pilot also revealed interesting divergences in relative priority between nationally mandated service developments and local health-care priorities

HEALTH ECONOMICS

Curtis L, Netten A The costs of training a nurse practitioner in primary care: the importance of allowing for the cost of education and training when making decisions about changing the professional mix Journal of Nursing Management 15 (4) 449-457 doi: 10.1111/j.1365-2834.2007.00668.x

What is already known on this topic * Cost containment through the most effective mix of staff achievable within available resources and organisational priorities is of increasing importance in most health systems. However, there is a dearth of information about the full economic implications of changing skill mix. * In the UK a major shift in the primary care workforce is likely in response to the rapidly developing role of nurse practitioners and policies aimed to encourage GP practices to transfer some of their responsibilities to other, less costly, professionals. * Previous research has developed an approach to incorporating the costs of qualifications, and thus the investment required to develop a skilled workforce, for a variety of health service professionals including GPs. What this study adds * This paper describes a methodology of costing nurse practitioners that incorporates the human capital cost implications of developing a skilled nurse practitioner workforce. With appropriate sources of data the method could be adapted for use internationally. * Including the full cost of qualifications results in nearly a 24 per cent increase in the unit cost of a Nurse Practitioner. * Allowing for all investment costs and adjusting for length of consultation, the cost of a GP consultation was nearly 60 per cent higher than that of a Nurse Practitioner

De Monaco H J, Von Hippel E Reducing medical costs and improving quality via self-management tools PLoS Medicine 2007 4:4 e 104 doi:10.1371/journal.pmed.0040104

In 2004 health-care providers in the United States consumed \$US1.9 trillion, or about 16% of the gross domestic product. By 2010, the cost of health care is predicted to exceed 20% of the US gross domestic product. The management of chronic diseases currently accounts for 70%-75% of health-care spending, and this proportion is likely to increase in the future. Unlike acute illness, chronic illness requires continuous and sometimes complex management over prolonged periods of time, with the goal of improving or stabilizing quality of life. One of the proposals for reducing the costs and improving the quality of chronic care is for patients to become their own providers of medical care. Empirical studies of a number of chronic diseases support the feasibility of such a proposal. Such studies found that self-management produced higher quality

outcomes at lower costs than conventional models of care. Self-management is defined as: (1) engaging in activities that protect and promote health; (2) monitoring and managing symptoms and signs of illness; (3) managing the impacts of illness on function, emotions, and interpersonal relationships; and (4) adhering to treatment regimens. In this essay, we consider the advantages and limitations of self-management tools

Dusheiko M, Gravelle H, Yu N, and Campbell S The impact of budgets for gatekeeping physicians on patient satisfaction: evidence from fundholding
Journal of Health Economics 2007 26 (4) 742-762 doi:
10.1016/j.jhealeco.2006.12.003

Between 1991 and 1998 English general practices had the option of holding budgets for prescribing and elective secondary care. Fundholding was reintroduced in 2005. We examine the effect of fundholding on patients' satisfaction with their practice, using a cross section of 4441 patients from 60 practices in the last year of fundholding (1998). We employ instrumental variables to allow for the endogeneity of fundholding. Patients of fundholders were less satisfied with the opening hours of their practice, their GP's knowledge of their medical history, with their GP's ability to arrange tests and willingness to refer to a specialist, and were more likely to agree that their doctor was more concerned about keeping costs down. Fundholder practices performed better on a number of process measures of care, and fundholding patients were more satisfied with additional non-medical services provided by the practice. The probability that patients were overall at least very satisfied with their GP practice was 0.073 (95% CI, 0.009-0.138) smaller in fundholding practices

Moscone F, Knapp M, and Tosetti E, Mental health expenditure in England: a spatial panel approach Journal of Health Economics 2007 26 (4) 842-864 doi:
10.1016/j.jhealeco.2006.12.008

We empirically investigate the determinants of local authority mental health expenditure in England. We adopt a reduced form demand and supply model, extended to incorporate possible interaction among authorities, as well as unobserved heterogeneity. The model is estimated using an annual panel dataset that allows us to explore both time-series and cross-municipality variation in mental health expenditure. Results are consistent with some degree of interdependence between neighbouring municipalities in spending decisions. This first attempt to apply spatial panels in investigating health expenditure offers insights and raises new questions

Richardson, J, McKie J Economic evaluation of services for a National Health Scheme: the case for a fairness-based framework Journal of Health Economics 2007 .26 (4) 785-799 doi: 10.1016/j.jhealeco.2006.11.004

In this paper we argue that the usual framework for evaluating health services may need modification in the context of a National Health Scheme (NHS). Some costs and benefits may need to be ignored or discounted, others included at face value, and some transfer payments included in the decision algorithm. In contrast with the standard framework, we argue that economic evaluation in the context of an NHS should focus on 'social transfers'

between taxpayers and beneficiaries, and that the nature and scope of these transfers is determined by the level of social generosity. Some of the implications of a modified framework are illustrated with a re-examination of (i) costs and transfer payments, (ii) unrelated future costs, (iii) moral hazard, and (iv) the rule that marginal costs should equal marginal benefits. We argue that an explicitly 'fairness-based' framework is needed for the evaluation of services in an NHS. In contrast, the usual welfare economic theoretic framework facilitates the sidelining of issues of fairness

Schwappach D L B, Boluarte T A , Suchrcke M The economics of primary prevention of cardiovascular disease - a systematic review of economic evaluations Cost Effectiveness and Resource Allocation 2007 5:5 doi:10.1186/1478-7547-5-5

Background In the quest for public and private resources, prevention continues to face a difficult challenge in obtaining tangible public and political support. This may be partly because the economic evidence in favour of prevention is often said to be largely missing. The overall aim of this paper is to examine whether economic evidence in favour of prevention does exist, and if so, what its main characteristics, weaknesses and strengths are. We concentrate on the evidence regarding primary prevention that targets cardiovascular disease event or risk reduction. **Methods** We conducted a systematic literature review of journal articles published during the period 1995-2005, based on a comprehensive key-word based search in generic and specialized electronic databases, accompanied by manual searches of expert databases. The search strategy consisted of combinations of freetext and keywords related to economic evaluation, cardiovascular diseases, and primary preventive interventions of risk assessment or modification. **Results** A total of 195 studies fulfilled all of the relevant inclusion criteria. Overall, a significant amount of relevant economic evidence in favour of prevention does exist, despite important remaining gaps. The majority of studies were cost-effectiveness-analyses, expressing benefits as "life years gained", were conducted in a US or UK setting, assessed clinical prevention, mainly drugs targeted at lowering lipid levels, and referred to subjects aged 35-64 years old with at least one risk factor. **Conclusions** First, this review has demonstrated the obvious lack of economic evaluations of broader health promotion interventions, when compared to clinical prevention. Second, the clear role for government to engage more actively in the economic evaluation of prevention has become very obvious, namely, to fill the gap left by private industry in terms of the evaluation of broader public health interventions and regarding clinical prevention, in light of the documented relationship between study funding and reporting of favourable results. Third, the value of greater adherence to established guidelines on economic evaluation cannot be emphasised enough. Finally, there appear to be certain methodological features in the practice of health economic evaluations that might bias the choice between prevention and cure in favour of the latter.

Williams I, Bryan S, and McIver S How should cost-effectiveness analysis be used in health technology coverage decisions? Evidence from the National Institute

**for Health and Clinical Excellence approach Journal of Health Services
Research and Policy April 2007 12 (2) , 73-79 doi: 10.1258/135581907780279521**

Background: In the National Health Service in England and Wales, technology coverage decisions are taken by the National Institute for Health and Clinical Excellence (NICE). The intention formally to apply cost-effectiveness analysis to the decision-making process distinguishes NICE from most other bodies making similar policy recommendations. We carried out a case study of the NICE Appraisals Committee to explore the influence and use of economic evaluation in the decision-making process. Methods: Qualitative case study methodology. This involved analysis of all relevant secondary sources, observations of Appraisals Committee deliberations and interviews with a cross-section of Committee members. Findings: Economic evaluation is integrated into the Committee's work. There are two main ways in which the use of economic analysis is understood by Committee members: an ordinal approach, whereby cost-effectiveness is only considered if the technology has passed a clinical effectiveness hurdle; and a framework approach, whereby the economic evaluation and model provide a structure for considering the decision problem and the evidence. These two approaches appear to operate simultaneously but are, in essence, inconsistent. Conclusions: The NICE 'experiment' has seen cost-effectiveness analysis move to the centre-ground of UK national policy deliberations regarding technology coverage. However, our case study implies that there may be room for further refinement of the appraisal process in order to resolve the observed tension between two different ways of incorporating cost-effectiveness analysis in NICE's decision-making

HEALTH INEQUALITIES

**Casalino L P, Elster A, Will pay-for-performance and quality reporting affect health care disparities? Health Affairs (Millwood) 2007 26 (3) w405-w414
doi: 10.1377/hlthaff.26.3.w405**

Pay-for-performance (P4P) and public quality-reporting programs can increase the quality of health care for the services being measured. However, unless carefully designed, these programs may have the unintended consequence of increasing racial and ethnic disparities. This paper describes ways in which P4P and public reporting programs may increase disparities and suggests ways in which programs might be designed that will make them likely to reduce, or at least not increase, disparities

Connolly S, O'Reilly D, Rosato M Increasing inequalities in health: is it an artefact caused by the selective movement of people? Social Science and Medicine 2007 64:10 2008-2015 doi:10.1016/j.socscimed.2007.02.021

Changes in health socio-economic inequalities are currently measured by comparing the mortality gradient across aggregates of small administrative areas at two points in time. However, this methodology may be flawed as it ignores population movement, which previous research has shown to be selective, with a net loss of the more affluent (and possibly healthier) residents from deprived to more affluent areas. This paper investigates whether selective migration contributed sufficiently to the observed socio-economic gradients in mortality in England and Wales throughout the 1990s so as to invalidate the current method of monitoring health inequalities. The ONS Longitudinal Study for England and Wales was used to calculate directly standardised mortality rates (DSR) by decile of deprivation in 1991 and 2001. The DSRs for 2001 were calculated twice, once according to decile of residence in 2001, and also according to the original decile in 1991. Selective migration was found to make an important contribution in explaining increases in inequalities between areas, accounting for about 50% of the increase for those aged less than 75. At the older age groups, however, selective migration was responsible for a narrowing of mortality differentials over time. These results indicate that caution should be exercised when using repeated ecological studies in assessing the extent of changes in inequalities over time.

Cookson,R, Dusheiko M, Hardman G, Socioeconomic inequality in small area use of elective total hip replacement in the English National Health Service in 1991 and 2001 Journal of Health Services Research and Policy 2007 12 Suppl 1, 10-17 doi: 10.1258/135581907780318365

Objectives: To compare socioeconomic inequality in small area use of elective total hip replacement in the English National Health Service (NHS) in 1991 and 2001. Methods: Hospital Episode Statistics and Census data were aggregated to a common geography of 'frozen' 1991 English electoral wards. The Townsend deprivation score was used as the primary indicator of socioeconomic status for each ward, and the sensitivity analysis used other Census indicators. Two main measures of inequality were examined: the indirectly age-sex standardized utilization rate ratio between most and least deprived quintile groups, and the concentration index of deprivation-related inequality in age-sex standardized utilization ratios between small areas. Each standardized utilization ratio is the observed use divided by the expected use, if each age and sex group in the study population had the same use rate as the national population. Results: In both years, observed use was below expected use for the bottom third of areas by socioeconomic status. The standardized utilization rate ratio between top and bottom Townsend quintiles fell from 1.41 (95% confidence interval [CI] 1.36-1.47) in 1991 to 1.27 (95% CI 1.23-1.32) in 2001. The proportionate increase in use required to bring the bottom quintile to the level of top thus fell significantly from 41% to 27%. The Townsend-based concentration index also fell from 0.069 (95% CI 0.059-0.079) in 1991 to 0.060 (95% CI 0.050-0.071) in 2001, although this fall was not statistically significant ($P = 0.085$). Other socioeconomic indicators yielded a similar pattern. Conclusions: Socioeconomic small area inequality in use of total hip replacement appears to have fallen between 1991 and 2001. One possible explanation is that increased hip replacement rates in the 1990s may have lowered barriers to access, thus allowing this health technology to diffuse further among lower socioeconomic groups

Dixon A, et al Is the British National Health Service equitable? The evidence on socioeconomic differences in utilization Journal of Health Services Research and Policy 2007 12 (2) 104-109 doi: 10.1258/135581907780279549

Is the British National Health Service (NHS) equitable? This paper considers one part of the answer to this: the utilization of the NHS by different socioeconomic groups (SEGs). It reviews recent evidence from studies on NHS utilization as a whole based on household surveys (macro-studies) and from studies of the utilization of particular services in particular areas (micro-studies). The principal conclusion from the majority of these studies is that, while the distribution of use of general practitioners (GPs) is broadly equitable, that for specialist treatment is pro-rich. Recent micro-studies of cardiac surgery, elective surgery, cancer care, preventive care and chronic care support the findings of an earlier review that use of services was higher relative to need among higher SEGs

Hanratt B, et al Inequality in the face of death? Public expenditure on health care for different socioeconomic groups in the last year of life Journal of Health Services Research and Policy 2007 12 (2) 90-94 doi: 10.1258/135581907780279585

Objective: To investigate the association between public expenditure on health care in the last year of life and individual socioeconomic status in Sweden. Methods: Population-based study of public expenditure using linked registers for all 16,617 deaths among Stockholm County Council residents in 2002 (population 1.8 million). Age-standardized, total and per capita spend were calculated by income categories, age and specialty. Multivariate analysis examined the association between socioeconomic status and public expenditure. Results: County council expenditure on health care in the last year of life rose with increasing income of the deceased person. Median per capita expenditure increased from 55,417 Swedish Kronor (SEK) (US\$ 7542) in the lowest income group to SEK 94,678 (US\$ 12,887) in the highest. Total age-standardized spend increased by 60% across the same interval (80,227 [95% confidence interval (CI) 79,946-80,497] to SEK 127,344 [95% CI 126,969-127,719]). Expenditure decreased with increasing age over 65 years in all income groups. Higher income was independently associated with greater total public health spend in multivariate analysis, adjusting for age, sex, health-care utilization and major diagnostic groups. Conclusions: There is inequality in public expenditure on health care at the end of life across socioeconomic groups in Stockholm. This phenomenon merits attention within Sweden, and beyond, in countries with less comprehensive welfare systems

Smith K E Health inequalities in Scotland and England: the contrasting journeys of ideas from research into policy Social Science and Medicine 2007 64 (7) 1438-1449 doi:10.1016/j.socscimed.2006.11.008

Abstract Both the UK's Labour Government and Scotland's devolved Labour-Liberal Democrat coalition Executive have committed themselves to reducing health inequalities.

Furthermore, both institutions have emphasised the importance of using evidence to inform policy responses. In light of such political commitments, a significant amount of work has been undertaken in the field of health inequalities in order to: (i) review the available research evidence; (ii) assess the extent to which policies have been based on this research evidence; and (iii) evaluate the success (or failure) of policies to tackle health inequalities. Yet so far only limited attention has been given to exploring how key actors involved in research-policy dialogues understand the processes involved. In an attempt to address this gap, this article draws on data from semi-structured interviews with 58 key actors in the field of health inequalities research and policymaking in the UK to argue that it is ideas, rather than research evidence, which have travelled from research into policy. The descriptions of the varying journeys of these ideas fit three types—successful, partial and fractured—each of which is outlined with reference to one example. The paper then employs existing theories about research-policy relations and the movement of ideas in an attempt to illuminate and better understand the contrasting journeys. In the concluding discussion, it is argued that the third approach, which focuses on the entrepreneurial processes involved in the marketing of ideas, is most helpful in understanding the research findings, but that this needs to be discussed in relation to the political context within which negotiations take place.

Tsuchiya A, Dolan P Do clinicians and members of the public share the same views about reducing inequalities in health? Social Science and Medicine 2007 64:12 2499-2503 doi:10.1016/j.socscimed.2007.03.013

Abstract Decisions about how to allocate resources in health care are as much about social value judgements as they are about getting the medical facts right. In this context, it is important to compare the social preferences of members of the general public with those of National Health Service (NHS) staff involved in service delivery. A questionnaire eliciting peoples' preferences over maximising life expectancy and reducing inequalities in life expectancy between the highest and lowest social classes was completed by 271 members of the UK public and 220 NHS clinicians. The two samples have different preferences with the general public showing a greater willingness than clinicians to sacrifice total health for a more equal distribution of health. These differences may highlight tensions between what the public wants and what clinicians want, and should be subject to further investigation.

HEALTH POLICY

Dooris M The challenge of developing corporate citizenship for sustainable public health: an exploration of the issues, with reference to the experience of North West England Critical Public Health 2006 16 (4) 331-343 doi: 10.1080/09581590601045170

Choosing Health is the first English public health strategy to highlight the concepts of corporate social responsibility and corporate citizenship and discuss their importance for health improvement. Although the terms are used most widely in relation to private

corporations, there has been growing discussion of their application to public sector organizations. The King's Fund report *Claiming the Health Dividend* led to a growing recognition that corporate citizenship within the National Health Service can make an important contribution to public health, regeneration, sustainable development and the reduction of inequalities - and a subsequent mapping exercise identified North West England as being one of the regions with a particularly well-developed approach. This paper introduces the concepts of corporate social responsibility and corporate citizenship; explores the theoretical and policy contexts relating to its application within the NHS - discussing links to sustainable development, Investment for Health and healthy settings; provides an overview of work within North West England with a particular focus on development work carried out with Salford Primary Care Trust (exploring how it could develop corporate citizenship work, specifically in relation to employment, procurement and transport); and critically reflects on and discusses emerging issues in the context of wider debates on global public health.

Navarro V What is a national health policy? International Journal of Health Services 2007 37 (1) 1-18

Unfortunately, most nation states have taken "health policy" to mean "medical care policy." Medical care, however, is only one variable in a nation's health equation. The article describes what the main components of a national health policy should be, including (1) the political, economic, social, and cultural determinants of health, the most important determinants of health in any country; (2) the lifestyle determinants, which have been the most visible types of public interventions; and (3) the socializing and empowering determinants, which link the first and second components of a national health policy: the individual interventions and the collective interventions. The author discusses the indicators that should be used for each component and for each intervention. The feasibility of this approach depends to a large degree on the political will of the national authorities and the broad understanding of the actual determinants of health. A good first step is the National Health Policy plan developed by the Swedish social democratic government. This article builds on and expands on that model.

