



NATIONAL PRIMARY CARE RESEARCH
AND DEVELOPMENT CENTRE



CURRENT AWARENESS BULLETIN

APRIL-JUNE 2010

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ACCESS TO CARE

Barron D S et al 2010 Seen but not heard – ethnic minorities’ views of primary health care interpreting provision: a focus group study *Primary Health Care Research & Development* (2010), 11:132-141

<http://dx.doi.org/10.1017/S1463423609990399>

Aim The aim of this study was to explore the awareness and views of members of the ethnic minority community towards primary health care interpreting provision in two localities in Hertfordshire. **Background** Ethnic minority groups often have to undertake many aspects of their day-to-day lives with limited English. The provision of high quality language interpretation services is vital for enabling access to public services, including healthcare. The use of accredited or professional interpreters has been minimal within primary care and undermines the principle of equity in the National Health Service. The local Primary Care Trust and ethnic minority forums initiated this study. **Methods** The overall research design was qualitative and data collection was undertaken using focus groups. Twenty-four participants from the Pakistani (Punjabi and Urdu speakers), Bangladeshi (Bengali speakers) and Chinese (Cantonese and Mandarin speakers) communities took part in one of five focus groups. Ethnic minority members recruited participants, conducted the focus groups and translated the interviews after receiving in-depth training. **Findings** Participants were unaware that healthcare professionals could access interpreting provision for their primary health care consultations, which were usually managed with the assistance of family members (including children) and friends. Both the appropriateness of using children and the potential compromising of confidentiality and privacy when using friends to interpret were concerns. Women discussed inventing illnesses rather than talking openly about embarrassing health issues in front of their children or husbands, which they suggested, may lead to depression or other mental health problems. Trust, accuracy, independence and confidentiality were important attributes participants expected in a professional interpreter whom they would prefer was from their own gender and culture.

Furler, J., et al 2010. "Managing Depression Among Ethnic Communities: A Qualitative Study". *Annals of Family Medicine* 8: 231-236.

<http://dx.doi.org/10.1370/afm.1091>

<http://pmid.us/20458106>

Purpose Clinical care for depression in primary care negotiates a path between contrasting views of depression as a universal natural phenomenon and as a socially constructed category. This study explores the complexities of this work through a study of how family physicians experience working with different ethnic minority communities in recognizing, understanding, and caring for patients with depression. Methods We undertook an analysis of in-depth interviews with 8 family physicians who had extensive experience in depression care in 3 refugee patient groups in metropolitan Victoria and Tasmania, Australia. Results Although different cultural beliefs about depression were acknowledged, the physicians saw these beliefs as deeply rooted in the recent historical and social context of patients from these communities. Traumatic refugee experiences, dislocation, and isolation affected the whole of communities, as well as individuals. Physicians nevertheless often offered medication simply because of the impossibility of addressing structural issues. Interpreters were critical to the work of depression care, but their involvement highlighted that much of this clinical work lies beyond words. Conclusions The family physicians perceived working across cultural differences, working with biomedical and social models of depression, and working at both community and individual levels, not as a barrier to providing high-quality depression care, but rather as a central element of that care. Negotiating the phenomenon rather than diagnosing depression may be an important way that family physicians continue to work with multiple, contested views of emotional distress. Future observational research could more clearly characterize and measure the process of negotiation and explore its effect on outcomes

Rohrer, J E., Angstman, K B., and Furst, J W. Early return visits by primary care patients: a retail nurse-practitioner clinic versus a medical office walk-in clinic. *Primary Health Care Research & Development* 11(01), 87-92. 2010.

<http://dx.doi.org/10.1017/S1463423609990387>

Aim The purpose of this study was to compare return visits in 2 weeks experienced by patients using a retail nurse-practitioner clinic to similar patients using standard drop-in clinic located in a medical office. Background Retail medicine clinics have become widely available. However, their impact on return visit rates compared to drop-in medical office visits for similar patients is unknown. Methods Medical records of primary care patients (both adults and children) seen in a large group practice in Minnesota in 2008 were analyzed for this study. Patients treated for five common conditions were selected (pink eye, sore throat, viral illness, bronchitis, and cough, n = 279). Two groups of patients were studied: those using a retail walk-in clinic staffed by nurse practitioners (n = 142) and a comparison group using regular office care for same-day visits (n = 137). The dependent variable was a return office visit within 2 weeks. Multiple logistic regression analysis was used to adjust for case mix differences between groups. Findings The percent of office visits within 2 weeks for these groups was 20.4 for retail drop-in patients and 27.7 for same-day medical office patients, respectively (P = 0.15). After adjustment for age, gender, visit reason, and number of office visits in the previous 6 months, no significant difference in risk of early return visits in comparison to an office-

based drop-in clinic was found (odds ratio 0.83, confidence interval 0.43–1.63). Our retail nurse-practitioner clinic appeared to increase access without increasing early return visits

CHRONIC ILLNESS

Blakeman T et al 2010 Bringing self-management into clinical view: a qualitative study of long-term condition management in primary care consultations. *Chronic Illness* 2010 May 5. [Epub ahead of print]

<http://dx.doi.org/10.1177/1742395309358333>

<http://pmid.us/20444765>

Objectives: To understand social processes underpinning support for self-management of long-term conditions in primary care. Methods: Comparative analysis of observational and interview data concerning the management of long-term conditions in UK primary-care consultations. Analysis of recordings of primary care consultations (n = 86) was conducted in conjunction with analysis of semi-structured interviews with health professionals (n = 17) and patients (n = 12) living with a long-term condition. Results: A key finding was the infrequency with which self-management topics became legitimate objects for discussion in consultations. Analysis suggested that the maintenance of self-other relations was a prime objective for both patients and professionals, and the introduction of self-management topics threatened this process. Technology and the division of labour among primary-care professionals reinforced this tension. Discussion: In order for self-management support to become embedded and integrated into primary care, interventions concerning long-term condition management need to take into account this tension underpinning care.

Freund T, Kayling F, Miksch A, Szecsenyi J, Wensing M. 2010 Effectiveness and efficiency of primary care based case management for chronic diseases: rationale and design of a systematic review and meta-analysis of randomized and non-randomized trials. *BMC Health Services Research* 2010;10:112.

<http://www.biomedcentral.com/1472-6963/10/112>

<http://pmid.us/20459654>

Background: Case management is an important component of structured and evidence-based primary care for chronically ill patients. Its effectiveness and efficiency has been evaluated in numerous clinical trials. This protocol describes aims and methods of a

systematic review of research on the effectiveness and efficiency of case management in primary care. Methods: According to this protocol Medline, Embase, CINAHL, PsychInfo, the Cochrane Central Register of Controlled trials, DARE, NHS EED, Science Citation Index, The Royal College of Nursing Database, Dissertation Abstracts, registers of clinical trials and the reference lists of retrieved articles will be searched to identify reports on randomized and non-randomized controlled trials of case management interventions in a primary care setting without limitations on language or publication date. We will further ask experts in the field to avoid missing relevant evidence. Study inclusion and data extraction will be performed independently by two reviewers. After assessing risk of bias according to predefined standards, included studies will be described qualitatively. Subgroup analyses are planned for different chronic diseases and intervention strategies. If appropriate, a quantitative synthesis of data will be performed to provide conclusive evidence about the effectiveness and efficiency of primary care based case management in chronic care. Registration: Centre for Reviews and Dissemination (University of York): CRD32009100316

Gambling, Tina and Long, Andrew. 2010 Tailoring advice and optimizing response: a case study of a telephone-based support for patients with type 2 diabetes. *Family Practice* 27(2), 179-185. 1-4-2010.