INFORMATION AND COMMUNICATION TECHNOLOGIES AND HEALTH

Cella D, et al The Patient-Reported Outcomes Measurement Information System (PROMIS): progress of an NIH Roadmap cooperative group during its first two years Medical Care 45 (5) Suppl 1 S3 – S11 doi: 10.1097/01.mlr.0000258615.42478.55

Background: The National Institutes of Health (NIH) Patient-Reported Outcomes Measurement Information System (PROMIS) Roadmap initiative (www.nihpromis.org) is a 5-year cooperative group program of research designed to develop, validate, and standardize item banks to measure patient-reported outcomes (PROs) relevant across common medical conditions. In this article, we will summarize the organization and scientific activity of the PROMIS network during its first 2 years. Design: The network consists of 6 primary research sites (PRSSs), a statistical coordinating center (SCC), and NIH research scientists. Governed by a steering committee, the network is organized into functional subcommittees and working groups. In the first year, we created an item library and activated 3 interacting protocols: Domain Mapping, Archival Data Analysis, and Qualitative Item Review (QIR). In the second year, we developed and initiated testing of item banks covering 5 broad domains of self-reported health. Results: The domain mapping process is built on the World Health Organization (WHO) framework of physical, mental, and social health. From this framework, pain, fatigue, emotional distress, physical functioning, social role participation, and global health perceptions were selected for the first wave of testing. Item response theory (IRT)-based analysis of 11 large datasets supplemented and informed item-level qualitative review of nearly 7000 items from available PRO measures in the item library. Items were selected for rewriting or creation with further detailed review before the first round of testing in the general population and target patient populations. Conclusions: The NIH PROMIS network derived a consensus-based framework for self-reported health, systematically reviewed available instruments and datasets that address the initial PROMIS domains. Qualitative item research led to the first wave of network testing which began in the second year

DeWalt D A, et al. Evaluation of item candidates: the PROMIS qualitative item review Medical Care 2007 45 (5) Suppl. 1 S12-S21 doi: 10.1097/01.mlr.0000254567.79743.e2

One of the PROMIS (Patient-Reported Outcome Measurement Information System) network's primary goals is the development of a comprehensive item bank for patient-reported outcomes of chronic diseases. For its first set of item banks, PROMIS chose to focus on pain, fatigue, emotional distress, physical function, and social function. An essential step for the development of an item pool is the identification, evaluation, and revision of extant questionnaire items for the core item pool. In this work, we also describe the systematic process wherein items are classified for subsequent statistical processing by the PROMIS investigators. Six phases of item development are documented: identification of extant items, item classification and selection, item review and revision, focus group input on domain coverage, cognitive interviews with individual items, and final revision before field testing. Identification of items refers to the systematic search for existing items in currently available scales. Expert item review and revision was conducted by trained professionals who reviewed the wording of each item and revised as appropriate for conventions adopted by the PROMIS network. Focus groups were used to confirm domain definitions and to identify new areas of item development for future PROMIS item banks. Cognitive interviews were used to examine individual items. Items successfully screened through this process were sent to field testing and will be subjected to innovative scale construction procedures

Stewart W F, et al Bridging the inferential gap: the electronic health record and clinical evidence Health Affairs 2007 26 (2) w181-191 doi: 10.1377/hlthaff.26.2.w181

Most clinical decisions involve bridging the inferential gap: Clinicians are required to "fill in" where they lack knowledge or where no knowledge yet exists. In this context we consider how the inferential gap is a product, in part, of how knowledge is created, the limits to gaining access to such knowledge, and the variable ways in which knowledge is translated into decisions. We consider how electronic health records (EHRs) will help narrow this gap by accelerating the creation of evidence relevant to everyday practice needs and facilitating real-time use of knowledge in practice

MEDICINES MANAGEMENT

Community Pharmacy Medicines Management Project Evaluation Team The MEDMAN study: a randomized controlled trial of community pharmacy-led medicines management for patients with coronary heart disease Family Practice 2007 24 (2) 189-200 doi: 10.1093/fampra/cml075

Background: There have been recent moves to extend the role of the community pharmacist to include medicine management. Methods: A randomized controlled trial was conducted in nine sites in England. Patients with coronary heart disease were identified from general practice computer systems, recruited and randomized (2:1) to intervention or control. The 12-month intervention comprised an initial consultation with a community pharmacist to review appropriateness of therapy, compliance, lifestyle, social and support issues. Control patients received standard care. The primary outcome measures were appropriate treatment [derived from the National Service Framework (NSF)], health status (SF-36, EQ-5D) and an economic evaluation. Secondary outcome measures were patient risk of cardiovascular death and satisfaction. Results: The study involved 1493 patients (980 intervention and 513 control), 62 pharmacists and 164 GPs. No statistically significant differences between intervention and control groups were shown at follow-up for any of the primary outcome measures such as numbers on aspirin or lifestyle measures. There were few differences in quality of life (SF-36) between the intervention and control groups at baseline or follow-up or with overall EQ-5D score over time. The total National Health Service cost increased between baseline and at 12 months in both groups but to a greater extent in the intervention group. Significant improvements were found in the satisfaction score for patients' most recent pharmacy visit for prescription medicines among the intervention group, compared with control group. Self-reported compliance was good for both groups at baseline and no significant differences were shown at follow-up. Conclusion: There was no change in the proportion of patients receiving appropriate medication as defined by the NSF. The pharmacist-led service was more expensive than standard care

Edgley A, "A spoonful of regulation helps the medicine go down": the changing face of medicine regulation Social Theory and Health 2007 5 (2) 145-160 doi:10.1057/palgrave.sth.8700095

The number of medicines that are being switched from prescription only to over-the-counter are rapidly increasing. The government has said it wishes to double the number of switches in the next ten years. To assist with this ambition, the MHRA has made it easier and commercially more attractive for pharmaceutical companies to apply for a switch. This paper explores the interests and drivers behind these developments. In particular, it interrogates Abraham's thesis that medicine regulation is neo-liberal and thus "industry-friendly". By examining the recent switch of statins, a cholesterol-lowering drug that can be used preventatively - the first switch of its kind - it is argued that far from being clearly an "industry-friendly" regulatory development, in the UK context it is instead a "state-friendly" regulatory development.

Grossman J M, et al Physicians' experiences using commercial e-prescribing systems Health Affairs (Millwood) 2007 26 (3) w393-w404 doi: 10.1377/hlthaff.26.3.w393

Public and private efforts are under way to promote electronic prescribing to improve health care safety, quality, and efficiency. Findings from this qualitative study of physician practices suggest that substantial gaps may exist between advocates' vision of e-prescribing and how physicians use commercial e-prescribing systems today. While physicians were positive about the most basic e-prescribing features, they reported major barriers to maintaining complete patient medication lists, using clinical decision support, obtaining formulary data, and electronically transmitting prescriptions to pharmacies. Three factors help explain the gaps: product limitations, external implementation challenges, and physicians' preferences about using specific product features

Prosser H, Walley T Perceptions of the impact of primary care organizations on GP prescribing: the iron fist in the velvet glove Journal of Health Organization and Management 2007 21 (1) 5-26

Abstract: Purpose - This qualitative study aims to examine key stakeholders' perspectives of primary care group/trust prescribing strategies. Within the context of general practice prescribing, the paper also debates the wider issue of whether GPs' prescribing autonomy is under threat from managerial expansion following recent organisational changes in primary care. Design/methodology/approach - Data were obtained from focus groups and a series of individual semi-structured interviews with GPs and key primary care organisation stakeholders. Findings - The data underlie a tension between the managerial objective of cost-restraint and GPs' commitment to quality improvement and individual clinical patient management. In presenting both managerial and medical narratives, two divergent and often conflicting discourses emerge, which leads to speculation that managerial attempts to constrain prescribing autonomy will achieve only limited success.

The contention is that GPs' discourse features as a challenge to a managerial discourse that reflects attempts to regulate, standardise and curtail clinical discretion. This is due not only to GPs' expressed hegemonic ideals that clinical practice centres on the interests of the individual patient, but also to the fact that the managerial discourse of evidence-based medicine encapsulates only a limited share of the knowledge that GPs draw on in decision making. However, while managers' discourse presented them as unwilling to impose change or directly challenge clinical practice, evidence also emerged to suggest that is not yet possible to be sufficiently convinced of the future retention of prescribing autonomy. On the other hand, the use of peer scrutiny posed an indirect managerial influence on prescribing, whilst the emergence of prescribing advisors as analysts of cost-effectiveness may threaten doctors' dominance of medical knowledge. Research Limitations/implications - There is a continuing need to analyse the impact of the new managerial reforms on primary care prescribing. Originality/value - This study provides a snapshot of managerial and GP relations at a time of primary care transition.

**Salter C, et al "I haven't even phoned my doctor yet." The advice giving role of the pharmacist during consultations for medication review with patients aged 80 or more: qualitative discourse analysis British Medical Journal 20-4-2007 doi: 10.1136/bmj.39171.577106.55
<http://www.bmj.com/cgi/content/abstract/bmj.39171.577106.55v1>**

Objective To explore the advice giving role of pharmacists during consultation for medication review with patients aged 80 or more. **Design** Discourse analysis. **Setting** Participants' homes. **Participants** Subsample of consultations within a large randomised trial of home medication review among patients aged 80 or more who had been admitted to hospital. **Main outcome measures** Extent to which advice given by pharmacists was accepted and acknowledged by patients. **Results** Pharmacists found many opportunities to offer advice, information, and instruction. These advice giving modes were rarely initiated by the patients and were given despite a no problem response and deliberate displays of competence and knowledge by patients. Advice was often resisted or rejected and created interactional difficulties and awkward moments during the consultations. **Conclusions** The advice giving role of pharmacists during consultations with patients aged 80 or more has the potential to undermine and threaten the patients' assumed competence, integrity, and self governance. Caution is needed in assuming that commonsense interventions necessarily lead to health gain

MENTAL HEALTH

Bamford C, et al Can primary care record review facilitate earlier diagnosis of dementia? Family Practice April 2007 24 (2) 108-116 doi: 10.1093/fampra/cml068

Background: There is concern over delayed diagnosis of dementia in primary care. Objective: To determine whether primary care record review can facilitate earlier diagnosis of dementia. Methods: Retrospective notes-based case-control study. Older people with dementia (cases) were identified through older age psychiatrists in the north-east of England. Age- and sex-matched controls were identified in primary care. Frequency and place of consultations, symptoms, presentation, tests and investigations, management, referrals and selected prescription data during the 5 years prior to the diagnosis of dementia were recorded. Results: Relevant symptoms, involvement of family members, unpredictable consulting patterns and problems with management were more likely to be recorded in the notes of cases than controls. Key variables predicting subsequent diagnosis of dementia included the absence of nurse and outpatient consultations and the presence of cognitive symptoms, consultations with primary care physicians and referral for clarification of diagnosis or management. Regression models were better at predicting cases (sensitivity = 80.2%) than controls (specificity = 69.8%). Applying the models to a typical primary care physician's list would result in the identification of 93 false positives in order to identify two new cases 18 months earlier than currently occurs. Conclusions: Differences in consultation patterns can be observed up to 4 years prior to formal diagnosis of dementia, indicating that primary care physicians are attending to possible signs of early dementia. However, it is not practicable to use the systematic review of primary care records to facilitate earlier diagnosis without identifying large numbers of false positives requiring investigation

Bramlett, M D, Blumberg S J, Family structure and children's physical and mental health Health Affairs 2007 26 (2) 549- 558 doi:

Using the 2003 National Survey of Children's Health, this paper examines the physical and mental health of children by family structure. Children in step, single-mother, or grandparent-only families had poorer health than children living with two biological parents. Adjusting for demographic differences reduced observed disparities, although children living in single-mother or grandparent-only families still had poorer health than children living with two biological parents. Adjusted estimates showed that children in single-father families generally did as well as (for mental health) or better than (for physical health) children living with two biological parents

Chew-Graham C A, et al A randomised controlled trial to test the feasibility of a collaborative care model for the management of depression in older people British Journal of General Practice 2007 57 (538) 364-379

Background: Depression is the most common mental health disorder in people aged over 65 years. Late-life depression is associated with chronic illness and disability. AIM: To investigate the feasibility of a collaborative care model for depression in older people in a primary care setting. Design of study: Randomised controlled trial with 16-weeks follow up. Setting: A primary care trust in Manchester. Method: Participants were 105 people

aged 60 years or older who scored 5 or more on the Geriatric Depression Scale; 53 were randomly allocated to an intervention group and 52 to a usual care group. The intervention group received care managed by a community psychiatric nurse who delivered an intervention comprising a facilitated self-help programme with close liaison with primary care professionals and old-age psychiatry according to a defined protocol. The usual care group received usual GP care. A nested qualitative study explored the views of the health professionals and patients regarding the acceptability and effectiveness of the intervention. Results: The main outcome measure was recovery from depression. Patients in the intervention group were less likely to suffer from major depressive disorder at follow up compared with usual care (0.32, 95% confidence = interval = 0.11 to 0.93, $P = 0.036$). The qualitative component of the study demonstrated the acceptability of the intervention to patients. Conclusion: A model of collaborative care for older people with depression, used in a primary care setting with a facilitated self-help intervention is more effective than usual GP care. This study demonstrates that the implementation of a collaborative care model is feasible in UK primary care and that the intervention is effective and acceptable to patients

Farrand P, Parker M, Lee C Intention of adolescents to seek professional help for emotional and behavioural difficulties. Health and Social Care in the Community 2007 OnlineEarly articles doi: 10.1111/j.1365-2524.2007.00705.x

Much is known about adolescent help seeking for severe mental health problems. Little is currently understood about the professionals that adolescents would seek help from for milder emotional and behavioural difficulties. A self-report questionnaire was completed by 968 adolescents (53% male), aged 13-14 years in school year 9, and 15-16 years in school year 11 (64% male), attending a purposive sample of four medium to large secondary schools in Devon, UK, during February 2005. Questionnaires were completed by adolescents during whole class teaching sessions with all in attendance being willing to participate. However, 39 (4%) responses were uncompleted or incorrectly completed and removed from subsequent analysis. Questionnaires contained a series of commonly experienced difficulties and asked adolescents to indicate who they would seek help from first, if anyone, from a list of professionals identified as common providers of support. Logistic regression analyses indicated that intention to seek help varied between a low of 30% for adolescents in Year 11 on the difficulty 'were arguing all the time with your parents' to a high of 95% for females on the difficulty 'had been unfairly treated or spoken to by a teacher' with Year and Sex influencing each difficulty separately. With the exception of the difficulty 'were feeling "down" for a long time' there was a high degree of discrimination regarding the professional group (School vs. Health) that would be approached for help. With respect to specific professionals, the Form tutor featured prominently across several difficulties involving school, friends and family (range 53-65%), but also significantly across several difficulties suggestive of emotional problems (range 49-61%). General practitioners were commonly identified as providing help with difficulties sleeping (76%), and along with the school nurse with problems concerning health advice (range 38-49%). Findings highlight the influence of Year and Sex, and importance of the Form tutor in adolescent help seeking across the range of difficulties. A need is identified for further training of Form tutors in recognition of their role in supporting the interface between adolescents and services aimed at engaging young

people and a recognition by health and social care professionals regarding the importance of this role.

Licht-Strunk E, et al The prognosis of depression in older patients in general practice and the community: a systematic review Family Practice 2007 24 (2) 168-180 doi: 10.1093/fampra/cml071

Background: Little is known about the prognosis of depression in older patients in general practice or the community. Objectives: To summarize available evidence on the course and prognostic factors of depression in older persons. Methods: We conducted a systematic, computerized search of Medline and PsycINFO. Manual search of references of included studies were done. Studies potentially eligible for inclusion were discussed by two reviewers. Methodological quality was independently assessed by two reviewers. Data regarding selection criteria, duration of follow-up, outcome of depression and prognostic factors were extracted. Results: We identified 40 studies reporting on four cohorts in general practice and 17 in the community. Of all, 67% were of high quality. Follow-up was up to 1 year in general practice and up to 10 years in the community. Information on treatment was hardly provided. About one in three patients developed a chronic course. Five cohorts used more than two measurements during follow-up, illustrating a fluctuating course of depression. Using a best evidence synthesis we summarized the value of prognostic indicators. General practice studies did not provide strong evidence for any factor. Community studies provided strong evidence for an association of baseline depression level, older age, external locus of control, somatic comorbidity and functional limitations with persistent depression. Conclusion: Within the older population, age seems to be a negative prognostic factor, while older people are more likely to be exposed to most of the other prognostic factors identified

Peckover S, Chidlaw R G, Too frightened to care? Accounts by district nurses working with clients who misuse substances Health and Social Care in the Community 2007 15 (3) 238-245 doi: 10.1111/j.1365-2524.2006.00683.x

Drug misusers have complex health and social care needs, and experience considerable difficulties in accessing the assessment, care and treatment that they require. Despite the development of specialist services in many parts of the UK, substance misuse is often marginalised within mainstream general healthcare, and many practitioners are unprepared for the challenges of working with this client group. The present paper reports findings from a qualitative study that aimed to explore district nurses' understandings and practices in relation to discrimination and inequalities issues. The research took place during 2003 in two city-based primary care trusts in the North of England. Semistructured interviews were undertaken with 18 'G' grade district nurses. The authors present findings that highlight some of the challenges and tensions district nurses encounter when providing care to clients who misuse substances. The discourses of 'prejudice' and 'risk' were intertwined throughout the data, and served to shape service provision for clients who misuse substances. This was reflected in the district nurses' accounts of their own practice and that of other services, suggesting that these clients receive suboptimal care. The discourse of 'risk' was also used by district nurses to construct themselves as 'vulnerable', and this helped to explain some of their own

practices of care provision. Many participants acknowledged their limited knowledge and experience of working with this client group. There is an urgent need for district nurses and other health professionals to develop their practice with these clients, who may present as both vulnerable and dangerous, in order to ensure that care is provided equitably and safely

Pierce D, Gunn, J GPs' use of problem solving therapy for depression: a qualitative study of barriers to and enablers of evidence based care BMC Family Practice 2007 8:1 doi: 10.1186/1471-2296-8-24

Abstract: Background: Depression is a major health concern, predominantly treated by general practitioners (GPs). Problem solving therapy (PST) is recognised as an effective treatment for depression that is not widely used by GPs. This research aims to explore barriers and enablers that may influence GPs use of this treatment. **METHOD:** Qualitative methodology was used including individual and focus group interviews of GPs, PST experts and consumers. Analysis was undertaken using the Theory of Planned Behaviour (TPB) as a framework. **Results:** A spectrum of potential influences, on GPs use of PST emerged. Both barriers and enablers were identified. PST was perceived as being close to current practice approaches and potentially beneficial to both doctor and patient. In addition to a broadly positive attitude to PST, expressed by those with previous experience of its use, potential solutions to perceived barriers emerged. By contrast some GPs expressed fear that the use of PST would result in loss of doctor control of consultations and associated potential adverse patient outcomes. Patient expectations, which emerged as not always coinciding with GPs perception of those expectations, were identified as a potential influence on GPs decision concerning adoption of PST. In addition specific factors, including GP skill and confidence, consultation time constraints and technical issues related to PST were noted as potential concerns. **Conclusions:** This research contributes to our knowledge of the factors that may influence GPs decisions regarding use of PST as a treatment for depression. It recognises both barriers and enablers. It suggests that for many GPs, PST is viewed in a positive light, providing encouragement to those seeking to increase the provision of PST by GPs. In identifying a number of potential barriers, along with associated options to address many of these barriers, it provides insights which may assist in the planning of GP training in PST

Roberts L Physical health of patients with schizophrenia in primary care Family Practice 2007 24 (1) 34-40 doi: 10.1093/fampra/cml054

Background: Excess morbidity and mortality associated with schizophrenia is well established. Despite this, no previous multi-centre study has investigated whether patients with schizophrenia receive equitable physical healthcare within primary care. **Objective:** To determine whether patients with a diagnosis of schizophrenia receive the same levels of physical health care from primary care practitioners as patients without schizophrenia. **Methods:** Design: Case-matched retrospective case note review. Setting: Twenty-two general practices in the Birmingham area (UK). Subjects: 195 patients with a diagnosis of schizophrenia, 390 matched controls with a diagnosis of asthma and 390 general control patients. Main outcome measures: Proportions of patients within each group having

received six pre-defined routine health checks in a 3 year period. Conditional logistic regression models were used to identify differences between groups. Results: Patients with schizophrenia were half as likely as asthma controls to have blood pressure and cholesterol levels recorded (odds ratio 0.51; 95% confidence interval (CI) 1.35-0.73 and 0.50; 0.31-0.82, respectively) and were also less likely to have smoking status noted (0.60; 0.41-0.85). Similarly, patients with schizophrenia were significantly less likely than general population controls to have either blood pressure or cholesterol recorded (0.68; 0.47-0.97 and 0.58; 0.35-0.95). The significant differences observed were maintained after adjusting for potential confounders with the exception of cholesterol recording between the asthma and schizophrenia groups (0.57; 0.30-1.05). Conclusions: Patients with a diagnosis of schizophrenia are less likely to receive some important general health checks than patients without schizophrenia.

Simon D, et al. Depressed patients' perceptions of depression treatment decision-making Health Expectations 2007 10 (1) 62-74 doi: 10.1111/j.1369-7625.2006.00424.x

Objective: Little is known about the feasibility and effects of patient-clinician shared decision-making (SDM) for depression treatment. Within a goal of informing the design of a SDM intervention, the objective of this study was to investigate depressed patients' perceptions of the treatment decision-making process with general practitioners (GPs). Setting and participantS: Data were gathered from a convenience sample of 40 depressed patients to understand key aspects of treatment decision-making from the patient perspective. The sample varied in depression severity and type of setting in which treatment was sought. Main variables studied: Semi-structured interview questions focused on patients' prior experiences with depression and treatment, perceptions of the treatment decision-making process, and needs and expectations about treatment. Current depression severity was also assessed. Results: Patient lack of insight regarding depression severity substantially delayed patient engagement in treatment seeking and decision-making. Patients expected their GPs to be a first and main source of objective information and discussion about depression and treatment and to provide emotional support for decision-making. Patients also identified needs for additional information about depression and its treatment, as well as concerns about certain aspects of treatment. Conclusions: The depression treatment context has some aspects that differ from treatment decision-making for other types of health conditions. SDM approaches for depression treatment should be adapted based on depression severity and patient-identified needs

Tischler V, Rademeyer A, Vostanis, P Mothers experiencing homelessness: mental health, support and social care needs Health and Social .Care in the Community 2007 15 (3) 246-253 doi: 10.1111/j.1365-2524.2006.00678.x

Little is known about the experiences of mothers who become homeless. The numbers of women with children in this situation are growing, most becoming homeless following domestic or neighbour abuse, or the breakdown of family relationships. This qualitative study aimed to describe mothers' experiences of homelessness in relation to their mental health, support and social care needs. Twenty-eight homeless women with dependent

children residing in hostels were interviewed. The experience of homelessness was stressful, but viewed as a respite for many of the participants because they had experienced violence and harassment prior to their stay in the hostels. Many described poor mental health, which they related to the conditions in hostels and traumas that they had experienced before becoming homeless. Their experiences and perceptions of the services available were mixed. Some valued the support offered by staff and other residents, but the majority felt that there was a lack of resources to address their needs. Many women had difficulty coping with homelessness, and several said that support from other homeless women was an important source of help. Services need to work together to meet the multiple health, social, psychological and housing needs of these women

MENTAL HEALTH SERVICES

Fickel J, et al Primary care - mental health collaboration: an example of assessing usual practice and potential barriers Journal of Interprofessional Care 2007 21 (2) 207- 16 doi: 10.1080/13561820601132827

Practice guidelines include recommendations for collaboration between primary care (PC) and mental health (MH) to improve the quality of depression management within primary care. There is little research, however, assessing usual care relationships between PC and MH providers, or providers' perceptions regarding collaboration. Based on the literature, we conceptualize a continuum of collaborative activities and strategies. We describe the extent of collaboration and perceived barriers in selected outpatient clinics. We conducted semi-structured interviews with 22 PC and MH clinical leaders from 10 outpatient facilities. Topics included existing referral, consultation, and collaboration practices between PC and MH, beliefs and barriers related to collaboration. Informants generally described good relationships between providers, and PC providers reported satisfaction with referrals to MH. Informal consultation also occurred, although it was not universal. There was little evidence of collaboration beyond this basic level. The leaders identified several potential barriers to collaboration, including inadequate staffing and resources for both services. In contrast with practice guidelines, the clinics we studied incorporated little collaboration with MH providers into PC management of depression. We identify strategies that can help overcome the barriers to collaboration that our informants most commonly identified.

Gallo J J, et al The effect of a primary care practice-based depression intervention on mortality in older adults: a randomized trial Annals of Internal Medicine 2007 146 (10) 689-698

Background: Few studies have tested the effects of a depression intervention on the risk for death associated with depression. Objective: To test whether an intervention to improve depression care can modify the risk for death. Design: Practice-based, randomized, controlled trial. Setting: 20 primary care practices in New York, New York,

and Philadelphia and Pittsburgh, Pennsylvania. Patients: 1226 randomly sampled patients identified through a 2-stage, age-stratified (60 to 74 years and ≥ 75 years) depression screening. Intervention: Depression care manager working with primary care physicians to provide algorithm-based care. Measurements: Depression status based on clinical interview and vital status at 5 years by using the National Death Index. Results: At baseline, 396 patients met criteria for major depression and 203 patients met criteria for clinically significant minor depression. After a median follow-up of 52.8 months, 223 patients died. Patients with depression in intervention practices were less likely to have died than those in usual care practices (adjusted hazard ratio, 0.67 [95% CI, 0.44 to 1.00]). Risk for death was reduced in patients with major depression (adjusted hazard ratio, 0.55 [CI, 0.36 to 0.84]) but not in patients with clinically significant minor depression (adjusted hazard ratio, 0.97 [CI, 0.49 to 1.92]). The benefit seemed to be almost entirely attributable to a reduction in deaths due to cancer. Limitations: The mechanism for an effect on deaths due to cancer is unclear. Depression status, cause of death, and vital status might have been misclassified. Conclusions: Older primary care patients with major depression in practices that implemented depression care management were less likely to die over a 5-year period than were patients with major depression in usual care practices. The effect seemed to be limited to deaths due to cancer. The mechanism for such an effect is unclear and warrants further investigation. Clinical Trials.gov registration number: NCT00000367

Gilchrist G, Gunn J Observational studies of depression in primary care: what do we know? BMC Family Practice 2007, 8:28 doi:10.1186/1471-2296-8-28

Background We undertook a systematic review of observational studies of depression in primary care to determine 1) the nature and scope of the published studies 2) the methodological quality of the studies; 3) the identified recovery and risk factors for persistent depression and 3) the treatment and health service use patterns among patients. **Methods** Searches were conducted in MEDLINE, CINAHL and PsycINFO using combinations of topic and keywords, and Medical Subject Headings in MEDLINE, Headings in CINAHL and descriptors in PsycINFO. Searches were limited to adult populations and articles published in English during 1985-2006. Results 40 articles from 17 observational cohort studies were identified, most were undertaken in the US or Europe. Studies varied widely in aims and methods making it difficult to meaningfully compare the results. Methodological limitations were common including: selection bias of patients and physicians; small sample sizes (range 35-108 patients at baseline and 20-59 patients at follow-up); and short follow-up times limiting the extent to which these studies can be used to inform our understanding of recovery and relapse among primary care patients with depression. Risk factors for the persistence of depression identified in this review were: severity and chronicity of the depressive episode, the presence of suicidal thoughts, antidepressant use, poorer self-reported quality of life, lower self-reported social support, experiencing key life events, lower education level and unemployment. **Conclusions** Despite the growing interest in depression being managed as a chronic illness, this review identified only 17 observational studies of depression in primary care, most of which have included small sample sizes and been relatively short-term. Future research should be large enough to investigate risk factors for chronicity and relapse, and should be conducted over a longer time frame.

Heideman J M C et al Improving primary mental health care: impact of a nationwide programme Health Policy 2007 81 (2-3) 146-154 doi: 10.1016/j.healthpol.2006.06.004

Objective: To determine the impact of a nationwide programme on primary mental health care practices. Design: Cohort study involving two surveys conducted in 2001 and 2003. Setting and subjects: Random sample of 2757 general practitioners. Intervention: In 2001, a nationwide programme was initiated to improve primary mental health care. The programme used a participatory approach with regional needs assessment and regional selection of the interventions. Main outcome measures: Perceived need, availability and participation in the interventions; self-reported mental health performance (self-reported diagnosis and management of mental health disorders); perceived barriers to optimal care. Results: Baseline and follow-up questionnaires were returned by 1336 and 1358 general practitioners, respectively. Interventions did not entirely match general practitioners' needs. Mental health performance did not change consistently while perceived barriers to optimal care decreased considerably. Actual participation in the interventions was not associated with improved mental health performance or decreased perception of barriers. Conclusions: The application of the nationwide programme had no considerable impact on the professional practices of general practitioners with regard to mental health care. This finding challenges the assumption that a bottom-up approach to quality improvement is effective. Extensive coordination at a national level and the provision of specific supportive products and services appears to be necessary to achieve improvement.

Hutton C M, Gunn J Do longer consultations improve the management of psychological problems in general practice: a systematic literature review BMC Health Services Research 2007 17:7(1) doi:10.1186/1472-6963-7-71

Background Psychological problems present a huge burden of illness in our community and GPs are the main providers of care. There is evidence that longer consultations in general practice are associated with improved quality of care; but this needs to be balanced against the fact that doctor time is a limited resource and longer consultations may lead to reduced access to health care. The aim of this research was to conduct a systematic literature review to determine whether management of psychological problems in general practice is associated with an increased consultation length and to explore whether longer consultations are associated with better health outcomes for patients with psychological problems. **Methods** A search was conducted on Medline (Ovid) databases up to 7 June 2006. The following search terms, were used: general practice or primary health care (free text) or family practice (MeSH) AND consultation length or duration (free text) or time factors (MeSH) AND depression or psychological problems or depressed (free text). A similar search was done in Web of Science, Pubmed, Google Scholar, and Cochrane Library and no other papers were found. Studies were included if they contained data comparing consultation length and management or detection of psychological problems in a general practice or primary

health care setting. The studies were read and categories developed to enable systematic data extraction and synthesis. Results 29 papers met the inclusion criteria. Consultations with a recorded diagnosis of a psychological problem were reported to be longer than those with no recorded psychological diagnosis. It is not clear if this is related to the extra time or the consultation style. GPs reported that time pressure is a major barrier to treating depression. There was some evidence that increased consultation length is associated with more accurate diagnosis of psychological problems. Conclusions Further research is needed to elucidate the factors in longer consultations that are associated with greater detection of psychological problems, and to determine the association between the detection of psychological problems and the attitude, gender, age or training of the GP and the age, gender and socioeconomic status of the patient. These are important considerations if general practice is to deal more effectively with people with psychological problems.

Mcalpine D, Wilson A R Trends in obesity-related counseling in primary care Medical Care 2007 45 (4) 322-329 doi: 10.1097/01.mlr.0000254575.19543.01

Objective: We sought to ascertain whether the percentage of visits in which physicians provided obesity-related counseling services increased between 1995 and 2004. Method: Data came from the 1995 to 2004 National Ambulatory Medical Care Survey, an annual national survey of visits to office-based physicians. Analyses are restricted to visits by adults to a primary care physician (PCP; general/family or internal medicine). The main outcome measure is the percentage of visits to physicians where patients were counseled about exercise, diet/nutrition or weight loss. Results: Sample sizes ranged from 9,583 to 14,071. In 2003/2004, approximately 20% of visits to PCPs included counseling for diet/nutrition, 14% for exercise, and 6% for weight loss. Approximately 24% of visits included at least one of these types of counseling. The odds of receiving counseling for any of these services were 22% lower in 2001/2002 and 18% lower in 2003/2004 compared with 1995/1996. Patients who went to the doctor for weight-related concerns or with an obesity-related diagnosis were more likely to receive counseling than the general population. Longer visits were associated with greater probability of obesity-related counseling. Conclusions: Obesity-related counseling does not appear to be a substantial part of the services provided by physicians. Further efforts in developing interventions that can be used by physicians and demonstrating their effectiveness within clinical practice are needed.

Schultz, P N, Remick-Barlow G A, Robbins L Equine-assisted psychotherapy: a mental health promotion/intervention modality for children who have experienced intra-family violence Health and Social Care in the Community 2007 15 (3) 265-271 doi: 10.1111/j.1365-2524.2006.00684.x

Equine-assisted psychotherapy (EAP) is a specialized form of psychotherapy using the horse as a therapeutic tool. This modality is designed to address self-esteem and personal confidence, communication and interpersonal effectiveness, trust, boundaries and limit-

setting, and group cohesion. Substantial numbers of children witness family violence. There is evidence that violence between parents has adverse effects on the children in the family. These children are at greater risk of behavioural problems and mental health disorders, including anxiety, anger, depression and suicidal ideations, withdrawal, low self-esteem, and attention deficit hyperactivity disorder. The purpose of the present pilot study was to test the efficacy of EAP in a cross-sectional group of children referred to a psychotherapist for various childhood behavioural and mental health issues over an 18-month period (June 2003-January 2005). Sixty-three children received a mean number of 19 EAP sessions. Scores on the Children's Global Assessment of Functioning (GAF) Scale were determined pre- and post-treatment. The mean (+/- standard deviation, SD) pretreatment score was 54.1 (SD 3.2) and post treatment mean score was 61.7 +/- 5.0 ($t = 9.06$, d.f. = 96, $P < 0.001$). All children showed improvement in GAF scores, and there was a statistically significant correlation between the percentage improvement in the GAF scores and the number of sessions given ($r = 0.73$, $P = 0.001$). Univariate analysis showed that the greatest improvement in the GAF scores occurred in the youngest of the subjects. Children in the group who had a history of physical abuse and neglect had a statistically significant greater percentage improvement in GAF scores after treatment than those who did not have a history of abuse and neglect. This study has demonstrated a quick response to EAP, especially in younger children, but it remains to be determined what kind of long-term effects this type of intervention may provide

NEED AND DEMAND FOR CARE

de Viggiani, N A new approach to prison public health? Challenging and advancing the agenda for prison health *Critical Public Health* 2007 16 (4) 307-318 doi: 10.1080/09581590601045212

This paper explores recent developments in prison public health, recommending that future prison health policies and practices become more 'upstream' in their outlook and approach. It is argued that this will require much firmer acknowledgement of the significance of broad, systemic and structural determinants of prisoner health, particularly if the World Health organization's vision for a 'healthy prison' is to be realized. Epidemiological evidence plainly shows that prisoners have experienced - and continue to experience - worse health than the general population, despite the fact that prison settings across the European Union have been targeted for health promotion by the World Health Organization since 1994. In 2005, WHO launched a new 10-year prison public health plan, which it envisages will begin to address key prison health determinants. In the UK, New Labour has identified prison health as a key public health objective within *Choosing Health*, although health interventions within prisons continue to be predominantly geared towards efficient and effective primary and secondary healthcare, and much less towards public health goals. This paper strives to open up the debate on prison public health, advocating a progressive and more sustainable approach to developing and commissioning health services for prisoners

Feldman-Stewart D A systematic review of information in decision aids Health Expectations 2007 10 (1) 46-61 doi: 10.1111/j.1369-7625.2006.00420.x

Objective: We completed a systematic review of information reported as included in decision aids (DAs) for adult patients, to determine if it is complete, balanced and accurate. Search strategy: DAs were identified using the Cochrane Database of DAs and searches of four electronic databases using the terms: 'decision aid'; 'shared decision making' and 'patients'; 'multimedia or leaflets or pamphlets or videos and patients and decision making'. Additionally, publications reporting DA development and actual DAs that were reported as publicly available on the Internet were consulted. Publications were included up to May 2006. Data extraction: Data were extracted on the following variables: external groups consulted in development of the DA, type of study used, categories of information, inclusion of probabilities, use of citation lists and inclusion of patient experiences. Main results: 68 treatment DAs and 30 screening DAs were identified. 17% of treatment DAs and 47% of screening DAs did not report any external consultation and, of those that did, DA producers tended to rely more heavily on medical experts than on patients' guidance. Content evaluations showed that (i) treatment DAs frequently omit describing the procedure(s) involved in treatment options and (ii) screening DAs frequently focus on false positives but not false negatives. About 1/2 treatment DAs reported probabilities with a greater emphasis on potential benefits than harms. Similarly, screening DAs were more likely to provide false-positive than false-negative rates. Conclusions: The review led us to be concerned about completeness, balance and accuracy of information included in decision aids.