<http://dx.doi.org/10.1093/fampra/cmp097>

<http://pmid.us/20032169>

Background and aims. Health care increasingly incorporates telephone counselling, but the dynamics of interactions supporting its delivery are not well understood. This paper explores how advice was packaged and received by participants with type 2 diabetes within the context of a Pro-Active Call-Centre Treatment Support (PACCTS) system delivered to provide diabetes self-care training over the telephone. Methods. The data relate to nine participants who formed part of the qualitative evaluation within the intervention arm of a randomized controlled trial (n = 591) of PACCTS. One consultation call between the tele-carer and the participant was tape recorded towards the end of the 3-year study and each participant was interviewed by telephone within 24 hours of the consultation. The nine calls and interviews were transcribed and analysed using the constant comparative method. Results. The type of advice the participants received was packaged in six forms: advice as explanation, general information-giving, generic advice, advice in the form of practitioner self-disclosure, personalized advice and responsive advice. Variation was evident in terms of the nature of advice provided, level of generality, form and context. Conclusions. As the participants had to make multiple behavioural changes over time, advice needed to be delivered, reiterated and reinforced to achieve understanding and uptake. The more specific and personalized the information and advice, the more likely it was for the participant to give a positive and engaged response. Seizing every opportunity to deliver good quality personalized and/or responsive advice is essential in order to facilitate effective behavioural change

Green, J, et al . Parent-mediated communication-focused treatment in children with autism (PACT): a randomised controlled trial [Online First]. *Lancet*. In press 2010

[http://dx.doi.org/10.1016/S0140-6736\(10\)60587-9](http://dx.doi.org/10.1016/S0140-6736(10)60587-9)

<http://pmid.us/20494434>

Background: Results of small trials suggest that early interventions for social communication are effective for the treatment of autism in children. We therefore investigated the efficacy of such an intervention in a larger trial. Methods: Children with core autism (aged 2 years to 4 years and 11 months) were randomly assigned in a one-to-one ratio to a parent-mediated communication-focused (Preschool Autism Communication Trial [PACT]) intervention or treatment as usual at three specialist centres in the UK. Those assigned to PACT were also given treatment as usual. Randomisation was by use of minimisation of probability in the marginal distribution of treatment centre, age (≤ 42 months or >42 months), and autism severity (Autism Diagnostic Observation Schedule-Generic [ADOS-G] algorithm score 12-17 or 18-24). Primary outcome was severity of autism symptoms (a total score of social communication algorithm items from ADOS-G, higher score indicating greater severity) at 13 months. Complementary secondary outcomes were measures of parent-child interaction, child language, and adaptive functioning in school. Analysis was by intention to treat. This study is registered as an International Standard Randomised Controlled Trial, number ISRCTN58133827. Results: 152 children were recruited. 77 were assigned to PACT (London [n=26], Manchester [n=26], and Newcastle [n=25]); and 75 to treatment as usual (London [n=26], Manchester [n=26], and Newcastle [n=23]). At the 13-month endpoint, the severity of symptoms was reduced by 3.9 points (SD 4.7) on the ADOS-G algorithm in the group assigned to PACT, and 2.9 (3.9) in the group assigned to treatment as usual, representing a between-group effect size of -0.24 (95% CI -0.59 to 0.11), after adjustment for centre, sex, socioeconomic status, age, and verbal and non-verbal abilities. Treatment effect was positive for parental synchronous response to child (1.22, 0.85 to 1.59), child initiations with parent (0.41, 0.08 to 0.74), and for parent-child shared attention (0.33, -0.02 to 0.68). Effects on directly assessed language and adaptive functioning in school were small. Interpretation: On the basis of our findings, we cannot recommend the addition of the PACT intervention to treatment as usual for the reduction of autism symptoms; however, a clear benefit was noted for parent-child dyadic social communication.

Harkness, E, et al 2010 Identifying psychosocial interventions that improve both physical and mental health in patients with diabetes: a systematic review and meta-analysis. *Diabetes Care* 2010;33 (4):926-930.

<http://dx.doi.org/10.2337/dc09-1519>

<http://pmid.us/20351228>

Objective Patients with diabetes suffer high rates of mental health problems, and this combination is associated with poor outcomes. Although effective treatments exist for both diabetes and mental health problems, delivering services for physical and mental health problems separately ignores their interaction and may be inefficient. This systematic review sought to identify psychosocial interventions that could improve both the physical and mental health of patients with diabetes. Research design and methods Studies were identified from the following databases: CENTRAL, MEDLINE, Excerpta Medica (EMBASE), Psychinfo, and Cumulative Index to Nursing and Allied Health Literature (CINAHL). The review included randomized controlled trials in patients with type 1 and type 2 diabetes who received psychosocial interventions and where both mental health and physical health outcomes were reported. Data were extracted on study quality, the content and process of interventions, and outcomes. Results Eighty-five eligible comparisons were identified, of which 49 reported sufficient data for analysis. Psychosocial interventions modestly improved A1C (standardized mean difference -0.29 [95% CI -0.37 to -0.21]) and mental health outcomes (-0.16 [-0.25 to -0.07]). However, there was a limited association between the effects on A1C and mental health, and no intervention characteristics predicted benefit on both outcomes. Conclusions Managing physical and mental health in long-term conditions are increasingly important. The review did not identify types of interventions that consistently provide benefits for both physical and mental health. Developing such interventions remains an important challenge. The findings have implications for understanding the interaction between physical and mental health problems and for the coordination of care.

Jansink, R., et al 2010. "Primary care nurses struggle with lifestyle counseling in diabetes care: a qualitative analysis". *BMC Family Practice* 11: 41.

<http://dx.doi.org/10.1186/1471-2296-11-41>

<http://pmid.us/20500841>

Background: Patient outcomes are poorly affected by lifestyle advice in general practice. Promoting lifestyle behavior change require that nurses shift from simple advice giving to a more counseling-based approach. The current study examines which barriers nurses encounter in lifestyle counseling to patients with type 2 diabetes. Based on this information we will develop an implementation strategy to improve lifestyle behavior change in general practice. Method: In a qualitative semi-structured study, twelve in-depth interviews took place with nurses in Dutch general practices involved in diabetes care. Specific barriers in counseling patients with type 2 diabetes about diet, physical activity, and smoking cessation were addressed. The nurses were invited to reflect on barriers at the patient and practice levels, but mainly on their own roles as counselors. All interviews were audio-recorded and transcribed. The data were analyzed with the aid of a predetermined framework. Results: Nurses felt most barriers on the level of the patient;

patients had limited knowledge of a healthy lifestyle and limited insight into their own behavior, and they lacked the motivation to modify their lifestyles or the discipline to maintain an improved lifestyle. Furthermore, nurses reported lack of counseling skills and insufficient time as barriers in effective lifestyle counseling. Conclusions: The traditional health education approach is still predominant in primary care of patients with type 2 diabetes. An implementation strategy based on motivational interviewing can help to overcome 'jumping ahead of the patient' and promotes skills in lifestyle behavioral change. We will train our nurses in agenda setting to structure the consultation based on prioritizing the behavior change and will help them to develop social maps that contain information on local exercise programs

Kahn, Richard; Alperin, Peter; Eddy, David; 2010 Age at initiation and frequency of screening to detect type 2 diabetes : a cost-effectiveness analysis. *Lancet* 2010; 375 (9723): 1365-1374 (17 April 2010)

[http://dx.doi.org/10.1016/S0140-6736\(09\)62162-0](http://dx.doi.org/10.1016/S0140-6736(09)62162-0)

<http://pmid.us/2035662>

Background: No clinical trials have assessed the effects or cost-effectiveness of sequential screening strategies to detect new cases of type 2 diabetes. We used a mathematical model to estimate the cost-effectiveness of several screening strategies. Methods: We used person-specific data from a representative sample of the U.S. population to create a simulated population of 325,000 people aged 30 years without diabetes. We used the Archimedes model to compare eight simulated screening strategies for type 2 diabetes with a no-screening control strategy. Strategies differed in terms of age at initiation and frequency of screening. Once diagnosed, diabetes treatment was simulated in a standard manner. We calculated the effects of each strategy on the incidence of type 2 diabetes, myocardial infarction, stroke, and microvascular complications in addition to quality of life, costs, and cost per quality-adjusted life-year (QALY). Findings: Compared with no screening, all simulated screening strategies reduced the incidence of myocardial infarction (3-9 events prevented per 1,000 people screened) and diabetes-related microvascular complications (3-9 events prevented per 1,000 people), and increased the number of QALYs (93-194 undiscounted QALYs) added over 50 years. Most strategies prevented a significant number of simulated deaths (2-5 events per 1,000 people). There was little or no effect of screening on incidence of stroke (0-1 event prevented per 1,000 people). Five screening strategies had costs per QALY of about US\$10,500 or less, whereas costs were much higher for screening started at 45 years of age and repeated every year (\$15,509), screening started at 60 years of age and repeated every three years (\$25,738), or a maximum screening strategy (screening started at 30 years of age and repeated every six months; \$40,778). Several strategies differed substantially in the number of QALYs gained. Costs per QALY were sensitive to the disutility assigned to the state of having diabetes diagnosed with or without symptoms. Interpretation: In the U.S. population, screening for type 2 diabetes is cost

effective when started between the ages of 30 years and 45 years, with screening repeated every 3-5 years.