Gately C, Rogers A, Sanders C Re-thinking the relationship between long-term self-management education and the utilization of health services. Social Science and Medicine Online 21/5/2007 doi:10.1016/j.socscimed.2007.04.018

Encouraging self-management has been viewed as one means of reducing health service utilisation and contributing to improved demand management. However, the processes and imputed relationship between self-management education skills and health service contact are poorly understood. This paper reports on data from an embedded qualitative study which ran alongside a randomised controlled trial in England designed to test the clinical and cost effectiveness of a self-care support policy which found no statistically significant reductions in health service utilisation. Drawing on concepts from the sociology of chronic illness, analyses suggest that the biographical and social context relevant to individuals' experience of living with a long-term condition, history of health service utilisation, and relationships with health professionals are relevant to understanding the impact of self-management education and related policies aimed at bringing about changes in service use. Our study suggests that future health policy assumptions about utilisation in the context of chronic disease management and self-care support policies may benefit by acknowledging the complex, contextual and recursive nature of health service utilisation operating in the life worlds of patients' experience of living with a long-term condition.

Lo Fo, Wong S, et al Utilisation of health care by women who have suffered abuse: a descriptive study on medical records in family practice British Journal of General Practice 2007 .57 (538) 396-400

Background: Female patients, abused by their partner, are heavy users of medical services. To date, valid indicators of partner abuse of women are lacking. Aim: To outline the healthcare utilisation in family practice of women who have suffered abuse, and compare this to the average female population in family practice. Design of Study: As part of a primary study on the role of family doctors in recognising and managing partner abuse a retrospective study was performed. Anonymised data from the electronic medical records of women who have suffered abuse were collected over the period January 2001-July 2004. These data were compared to those from the average female population of the Second Dutch National Survey in General Practice 2001 (DNSGP-2). Setting: Family practices in Rotterdam and surrounding areas in 2004. Method: The numbers of consultations and prescriptions for pain medication, tranquillisers and antidepressants of women who have suffered abuse (n = 92) were compared to those of the female population of the DNSGP-2 (n = 210 071). The presented health problems and referrals of the studied group were examined. Results: Pain, in all its manifestations, appeared to be the most frequently presented health problem. Compared to the female population of the DNSGP-2, in all age categories, women who have suffered abuse consult their family doctor almost twice as often and receive three to seven times more pain medication. Conclusion: A doubled consultation frequency, chronic pain and an excessively high number of prescriptions for pain medication are characteristics of healthcare utilisation of women have been abused in this study. These findings contribute to the development of the concept of the 'symptomatic' female patient

McDonald, R, Mead N, Cheraghi-Sohi, ., Bower, P, Whalley, D., and Roland, M. Governing the ethical consumer: identity, choice and the primary care medical encounter Sociology of Health and Illness 2007 29 (3) 430-456 doi: 10.1111/j.1467-9566.2007.00493.x

Government policy promoting consumerism in healthcare can be seen as offering up certain preferred identities to which its citizens are encouraged to aspire. Whilst many commentators reject the notion that health services users should be conceived of as consumers, this paper outlines the relevance of the concept to our understanding of the ways in which individuals manage their health and service use. The paper examines the identity work undertaken by individuals in relation to decisions about healthcare preferences and assesses the extent to which this is compatible with the identities promoted in Government policy. We suggest that in circumstances where individuals feel both a sense of personal entitlement and a desire to be supportive of the needs of other members of the community, 'doing' ethical consumer can be fraught with discomfort and anxiety. These anxieties are exacerbated in a context where citizenship is increasingly being defined in terms of consumer identities, and making good (health) choices might be seen as distinguishing the civilised from the marginalised

ORGANIZATIONS

Checkland K, Harrison S, Marshall, M, Is the metaphor of 'barriers to change' useful in understanding implementation? Evidence from general medical practice Journal of Health Services Research and Policy April 2007 12 (2) 95-100 doi: 10.1258/135581907780279657

Objectives: To investigate how general medical practices in the UK react to bureaucratic initiatives, such as National Health Service (NHS) National Service Frameworks (NSFs), and to explore the value of the metaphor of 'barriers to change' for understanding this. Methods: Interviews, non-participant observation and documentary analysis within case studies of four practices in northern England. Results: The practices had not actively implemented NSFs. At interview, various 'barriers' that had prevented implementation were listed, including the complexity of the documents and lack of time. Observation suggested that these barriers were constructions used by the participants to make sense of the situation in which they found themselves. Conclusion: The metaphor of 'removing barriers to change' was of limited use in a context where non-implementation of policy was an emergent property of underlying organizational realities, likely to be modifiable only if these realities were addressed

Fotaki M Can directors of public health implement the new public health agenda in primary care; a case study of primary care trusts in the North West of England. Policy and Politics 2007 35 (2) 311-335

The appointment of directors of public health (DsPH) to the Primary Care Trust (PCT) boards to work jointly with the local authorities in addressing health inequalities reflects the adoption of a multidimensional perspective of public health, and a shift in policy focus from treatment to illness prevention. Neo-institutional theory of change is applied to discuss findings obtained from a postal questionnaire with all DsPH (n=40) and qualitative interviews with executive and non-executive board members in five PCTs in the North West of England, and to conclude that public health potential may not be fulfilled because of pressures outside the public health area and the lack of capacity in the PCTs.

Smith J Primary care organizations in New Zealand and England: tipping the balance of the health system in favour of primary care. International Journal of Health Planning and Management 2007 22 (1) 3-19

This paper examines the experience of developing primary care organizations (PCOs) in New Zealand and England, exploring how far these new institutional forms have been able to 'tip the balance' of their host health system in favour of primary care. The original objectives for establishing PCOs in the two countries are assessed using published research evidence on the impact of PCOs covering: efficiency and cost containment; the development of clinical engagement and leadership; the development of primary care; and the purchasing of secondary and referred services. It is concluded that in both countries, progress has been made in aligning more closely the individual focus of

general practice with the population perspective of the wider public health system. The New Zealand approach of using non-governmental PCOs is judged consistent with harnessing the professional culture of general practice towards community-based public health. By contrast, English primary care trusts (PCTs) are at risk of becoming remote from their origins as purchasers in primary care and general practice, unless the re-introduction of practice-level purchasing can provide GPs with new enthusiasm for local planning and service development.

Walker R, Bisset P, Adam J Managing risk: risk perception, trust and control in a primary care partnership Social Science and Medicine 2007 64 (4) 911-923 doi:10.1016/j.socscimed.2006.10.034

In this article, managers' perceptions of risk on entering a newly formed primary health care partnership are explored, as are the mechanisms of trust and control used to manage them. The article reports a qualitative component of a 2-year National Health and Medical Research Council funded study of trust within the structures of a Primary Care Partnership (PCP) in Victoria, Australia. Multiple methods of data collection were employed. We found that managers identified risks at system, partnership and agency levels, and that as trust was built, concern about risks diminished. Trust effectively facilitated joint action, but it was betrayed on occasions, in which case the informal power of group process was used to contain the problems. The implications of this study for policy makers are in terms of understanding how perceptions of risk are constructed, the ways managers use social control to create a safer context in which to locate the trust-based relationships that facilitate joint action, and the importance of institutional arrangements. Without trust, joint action is hard to achieve, and without control, it is difficult to prevent breaches of trust from inhibiting joint action.

PATIENT AND PUBLIC INVOLVEMENT

Caldow J et al Treatment of minor illness in primary care: a national survey of patient satisfaction, attitudes and preferences regarding a wider nursing role th Expectations 2007 10 (1) 30-45 doi: 10.1111/j.1369-7625.2006.00422.x

Background: This study investigated patient opinion about the provision of nurse-led vs. doctor-led primary health care in the treatment of minor illness. Design: A postal questionnaire survey including discrete choice experiment (DCE) of a national sample followed by telephone interviews with respondent volunteers. Setting and participants: A large random sample of the population of Scotland from a range of general practices including traditional and extended practice nursing roles was invited to participate. Main outcome measures: patient satisfaction with, opinion of and preference for practice nurse

(PN) vs. doctor consultation in primary care in relation to gender, age, education and income. Results: Questionnaire response rate was 49% (1343 of 2740). Women, younger people, the less well-educated and those with higher income had a more positive attitude towards the PN. Older people had a more positive attitude to the doctor. Results from the DCE indicated that whilst most respondents would prefer a doctor consultation, many would be happy to consult with a nurse if other aspects of the consultation were improved. Forty-eight people were interviewed. The main perceived differences between doctors and nurses were academic ability and qualifications. Most respondents thought nurses could deal with relatively minor problems and should be able to prescribe some drugs. Conclusion: Patients would always want their choice of health professional to be available at first contact. However, this study suggests that, in primary health-care practices, if nurses take on more roles previously the preserve of doctors, patients would accept them, particularly if patients receive information on nurses' capabilities

Cheraghi-Sohi S, et al Making sense of patient priorities: applying discrete choice methods in primary care using 'think aloud' technique Family Practice 2-5-2007 epublication. Doi: 10.1093/fampra/cmm007

Background: Delivering effective health care within limited budgets requires an understanding of patient priorities. Discrete choice experiments (DCEs) provide patients with choices, where each choice differs in terms of certain attributes (such as waiting times, quality of care). Although this technique has significant potential in examining priorities, its use raises practical and conceptual issues. This paper describes the development of a DCE evaluating patient priorities in primary care. Methods: twenty patients completed a DCE using a 'think aloud' protocol, where they verbalized their thinking while making choices. The analysis examined their decision-making processes. Results: There was evidence that patients reinterpreted some attributes, and related some to others outside the task. The cost attribute was interpreted in a variety of ways, dominating some patients' decision-making, being seen as irrelevant by others and being interpreted appropriately by some. The degree to which patients exhibited trading in line with theoretical assumptions also varied. Some choices in the hypothetical task were restricted by their previous experience, but more frequently patients tested the boundaries of the task in ways which directly reflected the primary care context. Conclusion: Patient interpretation of the discrete choice task was varied and some went beyond the formal boundaries of the task to make their choices. This highlights the importance of piloting attributes, providing clear instructions about the task and developing models of patient decision-making so that responses can be interpreted correctly

O'Connor A M et al Toward the 'tipping point': decision aids and informed patient choice Health Affairs (Millwood) 2007 26 (3)716-725 doi: 10.1377/hlthaff.26.3.716

Preference-sensitive treatment decisions involve making value trade-offs between benefits and harms that should depend on informed patient choice. There is strong evidence that patient decision aids not only improve decision quality but also prevent the

overuse of options that informed patients do not value. This paper discusses progress in implementing decision aids and the policy prospects for reaching a "tipping point" in the adoption of "informed patient choice" as a standard of practice

PRIMARY/SECONDARY CARE INTERFACE

Ball E, Critchley S Patient and practitioner views of a new rheumatology (Tier 2) primary care service Quality in Primary Care 2007 15 (2) 101-106

The rheumatology Tier 2 service in Oldham was implemented to see patients in a primary care setting for their initial assessment. They were treated and discharged within the service, or referred on to secondary care in order to limit inappropriate attendance in secondary care and fast-track patients with inflammatory disease to the rheumatology consultant. The aim of this study was to evaluate patients' and general practitioners' (GPs') views about the transfer of rheumatological services from secondary to primary care. Patients and GPs were from a single primary care trust in Oldham, North West England. A thematic analysis of interview data was taken and findings showed high patient satisfaction with the service, favouring the primary care environment to a hospital setting. GPs reported on the cost-effectiveness of the service and better management of the disease. The Tier 2 service has the potential to set a new direction for multi-agency care within a primary care setting.

Julian S et al. An integrated care pathway for menorrhagia across the primary-secondary interface: patients' experience, clinical outcomes, and service utilization Quality and Safety in Health Care 2007 16 (2) 110-115 doi: 10.1136/qshc.2005.016782

Background: "Referral" characterises a significant area of interaction between primary and secondary care. Despite advantages, it can be inflexible, and may lead to duplication. Objective: To examine the outcomes of an integrated model that lends weight to general practitioner (GP)-led evidence based care. Design: A prospective, non-random comparison of two services: women attending the new (Bridges) pathway compared with those attending a consultant-led one-stop menstrual clinic (OSMC). Patients' views were examined using patient career diaries, health and clinical outcomes, and resource utilisation. Follow-up was for 8 months. Setting: A large teaching hospital and general practices within one primary care trust (PCT). Results: Between March 2002 and June 2004, 99 women in the Bridges pathway were compared with 94 women referred to the OSMC by GPs from non-participating PCTs. The patient career diary demonstrated a significant improvement in the Bridges group for patient information, fitting in at the point of arrangements made for the patient to attend hospital (ease of access) ($p < 0.001$),

choice of doctor ($p = 0.020$), waiting time for an appointment ($p < 0.001$), and less "limbo" (patient experience of non-coordination between primary and secondary care) ($p < 0.001$). At 8 months there were no significant differences between the two groups in surgical and medical treatment rates or in the use of GP clinic appointments. Significantly fewer (traditional) hospital outpatient appointments were made in the Bridges group than in the OSMC group ($p < 0.001$). Conclusion: A general practice-led model of integrated care can significantly reduce outpatient attendance while improving patient experience, and maintaining the quality of care.

Lyon D et al. Predicting the likelihood of emergency admission to hospital of older people: development and validation of the Emergency Admission Risk Likelihood Index (EARLI) Family Practice 2007 24 (2) 158-167 doi: 10.1093/fampra/cml069

Objective: To develop and evaluate an evidence-based tool for predicting the likelihood of emergency admission to hospital of older people aged 75 years and over in the UK. Methods: Prospective cohort study of older people registered with 17 general practices within Halton Primary Care Trust in the north-west of England. A questionnaire with 20 items was sent to older people aged ≥ 75 years. Items for inclusion in the questionnaire were selected from information gleaned from published literature and a pilot study. The primary outcome measurement was an emergency admission to hospital within 12 months of completing the questionnaire. A logistic regression analysis was carried out to identify those items which predicted emergency admission to hospital. A scoring system was devised to identify those at low, moderate, high and very high risk of admission, using the items identified in the predictive modelling process. Results: In total, 83% (3032) returned the questionnaire. A simple, six-item tool was developed and validated-the Emergency Admission Risk Likelihood Index (EARLI). The items included in the tool are as follows: do you have heart problems? [odds ratio (OR) 1.40, 95% confidence interval (CI) 1.15-1.72]; do you have leg ulcers? (OR 1.46, 95% CI 1.04-2.04); can you go out of the house without help? (OR 0.60, 95% CI 0.47-0.75); do you have problems with your memory and get confused? (OR 1.46, 95% CI 1.19-1.81); have you been admitted to hospital as an emergency in the last 12 months? (OR 2.16, CI 1.72-2.72); and would you say the general state of your health is good? (OR 0.66, 95% CI 0.53-0.82). The tool had high negative predictive value ($>79\%$) and identified over 50% of those at high or very high risk of emergency admission. A very high score (>20) identified 6% of older people, 55% of whom had an emergency admission in the following 12 months. A low score (≤ 10) identified 74% of the older population of whom 17% were admitted. Conclusions: In this study, we have developed and validated a simple-to-apply tool for identifying older people in the UK who are at risk of having an emergency admission within the following 12 months. EARLI can be used as a simple triage-screening tool to help identify the most vulnerable older people, either to target interventions and support to reduce demand on hospital services

Madigan S M, et al. General practitioners involvement in enteral tube feeding at home: a qualitative study BMC Family Practice 2007 8:29 doi: 10.1186/1471-2296-8-29

Abstract: background: Complex medical treatment is moving from hospital to primary care and General Practitioners (GPs) are increasingly asked to undertake new roles. It is estimated that over 19,500 adult patients are being fed in the UK in the community using a variety of different feeding tubes (Percutaneous endoscopic gastrostomy (PEG), Jejunostomy, or nasogastric (NG)). The majority of patients are over the age of 65 years when they had artificial feeding initiated and mainly because of dysphagia. The aim of this study was to explore GPs knowledge, attitudes and skills relating to enteral feeding in the community. Methods: Semi-structured one-to-one interviews with a convenience sample of GPs in Northern Ireland. Results: Twenty-three GPs in three health boards in Northern Ireland participated in the study. Most found dealing with enteral feeding to be a predominantly negative experience. They had little involvement in patient selection for the procedure and poor or no discharge information. GPs felt inadequately trained, there was poor communication between primary and secondary care and little support. There was anger and frustration among GPs about lack of resources (funding and training), and the perception that primary care was used as a dumping ground. Conclusions: Moving complex medical treatment from secondary to primary care has major implications for GPs who should be included in the patient selection process, have adequate discharge information about their patients, be adequately resourced and have appropriate support and training

Roberts N, Meade K, Partridge M. The effect of telephone reminders on attendance in respiratory outpatient clinics Journal of Health Services Research and Policy 2007 12 (2) 69-72 doi: 10.1258/135581907780279567

Introduction: Patient non-attendance is an area of concern for all health care providers. A randomized controlled trial was undertaken to investigate whether reminder telephone calls improved attendance at respiratory outpatient clinics in the English National Health Service (NHS). Methods: Patients were randomly allocated into one of two groups, either telephone reminder group or usual care. The telephone reminder group received a reminder telephone call between 9 am and 5 pm during the week prior to their appointment. Attendance and demographic information (age, sex, diagnosis and home postcode) were recorded. Results: A total of 504 patients were recruited, 258 patients were allocated to the control group and 246 patients were allocated to the telephone reminder group. Fifty-eight percent of the patients allocated to the telephone reminder group were not contactable. Within the telephone reminder group, of the 104 patients who could be contacted, 86% attended. There was a significant 15% increase in attendance in the contacted group (n = 104) when compared both with the control group (71%, n = 258) and with the patients who could not be contacted (68%, n = 142) (P = 0.007; P = 0.004). It was estimated that the cost of telephoning 200 patients could be offset by preventing one non-attendance. Conclusion: Routine telephoning of outpatients should become standard practice if reducing non-attendance is thought to be desirable, but general practitioner (GP) referral letters and hospital records of current hospital outpatients need to include an up-to-date telephone number. Consideration should be given to 'out-of-hours' reminder calls to maximize the contact rate

Sibbald B, McDonald R, Roland M Shifting care from hospitals to the community: a review of the evidence on quality and efficiency Journal of Health Services Research and Policy 2007 12 (2), 110-117 doi: 10.1258/135581907780279611

Objectives: A key objective in many health-care systems is to shift specialist services from acute hospitals to the community and so bring care closer to home for patients. Our aim was to review published research into the effectiveness of strategies for achieving this objective. Methods: We conducted a 'scoping' review and qualitative data synthesis of four strategies: transfer of services from hospital to primary care; relocation of hospital services to primary care; joint working between primary and acute care; and interventions to alter the referral behaviour of primary care practitioners. Results: One hundred and nineteen studies were identified and data systematically extracted. The findings suggest that transferring hospital services to primary care, and interventions that change the referral behaviour of primary care practitioners generally reduced outpatient activity but also risked reducing quality. Savings in cost were offset by increases in overall service volume and loss of economies of scale. Relocating specialists to primary care, and joint working between primary and acute care, improved access without jeopardizing quality. However, outpatient activity was rarely reduced and costs were generally increased due to loss of economies of scale. Conclusions: Our findings suggest that the policy may be effective in improving access to specialist care for patients and reducing demand on acute hospitals. There is a risk, however, that the quality of care may decline and costs may increase

QUALITY OF CARE

Casalino L P et al General internists' views on pay-for-performance and public reporting of quality scores: a national survey Health Affairs 2007 26 (2) 492-299 doi: 10.1377/hlthaff.26.2.492

Very little is known about rank-and-file physicians' views on pay-for-performance (P4P) and public reporting. In a national survey of general internists, we found strong potential support for financial incentives for quality, but less support for public reporting. Large majorities of respondents stated that these programs will result in physicians' avoiding high-risk patients and will divert attention from important types of care for which quality is not measured. Public and private policymakers might avoid a physician backlash and better succeed at improving health care quality if they consider these concerns when designing P4P and public reporting programs

Evans R G, et al Assessing the practicing physician using patient surveys: a systematic review of instruments and feedback methods Family Practice 2007 24 (2) 117-127 doi: 10.1093/fampra/cml072

Background: Individual physician performance assessment is a vital part of the medical regulation debate. In this context, the patient perspective is seen as a potentially valid component. Yet, the theoretical and empirical evidence base for such patient assessments is unclear. Objectives: To identify and evaluate instruments designed to assess patients' experiences with an individual practising physician, and to provide performance feedback at the individual level. Methods: Nine electronic databases were searched with no language restrictions: PubMed (1985-), Embase (1985-), PsycInfo (1985-), SIGLE (1985-), HMIC (1985-), ASSIA (1985-), CINAHL (1985-), Cochrane (1985-) and Dare (1985-). Study selection. Inclusion: (i) completed by patients; (ii) assess practising doctors; (iii) have capacity to assess individual doctors for performance feedback; and (iv) used for individual performance feedback. Exclusion: (i) completed by colleagues, observers or third parties; (ii) assess medical students, nurses or non-physicians; (iii) assess purely at an organizational level; and (iv) not been used for individual feedback. All electronic outputs were independently assessed by three reviewers. Data were extracted independently by two of three reviewers using a defined template. Results: Six instruments met the inclusion criteria. They all combine evaluation at both organizational and individual level and implementation methods lack standardization. There is limited data on their construct validity or correlations with other attributes. The purpose and method of individual feedback are not well specified, and the evidence to date about the effectiveness of feedback to obtain improvement indicates professional resistance. Conclusions: For formative goals, more clarity is needed about the aim of providing patient assessments feedback to individual doctors: 'who' should do it and 'how' to do so to best effect. We need to know whether feedback improves doctor performance and how these evaluations correlate with other physician attributes. For summative purposes more research is required on validity and reliability

Fuertes J N et al The physician–patient working alliance Patient Education and Counseling 2007 66 (1) 29-36 doi:10.1016/j.pec.2006.09.013

Objective Cognitive and emotional dimensions of the physician–patient relationship (*working alliance*) were examined in relation to patients' beliefs about the usefulness of treatment (*perceived utility*), patients' beliefs about being able to adhere to treatment (*adherence self-efficacy beliefs*), patients' follow through on their treatment plan (*adherence*), and patients' satisfaction. Methods Participants were 51 men and 67 women who averaged 38.9 years of age (S.D. = 12.28). Seventy-two were Euro-American, 23 African-American, 6 Asian-American, 11 Hispanic, and 6 "Other." They reported an average of 7.3 years (S.D. = 7.48) since being diagnosed with a chronic medical illness and an average of 7.1 (S.D. = 4.88) visits to their doctor within the last year. Patients' conditions included HIV+/AIDS, hypertension, diabetes, asthma, and cancer. Results show moderate to strong relationships between working alliance and perceived utility ($r = 0.63, P < 0.001$), self-efficacy ($r = 0.47, P < 0.001$), adherence ($r = 0.53, P < 0.001$), and satisfaction ($r = 0.83, P < 0.001$). Regression analyses showed that ratings of the working alliance (SB = 0.25, $P < 0.005$) and self-efficacy beliefs (SB = 0.48, $P < 0.001$) predicted patient adherence and that working alliance ratings (SB = 0.83, $P < 0.001$) also predicted patient satisfaction. Conclusion The working alliance can be measured in medical care and appears to be strongly associated with patients' adherence to and satisfaction with treatment. Practice implications The working alliance is

important in medical treatment, as it is associated with patient adherence and satisfaction. Patients' self-efficacy ought to be assessed and promoted as it is also associated with treatment adherence.

Geneau R, et al Primary care practice a la carte among GPs: using organizational diversity to increase job satisfaction Family Practice 2007 24 (2) 138-144 doi: 10.1093/fampra/cml073

Background: Primary care revival in Canada and elsewhere is viewed by many as conditional to the introduction of new organizational models. Endorsement by GPs is a key factor in the success of these models, and increasing GPs' job satisfaction is often one of the desired outcomes of the reforms currently underway. Objectives: The phenomenon of work satisfaction from the GP's perspective is not yet fully understood. The objectives of this study were to elicit its different facets and to understand better how organizational factors affect it. Methods: This is a case study carried out in the province of Quebec (Canada). We conducted semi-structured interviews with 28 GPs working in private clinics and community health centres (Centre local de services communautaires). Results: The main themes uncovered are related to the relationship between time management and quality of care, variation in work, autonomy in day-to-day practice, team 'orientedness' and social rewards. We also found that some GPs prefer to combine work in different organizations and models in order to increase their job satisfaction and to better cope with an increasingly complex task environment. Conclusion: Our study provides a comprehensive view of the various dimensions that GPs consider important in their professional life. Our findings suggest that, for many GPs, the perfect practice is tailor made and implies a combination of organizational models in order to fulfil their multiple professional goals. This has important implications for decision makers who are promoting new primary care models

Karlsson M. Quality incentives for GPs in a regulated market Journal of Health Economics 2007 16 (4) 699-720 doi: 10.1016/j.jhealeco.2006.12.001

This paper analyses whether GPs in a capitation system have incentives to provide quality even though health is a credence good. A model is developed where the quality of the service varies due to inherent differences between the GPs and rational patients make choices based on the outcome of treatment. We find that it is difficult to provide appropriate incentives since the search activity of patients offsets direct effects of a change in reimbursement. Variation in the inherent ability of the GPs is good since it increases the search activity of the patients and the optimal reimbursement scheme is inversely proportional to the dispersion in types. Finally, we find that offering a menu of contracts can potentially increase social welfare above the level of a simple capitation regime, but it tends to lead to a higher variation in quality levels

Mercer S W, Cawston P G, Bikker A P Quality in general practice consultations; a qualitative study of the views of patients living in an area of high socio-economic deprivation in Scotland BMC Family Practice 2007 8:22 doi: 10.1186/1471-2296-8-22

Background: Inequality in health and health care services is an important policy issue internationally as well as in the UK, and is closely linked to socio-economic deprivation, which in Scotland is concentrated in and around Glasgow. Patients' views on primary care in deprived areas are not well documented. In the present study we explore the views of patients living in a high deprivation area on the quality of consultations in general practice. Methods: Qualitative focus group study set in an area of high socio-economic deprivation in a large peripheral housing estate in Glasgow, Scotland. 11 focus groups were conducted; 8 with local community groups and 3 with other local residents. In total 72 patients took part. Grounded theory was used to analyse the data. Results: Patients' perceptions of the quality of the consultation with GPs consisted of two broad, inter-relating themes; (1) the GPs' competence, and (2) the GPs' empathy or 'caring'. Competence was often assumed but many factors coloured this assumption, in particular whether patients had experienced (directly or indirectly with a close family member) 'successful' outcomes with that doctor previously or not. 'Caring' related to patients feeling (a) listened to by the doctor and being able to talk; (b) valued as an individual by the doctor (c) that the doctor understood 'the bigger picture', and (d) the doctors' explanations were clear and understandable. Relational continuity of care (being able to see the same GP and having a good relationship), and having sufficient time in the consultation were closely linked with perceptions of consultation quality. Conclusion: Patients from deprived areas want holistic GPs who understand the realities of life in such areas and whom they can trust as both competent and genuinely caring. Without this, they may judge doctors as socially distant and emotionally detached. Relational continuity, empathy and sufficient time in consultations are key factors in achieving this

Nietert P J et al Using a summary measure for multiple quality indicators in primary care: the Summary Quality Index (SQUID) Implementation Science 2007 2:11 doi:10.1186/1748-5908-2-11

Background Assessing the quality of primary care is becoming a priority in national healthcare agendas. Audit and feedback on healthcare quality performance indicators can help improve the quality of care provided. In some instances, fewer numbers of more comprehensive indicators may be preferable. This paper describes the use of the Summary Quality Index (SQUID) in tracking quality of care among patients and primary care practices that use an electronic medical record (EMR). All practices are part of the Practice Partner Research Network, representing over 100 ambulatory care practices throughout the United States. Methods The SQUID is comprised of 36 process and outcome measures, all of which are obtained from the EMR. This paper describes algorithms for the SQUID calculations, various statistical properties, and use of the SQUID within the context of a multi-practice quality improvement (QI) project. Results At any given time point, the patient-level SQUID reflects the proportion of recommended care received, while the practice-level SQUID reflects the average proportion of recommended care received by that practice's patients. Using quarterly reports, practice- and patient-level SQUIDs are provided routinely to practices within the network. The SQUID is responsive, exhibiting highly significant ($p < 0.0001$) increases during a major QI initiative, and its internal consistency is excellent (Cronbach's $\alpha = 0.93$). Feedback

from physicians has been extremely positive, providing a high degree of face validity. Conclusion The SQUID algorithm is feasible and straightforward, and provides a useful QI tool. Its statistical properties and clear interpretation make it appealing to providers, health plans, and researchers.

Proudfoot J et al Team climate for innovation: what difference does it make in general practice. International Journal for Quality in Health Care 2007 19 (3) 164-169 doi: 10.1093/intqhc/mzm005

Objective. Teamwork in primary healthcare is associated with patient care processes and staff outcomes. The ability of teams to be innovative is a hypothesized mechanism. We examined the characteristics of general practices with good team climate for innovation, and assessed the impact of climate on chronically ill patients' assessment of their care and on the job satisfaction of the staff. Design. Large cross-sectional study. Setting. Australian general practices. Participants. A total of 654 general practitioners and staff and 7505 chronically ill patients from 93 general practices in 6 Australian states and territories. Measures. The Team Climate Inventory and the Overall Job Satisfaction Scale, customized for use with general practices, were administered to general practitioners and practice staff, and the General Practice Assessment Survey was administered to patients. Practice characteristics were collected by survey from the principal doctor or practice manager. Results. Mean scores of team climate in Australian general practices were similar to those reported in the UK, except that in our study there was no association between the number of doctors in a practice and their team climate. Better team climate was found in practices with fewer non-clinical staff. Team climate predicted the job satisfaction of the general practitioners and staff, irrespective of the number of practice staff. Better team climate was associated with greater satisfaction by patients with their care. Conclusions. Team climate is important for patient and staff satisfaction. In large general practices, separate sub-cultures may exist between administrative and clinical staff, which has implications for designing effective team interventions.

Reeves D, et al. Combining multiple indicators of clinical quality: an evaluation of different analytic approaches Medical Care 2007 45 (6) 489-496 doi: 10.1097/MLR.0b013e31803bb479

Objective. To compare different methods of combining quality indicators scores to produce composite scores that summarize the overall performance of health care providers. Methods:: Five methods for computing a composite quality score were compared: the "All-or-None," the "70% Standard," the "Overall Percentage," the "Indicator Average," and the "Patient Average." The first 2 "criterion-referenced" methods assess the degree to which a provider has reached a threshold for quality of care for each patient (100% or 70%). The remaining "absolute score" methods produce scores representing the proportion of required care successfully provided. Each method was applied to 2 quality indicator datasets, derived from audits of UK family practitioner records. Dataset A included quality indicator data for 1178 patients from 16 family practices covering 23 acute, chronic, and preventative conditions. Dataset B included data on 3285 patients from 60 family practices, covering 3 chronic conditions. Results:: The

results varied considerably depending on the method of aggregation used, resulting in substantial differences in how providers scored. The results also varied considerably for the 2 datasets. There was more agreement between methods for dataset B, but for dataset A 6 of the 16 practices moved between the top and bottom quartiles depending upon the method used. Conclusions:: Different methods of computing composite quality scores can lead to different conclusions being drawn about both relative and absolute quality among health care providers. Different methods are suited to different types of application. The main advantages and disadvantages of each method are described and discussed

Roach J K, et al Communication interventions make a difference in conversations between patients and physicians: a systematic review of the evidence Medical Care 2007 45(4) 340-349 doi: 10.1097/01.mlr.0000254516.04961.d5

Objective: We sought to synthesize the findings of studies examining interventions to enhance the communication behaviors of physicians and patients during outpatient encounters. Methods: We conducted searches of 6 databases between 1966 and 2005 to identify studies for a systematic review and synthesis of the literature. Eligible studies tested a communication intervention; were randomized controlled trials (RCTs); objectively assessed verbal communication behaviors as the primary outcome; and were published in English. Interventions were characterized by type (eg, information, modeling, feedback, practice), delivery strategy, and overall intensity. We abstracted information on the effects of the interventions on communication outcomes (eg, interpersonal and information exchanging behaviors). We examined the effectiveness of the interventions in improving the communication behaviors of physicians and patients. Results: Thirty-six studies were reviewed: 18 involved physicians; 15 patients; and 3 both. Of the physician interventions, 76% included 3 or 4 types, often in the form of practice and feedback sessions. Among the patient interventions, 33% involved 1 type, and nearly all were delivered in the waiting room. Intervention physicians were more likely than controls to receive higher ratings of their overall communication style and to exhibit specific patient-centered communication behaviors. Intervention patients obtained more information from physicians and exhibited greater involvement during the visit than controls. Conclusions: The interventions were associated with improved physician and patient communication behaviors. The challenge for future research is to design effective patient and physician interventions that can be integrated into practice.

Veldhuijzen W, et al. Characteristics of communication guidelines that facilitate or impede guideline use: a focus group study BMC Family Practice 2007 8:31 doi: 10.1186/1471-2296-8-31

Abstract: background: The quality of doctor-patient communication has a major impact on the quality of medical care. Communication guidelines define best practices for doctor patient communication and are therefore an important tool for improving communication. However, adherence to communication guidelines remains low, despite doctors participating in intensive communication skill training. Implementation research shows that adherence is higher for guidelines in general that are user centred and feasible, which

implies that they are consistent with users opinions, tap into users existing skills and fit into existing routines. Developers of communication guidelines seem to have been somewhat negligent with regard to user preferences and guideline feasibility. In order to promote the development of user centred and practicable communication guidelines, we elicited user preferences and identified which guideline characteristics facilitate or impede guideline use. Methods: Seven focus group interviews were conducted with experienced GPs, communication trainers (GPs and behavioural scientists) and communication learners (GP trainees and medical students) and three focus group interviews with groups of GP trainees only. All interviews were transcribed and analysed qualitatively. Results: The participants identified more impeding guideline characteristics than facilitating ones. The most important impeding characteristic was that guidelines do not easily fit into GPs day-to-day practice. This is due to rigidity and inefficiency of communication guidelines and erroneous assumptions underpinning guideline development. The most important facilitating characteristic was guideline structure. Guidelines that were structured in distinct phases helped users to remain in control of consultations, which was especially useful in complicated consultations. Conclusions: Although communication guidelines are generally considered useful, especially for structuring consultations, their usefulness is impaired by lack of flexibility and applicability to practice routines. User centred and feasible guidelines should combine the advantages of helping doctors to structure consultations with flexibility to tailor communication strategies to specific contexts and situations

RANDOMISED CONTROLLED TRIALS

Fransen G A, et al Pragmatic trials in primary care: methodological challenges and solutions demonstrated by the DIAMOND-study BMC Medical Research Methodology 2007 7:16 doi: 10.1186/1471-2288-7-16

Background: Pragmatic randomised controlled trials are often used in primary care to evaluate the effect of a treatment strategy. In these trials it is difficult to achieve both high internal validity and high generalisability. This article will discuss several methodological challenges in designing and conducting a pragmatic primary care based randomised controlled trial, based on our experiences in the DIAMOND-study and will discuss the rationale behind the choices we made. From the successes as well as the problems we experienced the quality of future pragmatic trials may benefit. Discussion: The first challenge concerned choosing the clinically most relevant interventions to compare and enable blinded comparison, since two interventions had very different appearances. By adding treatment steps to one treatment arm and adding placebo to both treatment arms both internal and external validity were optimized. Nevertheless, although blinding is essential for a high internal validity, it should be warily considered in a pragmatic trial because it decreases external validity. Choosing and recruiting a representative selection of participants was the second challenge. We succeeded in retrieving a representative relatively large patient sample by carefully choosing (few)

inclusion and exclusion criteria, by random selection, by paying much attention to participant recruitment and taking the participant's reasons to participate into account. Good and regular contact with the GPs and patients was to our opinion essential. The third challenge was to choose the primary outcome, which needed to reflect effectiveness of the treatment in every day practice. We also designed our protocol to follow every day practice as much as possible, although standardized treatment is usually preferred in trials. The aim of this was our fourth challenge: to limit the number of protocol deviations and increase external validity. Summary: It is challenging to design and conduct a pragmatic trial. Thanks to thorough preparation, we were able to collect highly valid data. To our opinion, a critical deliberation of where on the pragmatic--explanatory spectrum you want your trial to be on forehand, in combination with consulting publications especially on patient recruitment procedures, has been helpful in conducting a successful trial

RESEARCH AND DEVELOPMENT

Kelly D R et al Applying evidence in practice through small group learning: a qualitative exploration of success Quality in Primary Care 2007 15 (2) 93-100

Background. A particular approach to continuing professional development for general practitioners originated in Canada. The Canadian approach uses a modification of problem based learning that is based on evidence-based medicine with facilitated small groups. Evidence-based modules are developed for discussion in a small group, where the group exists over an extended period of time. An evaluation of a pilot of the "practice-based small group learning" (PBSG) approach in Scotland demonstrated enhanced participant knowledge and skills in evidence-based practice and small-group working. However, it is not known why PBSG was successful. Understanding this will help inform and further research and development of the approach for general practitioners and other professional groups. **Aim** The aim of this study was to explore the perceptions and experiences of PBSG participants to gain an understanding of how PBSG learning achieves its success. **Method.** A qualitative study of PBSG learning using one-to-one interviews. **Results.** The small group format is an important factor in the success of the approach, along with the crucial role of the facilitator. Other factors include: the strong need among general practitioners to update their skills and compare their practice with that of peers; the inclusive nature of the small-group environment; the importance of creating a learning environment that is the right balance between being not too cosy but not too threatening; a recognition of the learning power of group members instead of invited experts; the lack of trust among partners in practice and the lack of confidence of participants in their own skills as a facilitator. The findings highlight the importance of a learning environment conducive to learning and change, one that is based on honesty, openness and a willingness to acknowledge ignorance as a precursor to learning.