Lamb, S et al 2010 . Group cognitive behavioural treatment for low-back pain in primary care: a randomised controlled trial and cost-effectiveness analysis. *The Lancet* 375(9718), 916-923. 13-3-2010. 19-3-2010.

[http://dx.doi.org/10.1016/S0140-6736\(09\)62164-4](http://dx.doi.org/10.1016/S0140-6736(09)62164-4)

<http://pmid.us/20189241>

Summary Background Low-back pain is a common and costly problem. We estimated the effectiveness of a group cognitive behavioural intervention in addition to best practice advice in people with low-back pain in primary care. **Methods** In this pragmatic, multicentre, randomised controlled trial with parallel cost-effectiveness analysis undertaken in England, 701 adults with troublesome subacute or chronic low-back pain were recruited from 56 general practices and received an active management advisory consultation. Participants were randomly assigned by computer-generated block randomisation to receive an additional assessment and up to six sessions of a group cognitive behavioural intervention (n=468) or no further intervention (control; n=233). Primary outcomes were the change from baseline in Roland Morris disability questionnaire and modified Von Korff scores at 12 months. Assessment of outcomes was blinded and followed the intention-to-treat principle, including all randomised participants who provided follow-up data. This study is registered, number ISRCTN54717854. **Findings** 399 (85%) participants in the cognitive behavioural intervention group and 199 (85%) participants in the control group were included in the primary analysis at 12 months. The most frequent reason for participant withdrawal was unwillingness to complete questionnaires. At 12 months, mean change from baseline in the Roland Morris questionnaire score was 1+1 points (95% CI 0+39-1+72) in the control group and 2+4 points (1+89-2+84) in the cognitive behavioural intervention group (difference between groups 1+3 points, 0+56-2+06; p=0+0008). The modified Von Korff disability score changed by 5+4% (1+99-8+90) and 13+8% (11+39-16+28), respectively (difference between groups 8+4%, 4+47-12+32; p<0+0001). The modified Von Korff pain score changed by 6+4% (3+14-9+66) and 13+4% (10+77-15+96), respectively (difference between groups 7+0%, 3+12-10+81; p<0+0001). The additional quality-adjusted life-year (QALY) gained from cognitive behavioural intervention was 0+099; the incremental cost per QALY was ú1786, and the probability of cost-effectiveness was greater than 90% at a threshold of ú3000 per QALY. There were no serious adverse events attributable to either treatment. **Interpretation** Over 1 year, the cognitive behavioural intervention had a sustained effect on troublesome subacute and chronic low-back pain at a low cost to the health-care provider. **Funding** National Institute for Health Research Health Technology Assessment Programme

Peters-Klimm, F., et al 2010. "Case management for patients with chronic systolic heart failure in primary care: The HICMan exploratory randomised controlled trial". *Trials* 11: 56.

<http://dx.doi.org/10.1186/1745-6215-11-56>

<http://pmid.us/20478035>

Background: Chronic (systolic) heart failure (CHF) represents a clinical syndrome with high individual and societal burden of disease. Multifaceted interventions like case management are seen as promising ways of improving patient outcomes, but lack a robust evidence base, especially for primary care. The aim of the study was to explore the effectiveness of a new model of CHF case management conducted by doctors' assistants (DAs, equivalent to a nursing role) and supported by general practitioners (GPs). Methods: This patient-randomised controlled trial (phase II) included 31 DAs and employing GPs from 29 small office-based practices in Germany. Patients with CHF received either case management (n=99) consisting of telephone monitoring and home visits or usual care (n=100) for 12 months. We obtained clinical data, health care utilisation data, and patient-reported data on generic and disease-specific quality of life (QoL, SF-36 and KCCQ), CHF self-care (EHFScBS) and on quality of care (PACIC-5A). To compare between groups at follow-up, we performed analyses of covariance and logistic regression models. Results: Baseline measurement showed high guideline adherence to evidence-based pharmacotherapy and good patient self-care: Patients received angiotensin converting enzyme inhibitors (or angiotensin-2 receptor antagonists) in 93.8% and 95%, and betablockers in 72.2% and 84%, and received both in combination in 68% and 80% of cases respectively. EHFScBS scores (SD) were 25.4 (8.4) and 25.0 (7.1). KCCQ overall summary scores (SD) were 65.4 (22.6) and 64.7 (22.7). We found low hospital admission and mortality rates. EHFScBS scores (-3.6 [-5.7;-1.6]) and PACIC and 5A scores (both 0.5, [0.3;0.7/0.8]) improved in favour of CM but QoL scores showed no significant group differences (Physical / Mental SF-36 summary scores / KCCQ-os [95%CI]: -0.3 [-3.0;2.5] / -0.1 [-3.4;3.1] / 1.7 [-3.0;6.4]). Conclusions: In this sample, with little room for improvement regarding evidence-based pharmacotherapy and CHF self-care, case management showed no improved health outcomes or health care utilisation. However, case management significantly improved performance and key intermediate outcomes. Our study provides evidence for the feasibility of the case management model.

Sansom, A, et al 2010 . Routes to total joint replacement surgery: patients' and clinicians' perceptions of need [Online First]. *Arthritis Care & Research*. In press 2010

<http://dx.doi.org/10.1002/acr.20218>

<http://pmid.us/20506507>

Objective.: To explore patients' perspectives of need for total joint replacement (TJR) associated with decision-making in orthopaedic consultations for hip or knee osteoarthritis (OA). Methods.: Twenty-six orthopaedic consultations in three UK hospitals were observed and audio-recorded, and semi-structured interviews were conducted with the involved patients and clinicians. Data were analysed using thematic analysis. Results.: Two main routes to orthopaedic consultation were identified: patients who waited until their symptoms were no longer bearable (holding off); and patients who sought consultation pre-emptively (before it gets worse). These routes were mediated by age, comparison with others, demands and desires, deterioration, and convenience. Whether patients had held off or sought help pre-emptively influenced their perceptions of need. Patients' perceptions of their route to orthopaedic consultation, and consequently their perception of need, were either confirmed or contradicted by clinicians. Conclusion.: When clinicians and patients have differing perceptions of need there may be ongoing patient anxiety, concern, and feelings of disempowerment. It is important for primary and secondary care clinicians to identify and explore a patient's perception of need in order to provide consistency in referral pathways and to support patient involvement in, and understanding of, shared decision-making. Exploring the patient's perspective of their route to consultation is proposed as one easily achievable method of identifying patients' views on urgency of their need.

Vermunt, P. W. A., et al 2010. "An active strategy to identify individuals eligible for type 2 diabetes prevention by lifestyle intervention in Dutch primary care: the APHRODITE study" *Family Practice* 27: 312-319.