Kuruvilla, S, Mays N, Walt, G. Describing the impact of health services and policy research Journal of Health Services Research and Policy 2007 12 Suppl 1 23-31 doi: 10.1258/135581907780318374

Objectives: In an essentially applied area of research, there are particular pressures on health services and policy researchers to describe the impact of their work. However, specialized research impact assessments often require skills and resources beyond those available to individual researchers, and ad hoc accounts impose a considerable burden to generate. Further, these idiosyncratic accounts may not facilitate comparative analysis to inform research management, practice and assessment. This paper describes an initial attempt to develop a methodical approach to identify and describe research impact. **Methods:** A Research Impact Framework was developed, drawing on the literature and interviews with researchers at the London School of Hygiene and Tropical Medicine, and was used to structure impact narratives of selected research projects. These narratives were based on semi-structured interviews with principal investigators and documentary analysis of the projects. **Results:** Using the framework as a guide, researchers were relatively easily and methodically able to identify and present impacts of their work. Researchers' narratives contained verifiable evidence and highlighted a wide range of areas in which health services and policy research has impact. The standardized structure of the narratives also facilitated analysis across projects. Factors thought to positively influence the impact of research included researchers' continued involvement in research and policy networks, established track records in the field, and the ability to identify and use key influencing events, such as 'policy windows'. **Conclusions:** The framework helped develop research impact narratives and facilitated comparisons across projects, highlighting issues for research management and assessment

Nelson C What can the NHS and pharmaceutical research colleagues learn from each other; transferability of best practice in the pursuit of research excellence Quality in Primary Care 2007 15 (2) 113-118

The aim of healthcare research is to deliver 'better health through research-based knowledge'. The UK research base is found in universities, NHS trusts and pharmaceutical companies, all of whom conduct high-quality research with the aim of offering the most efficacious care to the UK population. Historically, regulations relating to quality assurance of such research have been the realm of the pharmaceutically sponsored trial. However, since 2001, frameworks and legislation have applied equally to commercial and grant-maintained studies. The last five years have therefore seen NHS and university researchers and research managers grapple with the challenge of demonstrating compliance with such standards without the historical expertise and experiences that can be found in pharmaceutical quality assurance departments. This paper argues that much could be learnt from pharmaceutical company researchers in this respect and that, if sharing of expertise became the norm, there is much that a commercial clinical research associate can learn from their counterparts in the NHS and higher education sectors. If the UK is to realise the aspirations described in the national research strategy, Best Research for Best Health, and recently reconfigured and redefined primary

care organisations are to base their commissioning decisions on robust UK-based research evidence, collaboration not competition has to become the norm.

Sullivan F. Primary care research networks in the United Kingdom British Medical Journal 26/5/2007 334 (7603) 1093-1094 doi: 10.1136/bmj.39190.648785.80

In British primary care, where 80% of National Health Service consultations take place, policy decisions often depend more on optimistic theory than on evidence. Conducting research has generally been a low priority for primary care clinicians in the United Kingdom. The ethos of independent small business in general practice tends more towards innovation than research, and scarce academic training opportunities are associated with a culture where research is not much expected, valued, or rewarded. Yet with leadership, resource, and good relationships between researchers and service providers, primary care research can underpin effective and efficient practice in ways that specialist perspectives alone cannot.

Waring J, Harrison S, McDonald R A culture of safety or coping? Ritualistic behaviours in the operating theatre Journal of Health Services. Research and Policy 2007 12 Suppl 1 3-9 doi: 10.1258/135581907780318347

Objectives: The creation of a 'safety culture' is a health services priority, yet there is little contemporary research examining the tacit, customary practices that relate to clinical risk. This paper investigates how the ritualistic behaviours of surgeons and anaesthetists serve to normalize risks within the operating theatre, thereby inhibiting organizational learning and enabling such risks to recur. **Methods:** A two-year ethnographic study in the operating department of a large teaching hospital in the north of England, including observations of the organizational and clinical setting and interviews with 80 members of staff. **Results:** Three ritualistic types of behaviour are identified and described. Each illustrates the taken-for-granted assumptions associated with clinical risk in the operating theatre and is characterized by a patterned response to risk, the first being to tolerate and endure risk, the second being to accommodate risk through slight modifications to clinical practice and the third being to innovate or implement unorthodox practices to control for risk. **Conclusion:** These ritualistic behaviours normalize risk within the operating theatre leading to the possibility that some threats will escape appropriate attention and may lead to patient harm. These culturally scripted behaviours also encourage a short-term reactive response to risk that emphasizes the importance of individual coping rather than the more systemic forms of learning associated with participation in incident reporting. This research extends and elaborates upon the current policy orthodoxy to better understand the cultural context of patient safety

RESEARCH GOVERNANCE

Cook M et al The impact of research governance in the United Kingdom on research involving a national survey Journal of Health Organization and Management 2007 21 (1) 59-67

Purpose: The purpose of this paper is to examine the impact that research governance processes in the National Health Service (NHS) are having on the conduct of research that involves a national survey and to point to ways that existing processes may develop to facilitate such research. **Design/methodology/approach:** The paper describes the experiences of a research team of seeking approval in 357 NHS organisations to carry out a national postal survey to investigate specialist services and specialist staffing for older people in England in the wake of recent policy developments. Through reflection on this experience, the team propose approaches for the development of existing research governance processes. The national survey was the first stage of the study, which was followed by a detailed investigation of the development of specialist service provision for older people in six case study sites across England. The national survey aimed to map specialist service provision for older people by identifying the range of service models, agency and professional involvements, and nature of the case load in statutory services (health and social care), independent and voluntary sector organisations. **Findings:** Of the 357 NHS organisations approached for approval to carry out the survey within the organisation, this was achieved only in 247 organisations over 12 months. Many organisations were facilitative of the process; however, protracted and extensive approval processes in others led to long delays and redesigning of the research that was commissioned by the Department of Health. **Originality/value:** The paper is of value in that it highlights processes and practices that hinder research and builds on those that work well

RESEARCH METHODS

Clarke L, Clarke M, Clarke T How useful are Cochrane reviews in identifying research needs? Journal of Health Services Research and Policy April 2007 12 (2) 101-103 doi: 10.1258/135581907780279648

ObjectiveS: To determine the extent to which reports of Cochrane reviews recommend the need for further research and, if so, the extent to which they make suggestions regarding that research. **Methods:** We examined all 2535 reviews in Issue 4, 2005 of The Cochrane Library. Each review was categorized on the basis of whether a suggestion was included about specific interventions, participants, or outcome measures that should be

included in future research. We also identified the frequency with which reviews conclude that no more research is needed or feasible, noted the need for further systematic reviewing, and referred to a relevant ongoing or planned study. We also report the number of studies listed in the 'Ongoing Studies' section in each review. Results: Only 3.2% of reviews suggested explicitly that no more research is needed or feasible. In 82.0% of reviews, suggestions were made as to the specific interventions that need evaluating, in 30.2% the appropriate participants were suggested, and in 51.9% outcome measures were suggested. Suggestions for all three domains were made in 16.9% of the reviews. While 11.6% did not include a specific suggestion about any of these domains, 21.2% of reviews mention a relevant ongoing or planned study in one or both of the 'Implications for Research' and the 'Ongoing Studies' sections. Conclusions: Most Cochrane reviews identify residual uncertainty and are a rich source of suggestions for further health-care research

Curran C et al Challenges in multidisciplinary systematic reviewing: a study on social exclusion and mental health policy Social Policy and Administration 2007 41 (3) 289-312 : doi:10.1111/j.1467-9515.2007.00553.x

In the clinical sciences, systematic reviews have proved useful in the aggregation of diverse sources of evidence. They identify, characterize and summate evidence, but these methodologies have not always proved suitable for the social sciences. We discuss some of the practical problems faced by researchers undertaking reviews of complex and cross-disciplinary topics, using the example of mental health and social exclusion. The barriers to carrying out social science and cross-disciplinary reviews are reported and some proposals for overcoming these barriers are made, not all of them tried and tested, and some of them controversial. Using a mapping approach, a wide-ranging search of both clinical and social science databases was undertaken and a large volume of references was identified and characterized. Population sampling techniques were used to manage these references. The challenges encountered include: inconsistent definitions of social phenomena, differing use of key concepts across research fields and practical problems relating to database compatibility and computer processing power. The challenges and opportunities for social scientists or multidisciplinary research teams carrying out reviews are discussed. Literature mapping and systematic reviews are useful tools but methods need to be tailored to optimize their usefulness in the social sciences.

Marcinowicz L, Chlabicz S, Grebowski R. Open-ended questions in surveys of patients' satisfaction with family doctors Journal of Health Services Research and Policy 2007 12 (2) 86-89 doi: 10.1258/135581907780279639

Objective: To compare replies to open-ended and closed questions about patient satisfaction with family doctors. Methods: Two centres of primary health care in Bialystok in northeast Poland were chosen. A self-administered questionnaire was mailed to 1000 people (500 from each centre) aged 18 years and over, randomly selected from the practices. Possible responses to the one closed question were: very good, good, bad, very bad or difficult to say. Replies to two open-ended questions were categorized as positive, neutral, negative or ambivalent. Results: The response rate was 57.9%. There were some discrepancies between the closed-question response and the open-ended question replies. Some of those who replied good or very good to the closed question expressed negative views in response to the two open-ended questions (14.0% and

12.4%). Conclusions: Answers to open-ended questions add value to a patient satisfaction survey by providing information that answers to closed questions may not elicit.

Moher D et al Epidemiology and reporting characteristics of systematic reviews
PLoS Medicine 2007 4:3 e78 doi:10.1371/journal.pmed.0040078

Systematic reviews (SRs) have become increasingly popular to a wide range of stakeholders. We set out to capture a representative cross-sectional sample of published SRs and examine them in terms of a broad range of epidemiological, descriptive, and reporting characteristics, including emerging aspects not previously examined. **Methods and Findings** We searched Medline for SRs indexed during November 2004 and written in English. Citations were screened and those meeting our inclusion criteria were retained. Data were collected using a 51-item data collection form designed to assess the epidemiological and reporting details and the bias-related aspects of the reviews. The data were analyzed descriptively. In total 300 SRs were identified, suggesting a current annual publication rate of about 2,500, involving more than 33,700 separate studies including one-third of a million participants. The majority (272 [90.7%]) of SRs were reported in specialty journals. Most reviews (213 [71.0%]) were categorized as therapeutic, and included a median of 16 studies involving 1,112 participants. Funding sources were not reported in more than one-third (122 [40.7%]) of the reviews. Reviews typically searched a median of three electronic databases and two other sources, although only about two-thirds (208 [69.3%]) of them reported the years searched. Most (197/295 [66.8%]) reviews reported information about quality assessment, while few (68/294 [23.1%]) reported assessing for publication bias. A little over half (161/300 [53.7%]) of the SRs reported combining their results statistically, of which most (147/161 [91.3%]) assessed for consistency across studies. Few (53 [17.7%]) SRs reported being updates of previously completed reviews. No review had a registration number. Only half (150 [50.0%]) of the reviews used the term "systematic review" or "meta-analysis" in the title or abstract. There were large differences between Cochrane reviews and non-Cochrane reviews in the quality of reporting several characteristics.

Moreira T Entangled evidence: knowledge making in systematic reviews in healthcare
Sociology of Health and Illness 2007 29 (2) 180-197
doi:10.1111/j.1467-9566.2007.00531.x

As the volume of biomedical information escalates and its uses diversify, systematic reviews and meta-analyses – the compilation, selection and statistical analysis of pooled results from similar studies – are becoming an increasingly accepted method in the evaluation of healthcare technologies and interventions. We thus observe a proliferation of laboratories conducting this type of research. How is knowledge constructed in systematic reviews and meta-analysis in healthcare? Drawing on ethnographic data collected during 18 months of fieldwork in a research centre devoted to the development of evidence-based clinical-practice guidelines and systematic reviews, the paper argues that knowledge construction in secondary research in healthcare is structured upon a parallel process of disentanglement and qualification of data. In disentanglement, knowledge practices attempt to extricate data from the milieus in which they are commonly found (databases, texts, other research centres, etc.). In qualification, the focus

of activities is on endowing data with new qualities – such as precision, unbiasedness or 'fairness' – through the use of templates, graphical platforms and techno-political debates. The accomplishment of these two processes is fundamental to establishing the persuasive power that meta-analyses appear to have in contemporary healthcare politics.

Rheis S et al Aggregation of qualitative studies—from theory to practice: patient priorities and family medicine/general practice evaluations Patient Education and Counseling 2007 65 (2) 214-222 doi:10.1016/j.pec.2006.07.011

Objective Aggregation (i.e., meta-ethnography or meta-synthesis) of qualitative studies remains relatively rare and controversial. We have attempted this procedure within an investigation of patient priorities and evaluations of primary care in order to triangulate an instrument development process as well as explore associated dilemmas. **Methods** The procedures included a literature search of qualitative research on patient priorities and evaluations and creation of a framework for quality assessment of retrieved papers. The tool for the evaluation of quality in qualitative studies was piloted, refined, and applied to the retrieved literature. The articles were equally distributed between two teams in random fashion, and inter-rater agreement calculated. Finally, we formulated and applied a strategy for aggregation of data from included papers that allowed comparison to a systematic review of quantitative studies on the topic. **Results** Thirty-seven articles met inclusion criteria. Twenty-four of these articles were of sufficient quality to be included in the qualitative aggregation. Inter-rater agreement ranged from 0.22 to 0.77 and 0.38 to 0.60 for pair and assessor comparisons, respectively. The aggregation strategy enabled synthesis within sub-categories of the heterogeneous papers. **Conclusions** We have devised a modestly reliable instrument to assess the quality of qualitative work. The procedure for quality assessment and aggregation appears to be both feasible and potentially useful, though both theoretical and practical problems underline the need for further refinement prior to widespread utilization of this approach. **Practice implications** An instrument to assess the quality of qualitative work within the context of aggregation efforts is described. Calculating inter-rater reliability in this framework can support future quality assessments. A method of breaking a heterogeneous collection of included papers into sub-categories to enable aggregation of qualitative studies is applied and demonstrates its feasibility and potential usefulness.