<http://dx.doi.org/10.1093/fampra/cmp100>

<http://pmid.us/20089573>

Background. Several trials have shown the potential of lifestyle intervention programmes for prevention of type 2 diabetes. The effectiveness of implementation of these programmes into daily practice is now being studied in several countries. The Active Prevention in High Risk individuals of Diabetes Type 2 in Eindhoven' (APHRODITE) study investigates whether type 2 diabetes prevention by lifestyle intervention is effective in Dutch primary care. In this article we describe the process of recruiting the study participants. Objective. To assess the reach of an active strategy to recruit participants for a programme on type 2 diabetes prevention by lifestyle intervention in Dutch primary care. Methods. A diabetes risk questionnaire was sent to general practice patients aged 40-70 years. Individuals with a risk score above threshold were invited for an admission interview with the GP and an oral glucose tolerance test (OGTT). All individuals with non-diabetic glucose levels were asked to participate in the intervention study. Results. In total, 8752 (54.6%) of the individuals returned the questionnaire in time. Of all high-risk individuals (n = 1533), 73.1% contacted their practice to schedule a consultation with the GP. Response rates varied significantly among practices. Conclusions. Using invitational letters, a substantial amount of individuals could be motivated to participate in a programme on type 2 diabetes prevention by lifestyle intervention in Dutch primary care.

Further research is needed on what kind of strategy would be most effective and efficient to screen for individuals at high risk for type 2 diabetes in primary care

Wermeling P, et al Towards a more efficient diabetes control in primary care: six-monthly monitoring compared with three-monthly monitoring in type 2 diabetes - The EFFIMODI trial: Design of a randomised controlled patient-preference equivalence trial in primary care. *BMC Family Practice* 2010;11:35.

<http://dx.doi.org/10.1186/1471-2296-11-35>

<http://pmid.us/20459820>

Background: Scientific evidence for the frequency of monitoring of type 2 diabetes patients is lacking. If three-monthly control in general practice could be reduced to six-monthly control in some patients, this would on the one hand reduce the use of medical services including involvement of practice nurses, and thus reduce costs, and on the other hand alleviate the burden of people with type 2 diabetes. The goal of this study is to make primary diabetes care as efficient as possible for patients and health care providers. Therefore, we want to determine whether six-monthly monitoring of well-controlled type 2 diabetes patients in primary care leads to equivalent cardiometabolic control compared to the generally recommended three-monthly monitoring. Methods: The study is a randomised controlled patient-preference equivalence trial. Participants are asked if they prefer three-monthly (usual care) or six-monthly diabetes monitoring. If they do not have a preference, they are randomised to a three-monthly or six-monthly monitoring group. Patients are eligible for the study if they are between 40 and 80 years old, diagnosed with type 2 diabetes more than one year ago, treated by a general practitioner, not on insulin treatment, and with HbA1c [less than or equal to]7.5%, systolic blood pressure [less than or equal to]145 mmHg and total cholesterol [less than or equal to]5.2 mmol/l. The intervention group (six-monthly monitoring) will receive the same treatment with the same treatment targets as the control group (three-monthly monitoring). The intervention period will last one and a half year. After the intervention, the three-monthly and six-monthly monitoring groups are compared on equivalence of cardiometabolic control. Secondary outcome measures are HbA1c, blood pressure, cholesterol level, Body Mass Index, smoking behaviour, physical activity, loss of work due to illness, health status, diabetes-specific distress, satisfaction with treatment and adherence to medications. We will use intention-to-treat analysis with repeated measures. For outcomes that have only baseline and final measurements, we will use ANCOVA. Depending on the results, a cost-minimisation analysis or an incremental cost-effectiveness analysis will be done. Discussion: This study will provide valuable information on the most efficient control frequency of well-controlled type 2 diabetes patients in primary care. Trial registration:

COMORBIDITY

Gili, M et al 2010 Comorbidity between common mental disorders and chronic somatic diseases in primary care patients. *General Hospital Psychiatry* 2010 May-Jun;32(3):240-5. Epub 2010 Mar 1.

<http://dx.doi.org/10.1016/j.genhosppsy.2010.01.013>

<http://pmid.us/20430226>

Objective To estimate the prevalence of the most common mental disorders in primary care patients with chronic somatic diseases based on physicians' diagnoses and compared with healthy probands. **Method** A systematic sample of 7940 adult primary care patients was recruited by 1925 general practitioners (GPs) in a large cross-sectional national epidemiological study. The Primary Care Evaluation of Mental Disorders (PRIME-MD) was used as standardized instrument for the assessment of mental disorders. Medical diagnoses were provided by patient's GP. **Results** The prevalence rate of mental disorder was significantly higher in patients with chronic somatic diseases (56.8%) compared with physically healthy subjects (48.9%; OR: 1.37). Prevalence of depressive and anxiety disorders is higher among individuals with neurological, oncological or liver disease. The differences are significant in all comparisons, with the exception of anxiety disorders in patients with musculoskeletal disorders. There is an increase in prevalence rates of mental disorders according to the number of somatic diseases. **Conclusions** The study provides evidence of the comorbidity of common mental disorders and somatic diseases. We need a predominant focus on affective and anxiety disorders in primary care patients with chronic somatic diseases. Symptoms overlap makes it necessary to discriminate these differences more in detail in future studies

Samoutis, G. A., et al . 2010. A pilot quality improvement intervention in patients with diabetes and hypertension in primary care settings of Cyprus *Family Practice* 27: 263-270.

<http://dx.doi.org/10.1093/fampra/cmq009>

<http://pmid.us/20348163>

Background. The achievement of quality of care constitutes a priority for modern health care systems. The objective of our study was to evaluate a quality improvement intervention in primary care of Cyprus. **Methods.** In a two-arm non-randomized

controlled study in primary care centres in Cyprus, all patients with hypertension (HTN) and diabetes (n = 539) were invited. In one urban and one rural centre, a quality improvement programme was implemented; two other centres (one urban and one rural) served as control practices. The intervention mainly consisted of the introduction of clinical disease management guidelines and an electronic medical record system. The primary outcome measurement was improvement of specific clinical indicators for HTN and diabetes. Patients' satisfaction was evaluated using the European Task Force on Patient Evaluations of General Practice (EUROPEP) questionnaire over an 18-month follow-up period. Results. Five hundred and four patients completed the study, 278 patients in the intervention practices and 226 patients in the control practices. Mean results for blood pressure, total cholesterol and low density lipoprotein-cholesterol and three annual performance measures (urine protein testing, dilated eye and foot examination) had improved at 18-month follow-up in the intervention as compared to the control group. There was no improvement of HbA1c levels. Patients' satisfaction improved in the intervention practices (improvement of 10/23 EUROPEP items) but decreased in the control group (decline of 20/23 items). Conclusions. A pilot multifaceted quality improvement intervention programme for patients with diabetes and HTN implemented in primary care settings in Cyprus showed promising results. Future studies need to involve a broader number of practices and patient populations

GOVERNANCE

Abraham, J 2009 Partial progress : governing the pharmaceutical industry and the NHS, 1948-2008. *Journal of Health Politics, Policy and Law* 2009; 34 (6): 931-977

<http://dx.doi.org/10.1215/03616878-2009-032>

Coinciding with sixty years of the U.K. National Health Service (NHS), this article reviews the neglected area of the governance of the pharmaceutical industry and the NHS. It traces the relationships between the pharmaceutical industry, the state, and the NHS from the creation of the health service to the present, as they have grappled with the overlapping challenges of pharmaceutical safety, efficacy, cost-effectiveness, pricing, promotion, and advertising. The article draws on the concepts of 'corporate bias' and 'regulatory capture' from political theory, and 'counter-vailing powers' and 'clinical autonomy' in medical sociology, while also introducing the new concepts of 'assimilated allies' and 'pharmaceuticalization' in order to synthesize a theoretical framework capable of longitudinal empirical analysis of pharmaceutical governance. The analysis identifies areas in which the governance of pharmaceuticals and the NHS has contributed to progress in health care since 1948. However, it is argued that that progress has been slow, restricted, and vulnerable to misdirection due to the enormous and unrivaled influence afforded to the pharmaceutical industry in policy developments. Countervailing influences against such corporate bias have often been limited and subject to

destabilization by the industry's assimilated allies either within the state or in the embrace of pharmaceuticalization and consumerism.