SELF CARE

Gysels M, Richardson A, Higginson I J Does the patient-held record improve continuity and related outcomes in cancer care: a systematic review2 Health Expectations 2007 10 (1) 75-91 doi: 10.1111/j.1369-7625.2006.00415.x

Objectives: To assess the effectiveness of the patient-held record (PHR) in cancer care. **Background:** Patients with cancer may receive care from different services resulting in

gaps. A PHR could provide continuity and patient involvement in care. Search strategy: Relevant literature was identified through five electronic databases (Medline, Embase, Cinahl, CCTR and CDSR) and hand searches. Inclusion criteria: Patient-held records in cancer care with the purpose of improving communication and information exchange between and within different levels of care and to promote continuity of care and patients' involvement in their own care. Data extraction and synthesis: Data extraction recorded characteristics of intervention, type of study and factors that contributed to methodological quality of individual studies. Data were then contrasted by setting, objectives, population, study design, outcome measures and changes in outcome, including knowledge, satisfaction, anxiety and depression. Methodological quality of randomized control trials and non-experimental studies were assessed with separate standard grading scales. MAIN Results and conclusions: Seven randomized control trials and six non-experimental studies were identified. Evaluations of the PHR have reached equivocal findings. Randomized trials found an absence of effect, non-experimental evaluations shed light on the conditions for its successful use. Most patients welcomed introduction of a PHR. Main problems related to its suitability for different patient groups and the lack of agreement between patients and health professionals regarding its function. Further research is required to determine the conditions under which the PHR can realize its potential as a tool to promote continuity of care and patient participation

Proudfoot J, et al. Patient Engagement and Coaching for Health: The PEACH study - a cluster randomised controlled trial using the telephone to coach people with type 2 diabetes to engage with their GPs to improve diabetes care: a study protocol BMC Family Practice 2007 8:20 doi: doi:10.1186/1471-2296-8-20

Background The PEACH study is based on an innovative 'telephone coaching' program that has been used effectively in a post cardiac event trial. This intervention will be tested in a General Practice setting in a pragmatic trial using existing Practice Nurses (PN) as coaches for people with type 2 diabetes (T2D). Actual clinical care often fails to achieve standards, that are based on evidence that self-management interventions (educational and psychological) and intensive pharmacotherapy improve diabetes control. Telephone coaching in our study focuses on both. This paper describes our study protocol, which aims to test whether goal focused telephone coaching in T2D can improve diabetes control and reduce the treatment gap between guideline based standards and actual clinical practice. **Methods/design** In a cluster randomised controlled trial, general practices employing Practice Nurses (PNs) are randomly allocated to an intervention or control group. We aim to recruit 546 patients with poorly controlled T2D (HbA1c >7.5%) from 42 General Practices that employ PNs in Melbourne, Australia. PNs from General Practices allocated to the intervention group will be trained in diabetes telephone coaching focusing on biochemical targets addressing both patient self-management and engaging patients to work with their General Practitioners (GPs) to intensify

pharmacological treatment according to the study clinical protocol. Patients of intervention group practices will receive 8 telephone coaching sessions and one face-to-face coaching session from existing PNs over 18 months plus usual care and outcomes will be compared to the control group, who will only receive only usual care from their GPs. The primary outcome is HbA1c levels and secondary outcomes include cardiovascular disease risk factors, behavioral risk factors and process of care measures. Discussion Understanding how to achieve comprehensive treatment of T2D in a General Practice setting is the focus of the PEACH study. This study explores the potential role for PNs to help reduce the treatment and outcomes gap in people with T2D by using telephone coaching. The intervention, if found to be effective, has potential to be sustained and embedded within real world General Practice.

Wilson PM, Kendall S, Brooks, F The Expert Patients Programme: a paradox of patient empowerment and medical dominance Health and Social Care in the Community 2007 OnlineEarly Articles doi: :10.1111/j.1365-2524.2007.00701.x

Self-care is seen as a key element in managing resource demand in chronic disease and is also perceived as an empowering right for patients. The Chronic Disease Self-Management Programme developed in the USA has been adopted in a number of countries and in the UK has been as adapted as the Expert Patients Programme. However, despite its potential as a lay-led empowering initiative, the Expert Patients Programme has been criticised as perpetuating the medical model and failing to reach those in most need. This paper revisits a critique of the Expert Patients Programme, and drawing upon a qualitative study seeks to explore whether the Expert Patients Programme enables empowerment or replicates traditional patterns of the patient-professional relationship. A grounded-theory approach was adopted utilising focus groups, in-depth interviews and participant observation. Data were analysed through the constant comparative method and the development of codes and categories. Conducted in the relatively affluent area of the south-east of England, this paper draws on data from 66 individuals with a chronic illness who were knowledgeable, active and informed. The study revealed a number of characteristics common to expert patients that were linked to a systematic, proactive and organised approach to self-management, a clear communication style and the ability to compartmentalise emotion. The study included participant observation of an Expert Patients Programme and a professional-led self-management course. The paradoxical nature of the Expert Patients Programme was revealed, for whilst there was evidence that it reinforced the medical paradigm, there was a concurrent acknowledgement and support for the subjective experience of living with a long-term condition. Furthermore, whilst the policy emphasis has been on individual empowerment within the Expert Patients Programme, there is some evidence that it may be triggering a health consumer movement.

McLaren S et al Developing the general practice manager's role: managers' experiences of engagement in continuing professional development Quality in Primary Care 2007 15 (2) 85-91

Introduction and aims. This study sought to review the recent and future range of continuing professional development (CPD) activities undertaken by practice managers in the context of role expansion, to explore practice managers' perceptions of the benefits of CPD and to identify practice managers' experiences of constraints and supports for engagement in CPD in the context of changing cultures for lifelong learning. Methods. A formative, exploratory evaluation was conducted, utilising qualitative methods. Semi-structured interviews were conducted with 16 randomly selected practice managers from general practices in the south east of England. Interviews were transcribed and content analysed using a structured framework. Results. Practice managers' recent engagement in CPD covered a diverse range of educational topics. Future plans also reflected priority areas delineated in the new General Medical Services contract. Benefits of CPD were identified as enhancing skills, motivation, confidence, skill-mix, roles and improvement of patient services. Constraints to CPD engagement were negative attitudes, time pressures, lack of finance and awareness of inclusivity in wider CPD policies. Role autonomy, a positive employer and trust attitudes to funding were supportive of CPD. Conclusions. Insights into a transitional culture marked by resistance to lifelong learning alongside a drive for increased professionalism and engagement in CPD were present. Challenges still exist in overcoming constraints to CPD engagement and in ensuring that practice managers reach the potential for role expansion delineated in recent primary care policy changes.

STATISTICAL METHODS

Le Lay A, et al Can discrete event simulation be of use in modelling major depression? Cost Effectiveness and Resource Allocation 2006 4:19 doi: 10.1186/1478-7547-4-19

Abstract: Background: Depression is among the major contributors to worldwide disease burden and adequate modelling requires a framework designed to depict real world disease progression as well as its economic implications as closely as possible. Objectives: In light of the specific characteristics associated with depression (multiple episodes at varying intervals, impact of disease history on course of illness, sociodemographic factors), our aim was to clarify to what extent "Discrete Event Simulation" (DES) models provide methodological benefits in depicting disease

evolution. **Methods:** We conducted a comprehensive review of published Markov models in depression and identified potential limits to their methodology. A model based on DES principles was developed to investigate the benefits and drawbacks of this simulation method compared with Markov modelling techniques. **Results:** The major drawback to Markov models is that they may not be suitable to tracking patients' disease history properly, unless the analyst defines multiple health states, which may lead to intractable situations. They are also too rigid to take into consideration multiple patient-specific sociodemographic characteristics in a single model. To do so would also require defining multiple health states which would render the analysis entirely too complex. We show that DES resolve these weaknesses and that its flexibility allow patients with differing attributes to move from one event to another in sequential order while simultaneously taking into account important risk factors such as age, gender, disease history and patients attitude towards treatment, together with any disease-related events (adverse events, suicide attempt etc.). **Conclusion:** DES modelling appears to be an accurate, flexible and comprehensive means of depicting disease progression compared with conventional simulation methodologies. Its use in analysing recurrent and chronic diseases appears particularly useful compared with Markov processes

WORKFORCE

Arah O A The metrics and correlates of physician migration from Africa BMC Public Health 2007 7:83 doi: :10.1186/1471-2458-7-83

Background Physician migration from poor to rich countries is considered an important contributor to the growing health workforce crisis in the developing world. This is particularly true for Africa. The perceived magnitude of such migration for each source country might, however, depend on the choice of metrics used in the analysis. This study examined the influence of choice of migration metrics on the rankings of African countries that suffered the most physician migration, and investigated the correlates of physician migration. **Methods** Ranking and correlational analyses were conducted on African physician migration data adjusted for bilateral net flows, and supplemented with developmental, economic, and health system data. The setting was the 53 African birth countries of African-born physicians working in nine wealthier destination countries. Three metrics of physician migration were used: total number of physician emigres, emigration fraction defined as the proportion of the potential physician pool working in destination countries, and physician migration density defined as the number of physician emigres per 1000 population of the African source country. **Results** Rankings based on any of the migration metrics differed substantially from those based on the other two metrics. Although the emigration fraction and physician migration density metrics gave proportionality to the migration crisis, only the latter was consistently associated with source countries' workforce capacity, health, health spending, economic, and development characteristics. As such, higher physician migration density was seen

among African countries with relatively higher health workforce capacity (0.401 [less than or equal to] r [less than or equal to] 0.694, p [less than or equal to] 0.011), health status, health spending, and development. **Conclusions** The perceived magnitude of physician migration is sensitive to the choice of metrics. Complementing the emigration fraction, the physician migration density is a metric which gives a different but proportionate picture of which African countries stand to lose relatively more of its physicians with unchecked migration. The nature of health policies geared at health-worker migration can be expected to depend on the choice of migration metrics.

Arksey H, Snape C, Watt, I. Roles and expectations of a primary care team
Journal of Interprofessional Care 2007 21 (2) 217-219 doi:
1080/13561820601076867

Primary care in the United Kingdom has changed over the last ten years: demands on the primary health care team (PHCT) have mushroomed and are set to continue to do so in a primary care-led National Health Service. Membership of the PHCT has broadened in line with government policy (Department of Health, 2000a,b). As well as general practitioners, multi-professional teams include nursing and other professionals such as counselors or clinical pharmacists. New nursing roles such as nurse practitioners and clinical nurse specialists are blurring traditional boundaries, and old roles are being extended. The roles of practice managers and reception staff are also being continuously modified and extended. There is little research available that looks at how individual members within a PHCT understand their own, and their colleagues' roles, including the views of non-clinical staff.

Barriball K L, et al Evaluation of return to practice: the views of nurse returnees from three NHS Hospital Trusts
Journal of Nursing Management 2007 15 (4) 433-441 doi: 10.1111/j.1365-2834.2007.00653.x

Aim: Exploration of the views and experiences of returnees on a Return to Practice programme based in three NHS Hospital Trusts. **Background:** In the light of nursing shortages in Britain, there is an ongoing need to encourage nurses to re-enter the profession through Return to Practice programmes. In order to maximize returnees' participation in the nursing workforce; however, evaluation of the effectiveness of Return to Practice programmes is necessary. **Method:** 17 returnees were recruited to the study completing self-report questionnaires at programme commencement and participating in focus group discussions on programme completion. **Findings:** Three key issues emerged from the data: the varied personal circumstances and professional histories of returnees; the challenge of providing adequate support in practice that reflected returnees' individual needs and aspirations and the importance of flexible employment opportunities to meet returnees' expectations of an appropriate work life balance. **Conclusions:** It is important that any schemes to attract nurses back to the profession are targeted at their specific needs

Barron D, West, E, Reeves R. Tied to the job: affective and relational components of nurse retention
Journal of Health Services Research and Policy 2007 12 Suppl 1 46-51 doi: 10.1258/135581907780318419

Objective: To investigate whether affective and relational components of nurses' experience of work have a significant impact on their intentions to leave either the job or the nursing profession in models that control for other factors (sociodemographic, work conditions, perceptions of quality of care) that are known to affect career decisions. Method: An exploratory, cross-sectional postal survey of 2880 nurses in grades A-I in 20 National Health Service (NHS) Hospital Trusts, 11 in inner London and nine in outer London, was carried out between January and July 2002, looking at nurses' intention to leave their current job or the nursing profession. The data were analysed using logistic regression with robust standard errors. Results: In models that controlled for known sources of job dissatisfaction, relationships with supervisors and managers were found to have a significant effect on respondents' career intentions. Feeling valued by the Trust and by society was very important. Nurses seemed to distinguish between local problems that are the responsibility of the Trust and those, such as levels of pay, that could only be solved at the national level. Conclusion: Nurses' career intentions are complex and multifactorial. Feelings of being valued and listened to play a role, as well as the individual and job-related characteristics. The study highlights the role of supervisors and managers in retaining staff and suggests that investment in robust systems of communication, conflict resolution and security could slow nurse turnover. The NHS as an employer may be most interested in the role of pay in nurse retention, and the general public in how societal attitudes and verbal abuse shape nurses' career decisions

Bourne J A et al. Survey of the perceived professional, educational and personal needs of physiotherapists in primary care and community settings Health and Social Care in the Community 2007 15 (3) 231-237 doi: 10.1111/j.1365-2524.2007.00677.x

The emphasis of UK Government policy on primary-care-based services has led to more physiotherapists working in the community. The aims of the present study were to identify the perceived professional, educational and personal needs of community physiotherapists, and to determine good practice in meeting these needs. A survey of physiotherapists working in 15 National Health Service community trusts in the West Midlands was carried out in September 2000. The survey questionnaire was developed through focus groups and mailed to a random sample of 200 community physiotherapists. The response rate was 67%, and the median age group of the respondents was 21-30 years. The participants worked mainly in 'urban but not inner city' areas, most commonly in domiciliary (31%, n = 38) and general practitioner surgery/health centre (26%, n = 32) locations. Fifty-one per cent (n = 66) of respondents had no specific learning objectives for continuing professional development (CPD); those with such objectives were more positive as to their helpfulness than those without them (Mann-Whitney U-test $z = 2.519$, $P = 0.012$). Fifty-three per cent (n = 68) also often/very often found it problematic getting cover for their caseloads so that they could take part in CPD activities. Access to library resources and use of computers were problems, as were confidence in appraising literature and opportunities to discuss research evidence with colleagues. Fifty-nine per cent (n = 77) of respondents indicated that they often/very often felt stressed by the size of their caseloads. Colleague support included mentorship, peer review, journal clubs, clinical interest groups and multidisciplinary in-service training; respondents with experience of these resources expressed more positive attitudes to them than those

without (Mann-Whitney U-test $z = 2.871$, $P < 0.0005$ for each). Forty-two per cent ($n = 54$) indicated that there were problems with safety issues. This study has identified needs that will have an impact on the ability of community physiotherapists to meet the demands of clinical governance. National Health Service management at all levels has a responsibility to facilitate the education, training and support of community physiotherapists

Buchan J, O'May F, Ball J New role, new country: introducing USA physician assistants to Scotland Human Resources for Health 2007 5 : 13 doi: 10.1186/1478-4491-5-13

This paper draws from research commissioned by the Scottish Executive Health Department (SEHD). It provides a case study in the introduction of a new health care worker role into an already well established and 'mature' workforce configuration. It assesses the role of USA style physician assistants (PAs), as a precursor to planned 'piloting' of the PA role within the National Health Service (NHS) in Scotland. The evidence base for the use of PAs is examined, and ways in which an established role in one health system (the USA) could be introduced to another country, where the role is 'new' and unfamiliar, are explored. The history of the development of the PA role in the USA also highlights what is occasionally a somewhat problematic relationship between PAs and the nursing profession. The paper highlights that the concept of the PA role as a dependent practitioner is not well understood or developed in the NHS, where autonomous practice within regulated professions is the norm. In the PA model, responsibility is shared, but accountability rests with the supervising physician. Clarity of role definition, and engendering mutual respect based on fair treatment and effective management of multi-disciplinary teams will be pre-requisites for effective deployment of this new role in the NHS in Scotland.

Carlisle J et al The role of healthcare assistants in screening for diabetes Quality in Primary Care 2007 15 (2) 77-84

Background: From 2003 to Autumn 2005, the National Screening Committee established a diabetes screening programme in 24 general practices across England. An independent evaluation of the pilots was carried out and provides the context for this paper. **Objective.** To examine the expanding role of health-care assistants in a national evaluation of the feasibility of screening for diabetes in general practice. **Design.** Qualitative case studies employing semi-structured interviews. **Sample.** Twenty-three staff working in general practice involved with a pilot diabetes screening programme in five general practices in four regions in England. Nine pilot programme facilitators from the nine English regions were also interviewed. **Findings.** Pilot screening for diabetes in four case study general practices was carried out by healthcare assistants who had been trained to carry out this task according to a practice-specific protocol. Staff in these practices described this as the most cost-effective and efficient way of organizing and recording screening. Healthcare assistants themselves had grown into, and enjoyed, the increased responsibility of their roles. The remaining practice employed a practice nurse to carry out screening. **Conclusions.** Delegating protocol-based tasks to healthcare assistants was seen as beneficial to the practice and to the job satisfaction and self-esteem

of healthcare assistants, and has the potential for further developments. However, evaluation of the effectiveness of screening and health promotion delivered by healthcare assistants is required before policy recommendations can be made.

Carter Y H, Peile E Graduate entry medicine Clinical Medicine 7 (2) 143-147

Four-year fast-track courses for graduates started in the UK in 2000, and are now offered at 14 UK medical schools. Graduate entry medicine (GEM) started five years earlier in Australia, and of course in the USA it has been the norm for students to begin studying medicine after university graduation. This paper reviews the aspirations for GEM and looks at the early evidence on delivery against those aspirations. Particular reference is made to the experience at Warwick Medical School which was one of the two pioneers of GEM in the UK, has the largest GEM intake and continues to admit only graduates.

Dahlin ME, Runeson B Burnout and psychiatric morbidity among medical students entering clinical training: a three year prospective questionnaire and interview-based study BMC Medical Education 2007 7:6 doi: 10.1186/1472-6920-7-6

Background: Mental distress among medical students is often reported. Burnout has not been studied frequently and studies using interviewer-rated diagnoses as outcomes are rarely employed. The objective of this prospective study of medical students was to examine clinically significant psychiatric morbidity and burnout at 3rd year of medical school, considering personality and study conditions measured at 1st year. Methods: Questionnaires were sent to 127 first year medical students who were then followed-up at 3rd year of medical school. Eighty-one of 3rd year respondents participated in a diagnostic interview. Personality (HP5-i) and Performance-based self-esteem (PBSE-scale) were assessed at first year, Study conditions (HESI), Burnout (OLBI), Depression (MDI) at 1st and 3rd years. Diagnostic interviews (MINI) were used at 3rd year to assess psychiatric morbidity. High and low burnout at 3rd year was defined by cluster analysis. Logistic regressions were used to identify predictors of high burnout and psychiatric morbidity, controlling for gender. Results: 98 (77%) responded on both occasions, 80 (63%) of these were interviewed. High burnout was predicted by Impulsivity trait, Depressive symptoms at 1st year and Financial concerns at 1st year. When controlling for 3rd year study conditions, Impulsivity and concurrent Workload remained. Of the interviewed sample 21 (27%) had a psychiatric diagnosis, 6 of whom had sought help. Unadjusted analyses showed that psychiatric morbidity was predicted by high Performance-based self-esteem, Disengagement and Depression at 1st year, only the later remained significant in the adjusted analysis. Conclusion: Psychiatric morbidity is common in medical students but few seek help. Burnout has individual as well as environmental explanations and to avoid it, organisational as well as individual interventions may be needed. Early signs of depressive symptoms in medical students

may be important to address. Students should be encouraged to seek help and adequate facilities should be available

Farrand P, Duncan F, Byng R Impact of graduate mental health workers upon primary care mental health: a qualitative study Health and Social Care in the Community OnlineEarly articles doi: 10.1111/j.1365-2524.2007.00705.x

The role of the primary care graduate mental health worker (GMHW) was developed to improve the availability of mental health services within primary care. However, little is known concerning the impact of the role upon primary care mental health. Semistructured interviews were undertaken with 27 key stakeholders (12 clients, 10 managers/supervisors, 5 general practitioners) who had experience of the GMHW role and activities provided. Thematic analysis of interview transcripts highlighted four main themes: Access to primary care mental health, Inappropriate referrals, GMHW characteristics, and Role developments. All participant groups highlighted a range of ways in which the GMHW role was making significant contributions to primary care mental health. Many of these were associated with increasing access to mental health services afforded by the range of interventions provided. Benefits, however, may exclude working clients who expressed concerns about a lack of flexibility in the appointment times offered. Concerns arise as a consequence of inappropriate referrals made by some general practitioners. Such referrals were, in part, motivated by a belief that developments in primary care mental health should have been directed towards clients with more severe difficulties. In conclusion, this study suggests that the GMHW role is having a significant impact upon primary care mental health. Attempts to improve primary care mental health through the incorporation of the GMHW role within stepped care models of mental health service delivery should be encouraged.