Dixon A, Storey J, Rosete AA 2010 Accountability of foundation trusts in the English NHS: views of directors and governors *Journal of Health Services Research and Policy* 2010;15:82-89

<http://dx.doi.org/10.1258/jhsrp.2009.009078>

<http://pmid.us/20147428>

Objectives: To map and describe the formal accountability relationships of foundation trusts in England and to explore the interpretations of these relationships by the key actors. Methods: Documentary analysis and interviews with chief executives, chairs, directors and governors in six acute trusts and two Strategic Health Authorities. **Results:** Although vertical accountability to the Department of Health (via Strategic Health Authorities) has, in formal terms, been removed some foundation trusts continue to be held to accountability by Strategic Health Authorities, albeit informally. Directors of foundation trusts perceive strong accountable to their regulator, Monitor, particularly for financial performance, but there is some confusion about where accountability for quality of care rests. Horizontal lines of accountability to the local population (through Local Involvement Networks and local government Overview and Scrutiny Committees) remain weak. Conclusions: Contrary to the major policy objectives of giving greater autonomy to foundation trusts and making them more accountable to the local population, they continue to look towards the Department of Health rather than to the local population and its representatives. The accountability of foundation trusts needs to be simplified, clarified and strengthened.

HEALTH ECONOMICS

Claxton, K, et al 2010 Discounting and decision making in the economic evaluation of health-care technologies [Online First]. *Health Economics*. In press 2010

<http://dx.doi.org/10.1002/hec.1612>

Discounting costs and health benefits in cost-effectiveness analysis has been the subject of recent debate - some authors suggesting a common rate for both and others suggesting a lower rate for health. We show how these views turn on key judgments of fact and value: on whether the social objective is to maximise discounted health outcomes or the

present consumption value of health; on whether the budget for health care is fixed; on the expected growth in the cost-effectiveness threshold; and on the expected growth in the consumption value of health. We demonstrate that if the budget for health care is fixed and decisions are based on incremental cost effectiveness ratios (ICERs), discounting costs and health gains at the same rate is correct only if the threshold remains constant. Expecting growth in the consumption value of health does not itself justify differential rates but implies a lower rate for both. However, whether one believes that the objective should be the maximisation of the present value of health or the present consumption value of health, adopting the social time preference rate for consumption as the discount rate for costs and health gains is valid only under strong and implausible assumptions about values and facts.

Martun-Fernandez, J et al Perception of the economic value of primary care services: A willingness to pay study. *Health Policy* 94(3), 266-272. 2010.

<http://dx.doi.org/10.1016/j.healthpol.2009.11.001>

<http://pmid.us/19945763>

Objective Identify the economic value the user attributes to the visit to the family physician, in a setting of a National Health System, by the Willingness to Pay (WTP) expressed. Methods Economic evaluation study, by the contingent valuation method. Questions were asked about WTP using a payment card format. Interviews were conducted with 451 subjects, in areas with different socioeconomic characteristics. An ordered probit was used to evaluate model's validity. Results Median WTP expressed was [euro]18 (interquartile range [euro]8-28), not including "zero-answers" of thirty-four subjects (7.5%). This value represents 2% of average adjusted family incomes. Patients with higher incomes or with chronic illnesses presented a probability of 5-14 percentage points of expressing a high WTP. For every point of increase of patient satisfaction, the probability of presenting a WTP in the lowest range decreases 7.0 percentage points. Subjects with a low education level and those older than 65 expressed a lower WTP. Accessibility, risk perception, nationality and having private insurance were not related to the WTP expressed. Conclusions Users of primary care have a clear perception of the economic value of care received from the family physician, even in a framework of providing services financed by taxes and without cost at the moment of use. This value increases in subjects with higher incomes, with greater need for care, or more satisfied

Rhys, G., Beerstecher, H., and Morgan, C. 2010. "Primary care capitation payments in the UK. An observational study". *BMC Health Services Research* 10: 156.

<http://dx.doi.org/10.1186/1472-6963-10-156>

<http://pmid.us/20529330>

Background: In 2004 an allocation formula for primary care services was introduced in England and Wales so practices would receive equitable pay. Modifications were made to this formula to enable local health authorities to pay practices. Similar pay formulae were introduced in Scotland and Northern Ireland, but these are unique to the country and therefore could not be included in this study. Objective: To examine the extent to which the Global Sum, and modifications to the original formula, determine practice funding. Methods: The allocation formula determines basic practice income, the Global Sum. We compared practice Global Sum entitlements using the original and the modified allocation formula calculations. Practices receive an income supplement if Global Sum payments were below historic income in 2004. We examined current overall funding levels to estimate what the effect will be when the income supplements are removed. Results: Virtually every Welsh and English practice (97%) received income supplements in 2004. Without the modifications to the formula only 72% of Welsh practices would have needed supplements. No appreciable change would have occurred in England. The formula modifications increased the Global Sum for 99.5% of English practices, while it reduced entitlement for every Welsh practice. In 2008 Welsh practices received approximately GBP 6.15 (9%) less funding per patient per year than an identical English practice. This deficit will increase to 11.2% when the Minimum Practice Income Guarantee is abolished. Conclusions: Identical practices in different UK countries do not receive equitable pay. The pay method disadvantages Wales where the population is older and has higher health needs

Stringhini, S; Sabia, S; Shipley, M (2010) Association of socioeconomic position with health behaviour and mortality. *JAMA* 2010; 303 (12): 1159-1166 (24/31 March 2010)

<http://dx.doi.org/10.1001/jama.2010.297>

<http://pmid.us/20332401>

Context: Previous studies may have underestimated the contribution of health behaviors to social inequalities in mortality because health behaviors were assessed only at the baseline of the study. Objective: To examine the role of health behaviors in the association between socioeconomic position and mortality and compare whether their contribution differs when assessed at only one point in time with that assessed longitudinally through the follow-up period. Design, setting, and Participants: Established in 1985, the British Whitehall II longitudinal cohort study includes 10,308 civil servants, aged 35 to 55 years, living in London, England. Analyses are based on 9590 men and women followed up for mortality until April 30, 2009. Socioeconomic position was derived from civil service employment grade (high, intermediate, and low) at baseline. Smoking, alcohol consumption, diet, and physical activity were assessed four times during the follow-up period. Main outcome MEASURES: All-cause and cause-specific mortality. Results: A total of 654 participants died during the follow-up period. In the analyses adjusted for sex and year of birth, those with the lowest socioeconomic position

had 1.60 times higher risk of death from all causes than those with the highest socioeconomic position (a rate difference of 1.94/1000 person-years). This association was attenuated by 42 per cent (95 per cent confidence interval [CI], 21 per cent - 94 per cent) when health behaviors assessed at baseline were entered into the model and by 72 per cent (95 per cent CI, 42 per cent - 154 per cent) when they were entered as time-dependent covariates. The corresponding attenuations were 29 per cent (95 per cent CI, 11 per cent - 54 per cent) and 45 per cent (95 per cent CI, 24 per cent - 79 per cent) for cardiovascular mortality and 61 per cent (95 per cent CI, 16 per cent - 425 per cent) and 94 per cent (95 per cent CI, 35 per cent - 595 per cent) for noncancer and noncardiovascular mortality. The difference between the baseline only and repeated assessments of health behaviors was mostly due to an increased explanatory power of diet (from seven per cent to 17 per cent for all-cause mortality, respectively), physical activity (from five per cent to 21 per cent for all-cause mortality), and alcohol consumption (from three per cent to twelve per cent for all-cause mortality). The role of smoking, the strongest mediator in these analyses, did not change when using baseline or repeat assessments (from 32 per cent to 35 per cent for all-cause mortality). Conclusion: In a civil service population in London, England, there was an association between socioeconomic position and mortality that was substantially accounted for by adjustment for health behaviors, particularly when the behaviors were assessed repeatedly.

Sutton, Matt 2010 Record rewards : the effects of targeted quality incentives on the recording of risk factors by primary care providers. *Health Economics* 2010; 19 (1): 1-13 (January 2010)

<http://dx.doi.org/10.1002/hec.1440>

Financial incentives may increase performance on targeted activities and have unintended consequences for untargeted activities. An innovative pay-for-performance scheme was introduced for UK general practices in 2004. It incentivised particular quality indicators for targeted groups of patients. We estimate the intended and unintended consequences of this Quality and Outcomes Framework (QOF) using dynamic panel probit models estimated on individual patient records from 315 general practices over the period 2000/1-2005/6. We focus on annual rates of recording of blood pressure, smoking status, cholesterol, body mass index and alcohol consumption. The recording of each risk factor is designated as incentivised or unincentivised for each individual based on whether they have one of the diseases targeted by the QOF. The effect on incentivised factors was substantially larger on the targeted patient groups (+19.9 percentage points) than on the untargeted groups (+5.3 percentage points). There was no obvious evidence of effort diversion but there was evidence of substantial positive spillovers (+10.9 percentage points) onto unincentivised factors for the targeted groups. Moreover, provider responses were larger on those indicators for which more stringent standards were set and greater rewards offered. We conclude that the incentives induced providers to improve targeted quality and make investments in quality that extended beyond the scheme. We estimate that the average provider was paid £20,500 for recording 410 additional items of information on the risk factors targeted by the financial incentives. Allowance for the

positive spillovers reduces the estimated average reward from £50 to £25 per additional record.

Videau Y et al 2010 Why patients of low socioeconomic status with mental health problems have shorter consultations with general practitioners *Journal of Health Services Research and Policy* 2010;15:76-81

<http://dx.doi.org/10.1258/jhsrp.2009.009034>

<http://pmid.us/20176660>

Objective: Poor people receive shorter consultations in general practice than more affluent people. Our aim was to study the two reasons generally advanced for this for patients consulting with mental health problems: people of low socioeconomic status (SES) demand shorter consultations or they tend to match with practitioners who devote little time to their patients. **Methods.** Of 600 general practitioners (GPs), 144 agreed to participate. During the study period (2005), 713 patients consulted with mental health problems of whom 405 (56.8%) completed questionnaires. Of these, 144 (34.8%) were defined as suffering from Major Depressive Disorder (MDD). Multilevel modelling was used to explore the relationship between patient and GP characteristics, and duration of the consultation. **Methods:** A multivariate model found two significant patient variables for the consultation duration: severity of MDD symptoms ($P = 0.01$) and SES (proxied by education level, $P = 0.05$). The multilevel model including GPs' characteristics demonstrated that the apparent correlation between patients' SES and consultation length was due to a confounding factor: low SES patients were visiting GPs who are, generally, providing shorter consultations ($P < 0.001$). With the SES variable no longer significant: $P = 0.2$, although severity of symptoms remained in the model ($P = 0.001$). **Conclusion.** The shortness of the consultation length is due to a supply-side effect, implicating dissatisfaction for patients with mental health problems. This may not be generalizable to other patients. Findings are in favour of a specific intervention aimed at giving poor people equal access to GPs' time.

HEALTH POLICY

Doran T, Roland M Lessons from major initiatives to improve primary care in the United Kingdom . *Health Affairs (Millwood)*, 2010 May;29(5):1023-9.

<http://dx.doi.org/10.1377/hlthaff.2010.0069>

<http://pmid.us/20439901>

Primary care in the United Kingdom faced a crisis in 2000. General practitioners (GPs) complained of low morale, long hours, and low pay. The quality of care delivered to patients, meanwhile, was highly variable. The U.K. government responded with a program of quality improvement initiatives, a substantial increase in funding, and an ambitious pay-for-performance scheme that introduced publicly reported quality-of-care targets. Following these reforms, GPs' income and morale increased, the number of working hours declined, and the quality of care improved. The reforms, however, presented a serious challenge to medical professionalism, and the long-term effects on patient outcomes remain uncertain.

Parker L et al 2010 Health information and advocacy for "Health in All Policies": a research agenda. *Journal of Epidemiology and Community Health*. 2010 Feb;64(2):114-6.

<http://dx.doi.org/10.1136/jech.2008.081976>

<http://pmid.us/20056965>

Placing health in the agendas of all policy makers remains a challenge. Finding new ways to boost Health in All Policies should be a continuous process. Currently, health information initiatives gather core health statistics, indicators related to healthcare, along with individual level risk factors such as smoking or obesity. However, there is a lack of identifiable information showing the effect of non-primary health policies on population health. A research agenda is proposed, focusing on three related areas that would frame health information in such a way that the implications for decision-makers from non-health sectors are clear: (a) research in order to provide solid and quantitative evidence linking the social and environmental determinants of health with their ultimate health outcomes; (b) research that shows and quantifies the effect of policies and specific interventions on these determinants; and (c) the development of policy-linked indicators which provide a quantitative estimate of the health that would be gained (or disease burden that could be avoided) by adoption of a specific policy.

INFORMATION AND COMMUNICATIONS TECHNOLOGY

Christensen, M C. Remler, D 2009 Information and communications technology in U.S. health care : why is adoption so slow and is slower better? *Journal of Health Economics, Policy and Law.* 2009; 34 (6): 1011-1034 (December 2009)

<http://dx.doi.org/10.1215/03616878-2009-034>

Politicians across the political spectrum support greater investment in health care information and communications technology (ICT) and expect it to significantly decrease costs and improve health outcomes. We address three policy questions about adoption of ICT in health care: First, why is there so little adoption? Second, what policies will facilitate and accelerate adoption? Third, what is the best pace for adoption? We first describe the unusual economics of ICT, particularly network externalities, and then determine how those economics interact with and are exacerbated by the unusual economics of health care. High replacement costs and the need for technical compatibility are general barriers to ICT adoption and often result in lock-in to adopted technologies. These effects are compounded in health care because the markets for health care services, health insurance, and labor are interlinked. In addition, the government interacts with all markets in its role as an insurer. Patient heterogeneity further exacerbates these effects. Finally, ICT markets are often characterized by natural monopolies, resulting in little product diversity, an effect ill-suited to patient heterogeneity. The ongoing process for setting technical standards for health care ICT is critical but needs to include all relevant stakeholders, including patient groups. The process must be careful (i.e., slow), flexible, and allow for as much diversity as possible. We find that waiting to adopt ICT is a surprisingly wise policy

.Crowe, S et al 2010 Information in general medical practices: the information processing model. *Family Practice* 27(2), 230-236. 1-4-2010.

<http://dx.doi.org/10.1093/fampra/cmp102>

<http://pmid.us/20022907>

Background. The need for effective communication and handling of secondary care information in general practices is paramount. Objective. To explore practice processes on receiving secondary care correspondence in a way that integrates the information needs and perceptions of practice staff both clinical and administrative. Methods. Qualitative study using semi-structured interviews with a wide range of practice staff (n = 36) in nine practices in the Northwest of England. Analysis was based on the framework approach using N-Vivo software and involved transcription, familiarization, coding, charting, mapping and interpretation. Results. The information processing model' was developed to describe the six stages involved in practice processing of secondary care

information. These included the amendment or updating of practice records whilst simultaneously or separately actioning secondary care recommendations, using either a one-step' or two-step' approach, respectively. Many factors were found to influence each stage and impact on the continuum of patient care. Conclusion. The primary purpose of processing secondary care information is to support patient care; this study raises the profile of information flow and usage within practices as an issue requiring further consideration

De Coster, C., et al 2010. Follow-through after calling a nurse telephone advice line: a population-based study. *Family Practice* 27: 271-278.