Harkness E, Bower P, Gask L, Sibbald B. Retention and future job intentions of graduate primary care mental health workers: a newly developed role in England Journal of Health Services Research and Policy 2007 12 Suppl 1 18-22 doi: 10.1258/135581907780318383

Objectives: modernization of the English National Health Service (NHS) workforce has led to the introduction of a number of new roles. One such role is the graduate primary care mental health worker (PCMHW). Although generally successful in expanding primary mental health care, several challenges were raised by the initial implementation, including retention and development of effective career pathways for these workers. The aim of this study was to examine retention and future job intentions of graduate PCMHWs at the end of their one-year training. Methods: Mail surveys of the first cohort of graduate PCMHWs recruited in 2004 were conducted at the beginning and end of their 12-month training. Results: Satisfaction with training courses was generally low. Over half indicated they were likely to leave their graduate PCMHW post within the next few months. However, most intended to stay within the NHS. Conclusions: After training, problems were highlighted in relation to the quality of the training programmes and lack of development of an effective career pathway. This has serious consequences for the viability of this initiative

Herbertson R, et al The role of clinical support workers in reducing junior doctors' hours and improving quality of patient care Journal of Evaluation in Clinical Practice 2007 13 (2) 272 -275 doi: 10.1111/j.1365-2753.2006.00694.x

Aim: The aim of the study was to see if the introduction of clinical support workers (CSWs) at a teaching hospital could reduce the medical work intensity for junior doctors without compromising the quality of patient care. **Background:** The 'New Deal' and 'European Working Time Directive' have prompted hospitals to take a close look at junior doctors' hours and work intensity in order to make posts compliant. Following the Department of Health's publication 'reducing junior doctors' hours', it was felt that certain clinical duties could be shared with nursing staff. **Methods:** Two audits were undertaken 8 months apart. The first was to determine the areas where the introduction of CSW would make the biggest impact. The second was to determine if this impact had had an effect on the intensity of work carried out by the junior doctors. **Findings:** The CSW greatly reduced the number of cannulations and venepunctures performed by the doctors without any compromise to patient care. **Relevance to clinical practice:** This study shows that other allied health professionals can be trained to carry out certain tasks that previously were only performed by doctors. This not only reduces the impact on junior doctors' hours but can also improve patient care, with fewer delays encountered when patients are waiting for a procedure.

Holland R, et al Effectiveness of visits from community pharmacists for patients with heart failure: HeartMed randomised controlled trial British Medical Journal 26th May 2007 334 (7603) 1098-1101 doi: 10.1136/bmj.39164.568183.AE

Objective: To test whether a drug review and symptom self management and lifestyle advice intervention by community pharmacists could reduce hospital admissions or mortality in heart failure patients. **Design:** Randomised controlled trial. **Setting:** Home based intervention in heart failure patients. **ParticipantS:** 293 patients diagnosed with heart failure were included (149 intervention, 144 control) after an emergency admission. **intervention:** Two home visits by one of 17 community pharmacists within two and eight weeks of discharge. Pharmacists reviewed drugs and gave symptom self management and lifestyle advice. Controls received usual care. **MAIN Outcome measures:** The primary outcome was total hospital readmissions at six months. Secondary outcomes included mortality and quality of life (Minnesota living with heart failure questionnaire and EQ-5D). **Results:** Primary outcome data were available for 291 participants (99%). 136 (91%) intervention patients received one or two visits. 134 admissions occurred in the intervention group compared with 112 in the control group (rate ratio=1.15, 95% confidence interval 0.89 to 1.48; P=0.28, Poisson model). 30 intervention patients died compared with 24 controls (hazard ratio=1.18, 0.69 to 2.03; P=0.54). Although EQ-5D scores favoured the intervention group, Minnesota living with heart failure questionnaire scores favoured controls; neither difference was statistically significant. **Conclusion:** This community pharmacist intervention did not lead to reductions in hospital admissions in contrast to those found in trials of specialist nurse led interventions in heart failure. Given that heart failure accounts for 5% of hospital admissions, these results present a problem for policy makers who are faced with a shortage of specialist provision and have hoped

that skilled community pharmacists could produce the same benefits. Trial Registration Number: ISRCTN59427925

Hysong SJ, Best RG, Moore FI Are we under-utilizing the talents of primary care personnel? A job analytic examination Implementation Science 2007 2:10 doi:10.1186/1748-5908-2-10

Background Primary care staffing decisions are often made unsystematically, potentially leading to increased costs, dissatisfaction, turnover, and reduced quality of care. This article aims to (1) catalogue the domain of primary care tasks, (2) explore the complexity associated with these tasks, and (3) examine how tasks performed by different job titles differ in function and complexity, using Functional Job Analysis to develop a new tool for making evidence-based staffing decisions. **Methods** Seventy-seven primary care personnel from six US Department of Veterans Affairs (VA) Medical Centers, representing six job titles, participated in two-day focus groups to generate 243 unique task statements describing the content of VA primary care. Certified job analysts rated tasks on ten dimensions representing task complexity, skills, autonomy, and error consequence. Two hundred and twenty-four primary care personnel from the same clinics then completed a survey indicating whether they performed each task. Tasks were catalogued using an adaptation of an existing classification scheme; complexity differences were tested via analysis of variance. **Results***Objective one:* Task statements were categorized into four functions: service delivery (65%), administrative duties (15%), logistic support (9%), and workforce management (11%). *Objective two:* Consistent with expectations, 80% of tasks received ratings at or below the mid-scale value on all ten scales. *Objective three:* Service delivery and workforce management tasks received higher ratings on eight of ten scales (multiple functional complexity dimensions, autonomy, human error consequence) than administrative and logistic support tasks. Similarly, tasks performed by more highly trained job titles received higher ratings on six of ten scales than tasks performed by lower trained job titles. Contrary to expectations, the distribution of tasks across functions did not significantly vary by job title. **Conclusion** Primary care personnel are not being utilized to the extent of their training; most personnel perform many tasks that could reasonably be performed by personnel with less training. Primary care clinics should use evidence-based information to optimize job-person fit, adjusting clinic staff mix and allocation of work across staff to enhance efficiency and effectiveness.

Lian O S Rural doctors on a global stage: do local communities make a difference? Social Theory and Health 2007 5 (1) 88-102 doi:10.1057/palgrave.sth.8700086

In an age of globalization, do places matter for medical practices? Rural doctors throughout the world seem to think so, as they strive to understand the nature of rural practice as something different from urban practice. This essay presents some

sociological reflections on this subject. Based on a discussion of theories of local communities in modern societies, it is argued that globalization has not altered the distinct qualities of social relations in local communities: the interaction is stable and transparent, and it takes place between total persons. Through these characteristics of the place of practice, distinctive features of rural medicine appear: a local community is a social place in which doctors are offered particularly favourable conditions for recognizing their patients as total and unique persons. This feature is a constituent element of the practice form of rural doctors. Each doctor, however, has to obtain this knowledge and acknowledge its clinical relevance in order for the local community to make a difference.

Malone D C, et al. Pharmacist workload and pharmacy characteristics associated with the dispensing of potentially clinically important drug-drug interactions Medical Care 2007 45 (5) 456-462 doi: 10.1097/01.mlr.0000257839.83765.07

Background: Drug-drug interactions (DDIs) are preventable medical errors, yet exposure to DDIs continues despite systems that are designed to prevent such exposures. The purpose of this study was to examine pharmacy characteristics that may be associated with dispensed potential DDIs. Methods: This study combined survey data from community pharmacies in 18 metropolitan statistical areas with pharmacy claims submitted to 4 pharmacy benefit managers (PBMs) over a 3-month period from January 1, 2003 to March 31, 2003. Pharmacy characteristics of interest included prescription volume, the number of full-time equivalent pharmacists and pharmacy staff, computer software programs, and the ability to modify those programs with respect to DDI alerts, the use of technologies to assist in receiving, filling and dispensing medication orders, and prescription volume. The dependent variable in this study was the rate of dispensed medications that may interact. Results: A total of 672 pharmacies were included in the analysis. On average (\pm SD), the respondents filled 1375 \pm 691 prescriptions per week, submitted 17,948 \pm 23,889 pharmacy claims to the participating PBMs, had 1.2 \pm 0.3 full-time equivalent pharmacists per hour open, and 545 (81%) were affiliated with a chain drug store organization. Factors significantly related to an increased risk of dispensing a potential DDI included pharmacist workload (odds ratio [OR] 1.03; 95% confidence interval [CI] 1.028-1.048), pharmacy staffing (OR 1.10; 95% CI: 1.09-1.11), and various technologies (eg, sophisticated telephone systems, internet receipt of orders, and refill requests) that assist with order processing, and the ability to modify DDI alert-screening sensitivity and detailed pharmacological information about DDIs. Conclusions: This study found that there was an increase in the risk of dispensing a potential DDI with higher pharmacist and pharmacy workload, use of specific automation, and dispensing software programs providing alerts and clinical information

Mackinko J, et al. Quantifying the health benefits of primary care physician supply in the United States. International Journal of Health Services 2007 37 (1) 111-126

This analysis addresses the question, Would increasing the number of primary care physicians improve health outcomes in the United States? A search of the PubMed database for articles containing "primary care physician supply" or "primary care supply"

in the title, published between 1985 and 2005, identified 17 studies, and 10 met all inclusion criteria. Results were reanalyzed to assess primary care effect size and the predicted effect on health outcomes of a one-unit increase in primary care physicians per 10,000 population. Primary care physician supply was associated with improved health outcomes, including all-cause, cancer, heart disease, stroke, and infant mortality; low birth weight; life expectancy; and self-rated health. This relationship held regardless of the year (1980-1995) or level of analysis (state, county, metropolitan statistical area (MSA), and non-MSA levels). Pooled results for all-cause mortality suggest that an increase of one primary care physician per 10,000 population was associated with an average mortality reduction of 5.3 percent, or 49 per 100,000 per year

McCarthy G, Tyrell M P, Lehane E Intention to “leave” or “stay” in nursing. Journal of nursing management 2007 15 (3) 248-255 doi: doi:10.1111/j.1365-2834.2007.00648.x

Background Turnover in nursing and midwifery has recently become a problem in the Republic of Ireland and Irish health-care managers are constantly challenged to retain qualified nurses. The literature suggests that intention to stay or leave employment is the final step in the decision-making process. It is, therefore, reasonable to suggest that understanding ‘intent to stay or leave’ might facilitate nurse managers in introducing of appropriate retention strategies. **Aim** The aim of this study was to investigate registered nurses ‘intent to stay or leave’ employment. **Methods** A cross-sectional quantitative design was utilized. A questionnaire was designed and these were randomly distributed to 352 registered nurses at 10 hospital sites throughout the Republic of Ireland. **Results** Almost 60% of the sample, comprising of young, female, college educated nurses, expressed an intent to leave their current post. The most statistically significant predictors of intent to leave were ‘kinship responsibilities’ ($P < 0.05$) and ‘job satisfaction’ ($P < 0.0001$). **Conclusion** ‘Intent to leave’ has serious implications for workforce planning. Investigating the impact of focussed interventions in relation to job satisfaction and kinship responsibilities may be key retention strategies for nurse managers.

McLaren S et al Developing the general practice manager’s role: managers’ experiences of engagement in continuing professional development Quality in primary care 2007 15 (2) 85-91

Introduction and aims This study sought to review the recent and future range of continuing professional development (CPD) activities undertaken by practice managers in the context of role expansion, to explore practice managers' perceptions of the benefits of CPD and to identify practice managers' experiences of constraints and supports for engagement in CPD in the context of changing cultures for lifelong learning. **Methods** A formative, exploratory evaluation was conducted, utilising qualitative methods. Semistructured interviews were conducted with 16 randomly selected practice managers from general practices in the south east of England. Interviews were transcribed and content analysed using a structured framework. **Results** Practice managers' recent

engagement in CPD covered a diverse range of educational topics. Future plans also reflected priority areas delineated in the new General Medical Services contract. Benefits of CPD were identified as enhancing skills, motivation, confidence, skill-mix, roles and improvement of patient services. Constraints to CPD engagement were negative attitudes, time pressures, lack of finance, and awareness of inclusivity in wider CPD policies. Role autonomy, a positive employer and trust attitudes to funding were supportive of CPD. Conclusions Insights into a transitional culture marked by resistance to lifelong learning alongside a drive for increased professionalism and engagement in CPD were present. Challenges still exist in overcoming constraints to CPD engagement and in ensuring that practice managers reach the potential for role expansion delineated in recent primary care policy changes.

Miller D, Jaye C GPs' perception of their role in the identification and management of family violence Family Practice 2007 24 (2) 95-101 doi: 10.1093/fampra/cmm001

Objectives: To examine the following: (1) GPs' perception of their role in identification and management of family violence in New Zealand, possible barriers and how these might be overcome and (2) opinions of GPs regarding the prevalence of family violence in their practices. Methods: Three focus group (18 participants) discussions were conducted in 2002. Participants were GPs from southern New Zealand urban and rural general practices, Student Health and one medical officer from a provincial hospital. The groups' discussions were audio taped, transcribed, then analysed and coded using qualitative methodology. Results: Participating GPs thought they were in a good position to identify and manage family violence but estimated prevalence in their practice populations was low. Barriers included perceived difficulty, complexity and stress in dealing with family violence. Lack of time, confidence or experience in dealing with family violence, lack of information and access to referral agencies were also noted. GPs felt powerless when victims would not change their situation. Dealing with the perpetrator was difficult. Training and coordinated support and referral systems could improve GPs' involvement with identification and management of family violence. Conclusions: The GPs' estimation of family violence prevalence in their practices is low compared to community-based research. Many issues affect the GP in identifying and managing family violence and must be considered in developing guidelines and training, referral systems and support for GPs

Taylor L J Optimal wages in the market for nurses: an analysis based on Heyes' model Journal of Health Economics 27/2/2007 doi: 10.1016/j.jhealeco.2007.01.005

In a recent paper "The economics of vocation or 'why is a badly paid nurse a good nurse?'" Anthony Heyes posits a novel adverse selection mechanism whereby the average quality of nurses employed is declining in the wage, and evaluates the consequences for

an optimizing monopsonistic National Health Service (NHS). I conduct a standard welfare analysis here, based on the proposed model. It turns out that, contrary to concerns raised by Heyes, the NHS will always choose a wage that is lower than the wage chosen by a welfare-maximizing social planner. Nurse are underpaid. I also extend the analysis to the case of a competitive labor market for nurses

Wallace J E, Lemaire J On physician well being: you'll get by with a little help from your friends Social Science and Medicine 2007 64:12 2565-2577 doi:10.1016/j.socscimed.2007.03.016

This study identifies positive and negative factors associated with physician well being. We collected two sets of data from physicians at a university-based Department of Medicine in Western Canada. First, we conducted exploratory, in-depth interviews with 54 physicians to identify factors associated with their well being. Participants explained that certain aspects of their work are demanding and negatively related to their well being, whereas other 5 factors are more enabling and contribute positively. Second, we mailed a structured questionnaire including measures of the key factors identified in the physician interviews to all physicians in the same Department of Medicine. Multivariate analysis was used to assess the extent to which the factors identified in the interviews are significantly related to physicians' well being. The findings show the importance of co-worker support, both in terms of being directly related to physician well being as well as buffering the negative effects of work demands. We discuss several important implications for physicians and the organizations that employ them in understanding the factors related to physician well being. In addition, patient interactions appear to be both a key source of stress and a major source of satisfaction in physicians' daily work lives.

Weissman J S , et al. Hospital workload and adverse events Medical Care 2007 45 (5) 448-455 doi: 10.1097/01.mlr.0000257231.86368.09

Context: Hospitals are under pressure to increase revenue and lower costs, and at the same time, they face dramatic variation in clinical demand. Objective:: We sought to determine the relationship between peak hospital workload and rates of adverse events (AEs). Methods: A random sample of 24,676 adult patients discharged from the medical/surgical services at 4 US hospitals (2 urban and 2 suburban teaching hospitals) from October 2000 to September 2001 were screened using administrative data, leaving 6841 cases to be reviewed for the presence of AEs. Daily workload for each hospital was characterized by volume, throughput (admissions and discharges), intensity (aggregate DRG weight), and staffing (patient-to-nurse ratios). For volume, we calculated an "enhanced" occupancy rate that accounted for same-day bed occupancy by more than 1 patient. We used Poisson regressions to predict the likelihood of an AE, with control for workload and individual patient complexity, and the effects of clustering. Results: One urban teaching hospital had enhanced occupancy rates more than 100% for much of the year. At that hospital, admissions and patients per nurse were significantly related to the likelihood of an AE ($P < 0.05$); occupancy rate, discharges, and DRG-weighted census

were significant at $P < 0.10$. For example, a 0.1% increase in the patient-to-nurse ratio led to a 28% increase in the AE rate. Results at the other 3 hospitals varied and were mainly non significant. Conclusions: Hospitals that operate at or over capacity may experience heightened rates of patient safety events and might consider re-engineering the structures of care to respond better during periods of high stress