<http://dx.doi.org/10.1093/fampra/cmq003>

<http://pmid.us/20215333>

Background. Nurse telephone advice (NTA) lines, a major initiative in primary health care reform, provide symptom triage and health information. Compliance studies utilizing database analysis are frequently limited to a defined population, such as children or Emergency Department (ED) users. Objectives. To explore caller characteristics associated with following NTA advice to go to the ED, see a health care professional or self-care for Calgary, Canada (population 1 million). Methods. NTA data were linked with utilization data to assess ED and physician visits following a call. Four nurse advice categories were defined: go to ED, health care provider in 24 hours, health care provider in 72 hours if symptoms persist and self-care. Follow-through was defined based on health care utilization within specified time periods following the call. Logistic regression identified characteristics associated with follow-through of NTA nurse advice; characteristics included age, sex, neighbourhood income, health status, time of call and type of care protocol. Results. Follow-through was highest for self-care advice (83.7%), followed by ED advice (52.3%) and then 24-hour advice (43.2%). Lower follow-through on ED or 24-hour advice was associated with age <4 years, and having lower income, and the opposite was true for self-care advice. Patients with a cardiac complaint had the highest odds of following ED advice. Patients with a gastrointestinal or obstetrics/gynaecology/genitourinary complaint were less likely to follow 24-hour advice. Patients with fever were less likely to follow self-care advice. Conclusions. Understanding characteristics associated with lower follow-through may help the NTA service to refine its approaches to clients

Grayston J et al 2010 Using new technologies to deliver test results in primary care: structured interview study of patients' views *Primary Health Care Research & Development* (2010), 11:142-154

<http://dx.doi.org/10.1017/S146342360999034X>

Background An increasing number of blood tests are being performed in primary care. Informing patients of results takes up a considerable proportion of practice-staff time. The use of new technologies may be more time-efficient for staff but little is known about the acceptability to patients. Objective To determine patient attitudes towards the use of three technologies – short message service (SMS), webpage and e-mail – for the delivery of laboratory results. Design Structured interview. Methods Two hundred patients were interviewed in two general practices in Lothian, Scotland. Satisfaction with current methods and preferred methods of obtaining test-results were assessed. Patients were asked about their current access to different technologies and their favourability to using such technologies for receiving results and their views on appropriate content and information security. Results were analyzed by age, sex and educational attainment using χ^2 test. Results A total of 79.5% of patients had mobile phones, 53% used SMS, 46.5% had internet, and 37.5% used e-mail. E-mail, SMS and webpage was the favoured delivery system for 53.3%, 37.1% and 33.3%, respectively. Conclusion Patients were favourable towards e-mail but not SMS or a webpage. The main concern over the three technologies was information security. New technology may be useful for delivering results but patients will have to be persuaded that any such system is reliable and secure.

Greenhalgh T, Stones R 2010 Theorising big IT programmes in healthcare: Strong structuration theory meets actor-network theory *Social Science & Medicine* Volume 70, Issue 9, May 2010, Pages 1285-1294

<http://dx.doi.org/10.1016/j.socscimed.2009.12.034>

<http://pmid.us/20185218>

The UK National Health Service is grappling with various large and controversial IT programmes. We sought to develop a sharper theoretical perspective on the question “What happens – at macro-, meso- and micro-level – when government tries to modernise a health service with the help of big IT?” Using examples from data fragments at the micro-level of clinical work, we considered how structuration theory and actor-network theory (ANT) might be combined to inform empirical investigation. [Giddens \(1984\)](#) argued that social structures and human agency are recursively linked and co-evolve. ANT studies the relationships that link people and technologies in dynamic networks. It considers how discourses become inscribed in data structures and decision models of software, making certain network relations irreversible. [Stones' \(2005\)](#) strong structuration theory (SST) is a refinement of Giddens' work, systematically concerned with empirical research. It views human agents as linked in dynamic networks of position-practices. A quadripartite approach considers [a] external social structures (conditions for action); [b] internal social structures (agents' capabilities and what they ‘know’ about the social world); [c] active agency and actions and [d] outcomes as they feed back on the position-practice network. In contrast to early structuration theory and ANT, SST insists on disciplined conceptual methodology and linking this with empirical evidence. In this paper, we adapt SST for the study of technology programmes, integrating elements from material interactionism and ANT. We argue, for example, that

the position-practice network can be a socio-technical one in which technologies in conjunction with humans can be studied as 'actants'. Human agents, with their complex socio-cultural frames, are required to instantiate technology in social practices. Structurally relevant properties inscribed and embedded in technological artefacts constrain and enable human agency. The fortunes of healthcare IT programmes might be studied in terms of the interplay between these factors.

Henderson J et al 2010 Effect of computerisation on Australian general practice: does it improve the quality of care? *Quality in Primary Care* 2010;18(1):33-47

<http://pmid.us/20359411>

Background: There is an assumption expressed in literature that computer use for clinical activity will improve the quality of general practice care, but there is little evidence to support or refute this assumption. Aim: This study compares general practitioners (GPs) who use a computer to prescribe, order tests or keep patient records, with GPs who do not, using a set of validated quality indicators. MethodS: BEACH (Bettering the Evaluation and Care of Health) is a continuous national crosssectional survey of general practice activity in Australia. A sub-sample of 1257 BEACH participants between November 2003 and March 2005 were grouped according to their computer use for test ordering, prescribing and/or medical records. Linear and logistic regression analysis was used to compare the two groups on a set of 34 quality indicators. Results: Univariate analyses showed that computerised GPs managed more problems; provided fewer medications; ordered more pathology; performed more Pap smear tests; provided more immunisations; ordered more HbA1c tests and provided more referrals to ophthalmologists and allied health workers for diabetes patients; provided less lifestyle counselling, and had fewer consultations with Health Care Card (HCC) holders. After adjustment, differences attributable solely to computer use were prescribed medication rates, lifestyle counselling, HCC holders and referrals to ophthalmologists. Three other differences emerged - computerised GPs provided fewer referrals to allied health workers and detected fewer new cases of depression, and fewer of them prescribed anti-depressants. Twenty-three measures failed to discriminate before or after adjustment. Conclusion: Deciding on 'best quality' is subjective. While literature and guidelines provide clear parameters for many measures, others are difficult to judge. Overall, there was little difference between these two groups. This study has found little evidence to support the claim that computerisation of general practice in Australia has improved the quality of care provided to patients.

MEDICINES MANAGEMENT

McDonald R et al Professional status in a changing world: the case of medicines use reviews in English community pharmacy. *Social Science and Medicine* 2010 Available online 12 May 2010

<http://dx.doi.org/10.1016/j.socscimed.2010.04.021>

<http://pmid.us/20570427>

The health professions are engaged in an ongoing and dynamic process involving reflection and adaptation, with factors such as socio-economic and cultural developments and technological innovations compelling professions to respond to changed circumstances. This paper concerns English community pharmacy, where recent reforms provide financial incentives to deliver interventions, which have the potential for pharmacists to promote their knowledge and skills, as part of a professionalising strategy. The paper, drawing on interviews with 49 pharmacists, describes how responses to reforms are not necessarily in accordance with either national policy goals or enhancement of professional status. Debates about professional status and role extension have often focused on health professions' subordination to medicine. This paper highlights the importance and interplay of other factors which help explain the inability to capitalise fully on the potential contribution to professional status, which reforms to extend professional roles afford.

Mousques, J, Renaud, T, and Scemama, O 2010 . Is the "practice style" hypothesis relevant for general practitioners? An analysis of antibiotics prescription for acute rhinopharyngitis. *Social Science & Medicine* 70(8), 1176-1184. 2010.

<http://dx.doi.org/10.1016/j.socscimed.2009.12.016>

<http://pmid.us/20137844>

Much research in France or abroad has highlighted the medical practice variation (MPV) phenomenon. There is no consensus on the origin of MPV between preference-centered approaches versus opportunities and constraints approaches. This study's main purpose is to assess the relevance of hypotheses which assume that physicians adopt a uniform practice style for their patients for each similar clinical decision in a context of medical decision with low uncertainty and professional practice with weak regulation. Multilevel models are evaluated: first to measure variability of antibiotics prescription by French general practitioners (GPs) for acute rhinopharyngitis regarding clinical guidelines, and to test its significance in order to determine to what extent prescription differences are

due to between or within GPs discrepancies; second, to prioritize its determinants, especially those relating to a GP or his/her practice setting environment, while controlling visit or patient confounders. The study was based on 2001 activity data, along with an ad hoc questionnaire, of a sample of 778 GP taken from a panel of 1006 computerized French GPs. We observed that a large part of the total variation was due to intra-physician variability (70%). It is patient characteristics that largely explain the prescription, even if GP or practice setting characteristics (location, level of activity, network participation, continuing medical education) and environmental factors (visit from pharmaceutical sales representatives) also exert considerable influence. This suggests that MPV are partly caused by differences in the type of dissemination of medical information and this may help policy makers to identify and develop facilitators for promoting better use of antibiotics in France and, more generally, for influencing GP practices when it is of interest

Sweidan, Michelle, et al 2010 Identification of features of electronic prescribing systems to support quality and safety in primary care using a modified Delphi process. *BMC Medical Informatics and Decision Making* 10(1), 21. 2010.

<http://www.biomedcentral.com/1472-6947/10/21>

<http://pmid.us/20398294>

Background: Electronic prescribing is increasingly being used in primary care and in hospitals. Studies on the effects of e-prescribing systems have found evidence for both benefit and harm. The aim of this study was to identify features of e-prescribing software systems that support patient safety and quality of care and that are useful to the clinician and the patient, with a focus on improving the quality use of medicines. Methods: Software features were identified by a literature review, key informants and an expert group. A modified Delphi process was used with a 12-member multidisciplinary expert group to reach consensus on the expected impact of the features in four domains: patient safety, quality of care, usefulness to the clinician and usefulness to the patient. The setting was electronic prescribing in general practice in Australia. Results: A list of 114 software features was developed. Most of the features relate to the recording and use of patient data, the medication selection process, prescribing decision support, monitoring drug therapy and clinical reports. The expert group rated 78 of the features (68%) as likely to have a high positive impact in at least one domain, 36 features (32%) as medium impact, and none as low or negative impact. Twenty seven features were rated as high positive impact across 3 or 4 domains including patient safety and quality of care. Ten features were considered "aspirational" because of a lack of agreed standards and/or suitable knowledge bases. Conclusions :This study defines features of e-prescribing software systems that are expected to support safety and quality, especially in relation to prescribing and use of medicines in general practice. The features could be used to develop software standards, and could be adapted if necessary for use in other settings and countries

MENTAL HEALTH

Agnera, L et al **Medically unexplained pain complaints are associated with underlying unrecognized mood disorders in primary care.** *BMC Family Practice* 11(1), 17. 2010.

<http://www.biomedcentral.com/1471-2296/11/17>

<http://pmid.us/20199657>

Background: Patients with chronic pain frequently display comorbid depression, but the impact of this concurrence is often underestimated and mistreated. The aim of this study was to determine the prevalence of unrecognized major depression and other mood disorders and comorbid unexplained chronic pain in primary care settings and to explore the associated factors. Also, to compare the use of health services by patients with unexplained chronic pain, both with and without mood disorder comorbidity. Methods: A cross-sectional study was carried out in a sample of primary care centers. 3189 patients consulting for "unexplained chronic pain" were assessed by the Visual Analogue Scales (VAS) and the Primary Care Evaluation of Mental Disorders (PRIME-MD) questionnaire. Results: We report: a) a high prevalence of unrecognized mood disorders in patients suffering from unexplained chronic pain complaints (80.4%; CI 95%: 79.0%; 81.8%); b) a greater susceptibility of women to mood disorders (OR adjusted = 1.48; CI 95%: 1.22; 1.81); c) a direct relationship between the prevalence of mood disorders and the duration of pain (OR adjusted = 1.01; CI 95%: 1.01; 1.02) d) a higher comorbidity with depression if the pain etiology was unknown (OR adjusted = 1.74; CI 95%: 1.45; 2.10) and, e) an increased use of health care services in patients with such a comorbidity ($p < 0.0001$). Conclusions: The prevalence of undiagnosed mood disorders in patients with unexplained chronic pain in primary care is very high, leading to dissatisfaction with treatment processes and poorer outcomes. Consequently, it seems necessary to explore this condition more regularly in general practice in order to reach accurate diagnoses and to select the appropriate treatment

Baik, S. Y., et al 2010 **Reinvention of Depression Instruments by Primary Care Clinicians** *Annals of Family Medicine* 8: 224-230.

<http://dx.doi.org/10.1370/afm.1113>

<http://pmid.us/20458105>

Purpose Despite the sophisticated development of depression instruments during the past 4 decades, the critical topic of how primary care clinicians actually use those instruments in their day-to-day practice has not been investigated. We wanted to understand how primary care clinicians use depression instruments, for what purposes, and the conditions that influence their use. Methods Grounded theory method was used to guide data collection and analysis. We conducted 70 individual interviews and 3 focus groups (n = 24) with a purposeful sample of 70 primary care clinicians (family physicians, general internists, and nurse practitioners) from 52 offices. Investigators' field notes on office

practice environments complemented individual interviews. Results The clinicians described occasional use of depression instruments but reported they did not routinely use them to aid depression diagnosis or management; the clinicians reportedly used them primarily to enhance patients' acceptance of the diagnosis when they anticipated or encountered resistance to the diagnosis. Three conditions promoted or reduced use of these instruments for different purposes: the extent of competing demands for the clinician's time, the lack of objective evidence of depression, and the clinician's familiarity with the patient. No differences among the 3 clinician groups were found for these 3 conditions. Conclusions Depression instruments are reinvented by primary care clinicians in their real-world primary care practice. Although depression instruments were originally conceptualized for screening, diagnosing, or facilitating the management of depression, our study suggests that the real-world practice context influences their use to aid shared decision making--primarily to suggest, tell, or convince patients to accept the diagnosis of depression

Balestrieri, M et al 2010 Assessing mixed anxiety-depressive disorder. A national primary care survey. *Psychiatry Research* 176(2-3), 197-201. 30-4-2010.

<http://dx.doi.org/10.1016/j.psychres.2008.11.011>

Prevalence and risk factors associated with mixed anxiety-depressive disorder (MAD) have yet to be established. Using MINI 5.0.1 and HADS, a two-week survey involving 21,644 primary care patients was carried out. We found 1.8% of subjects with MAD and 20% of subjects with a co-morbid anxiety and depression (CAD) disorder. MAD patients without a past history of anxiety/affective episodes were defined as "pure MAD" (pMAD: 0.9% of the sample). While MAD patients showed a number of differences vs. the other groups of patients in the socio-demographic statistics, pMAD patients were not different, apart from a higher proportion of males vs. CAD patients. Nearly in all the comparisons, MAD and pMAD patients showed lower association with life events and with a familial predisposition than the other patients. On HADS assessment, MAD showed a higher risk of anxiety and depressive symptoms than anxiety diagnoses, a lower risk of depressive symptoms than depressive diagnoses and a lower risk of both anxiety and depressive symptoms than CAD. Since more than a half of MAD patients were classified as pMAD, the hypothesis that MAD should be viewed as a partial remission of a major depression is not entirely confirmed in our study

Bee, PE et al 2010 Improving health and productivity of depressed workers: a pilot randomized controlled trial of telephone cognitive behavioral therapy delivery in workplace settings. *General Hospital Psychiatry*. 2010 May-Jun;32(3):337-40. Epub 2010 Feb 1.

<http://dx.doi.org/10.1016/j.genhosppsych.2010.01.006>

<http://pmid.us/20430241>

Objective: To examine the feasibility of telephone-delivered cognitive behavioral therapy (T-CBT) in an occupational context, with reference to participant recruitment, treatment adherence, follow-up and effect. Method: Eligible participants comprised all employees of a large communications company with authorized work absence due to mild/moderate mental health difficulties over a 10-month period. Fifty-three consenting participants were centrally randomized to 12 weeks T-CBT or usual care, with minimization on age, gender and illness severity. Primary (symptom severity) and secondary outcomes (self-rated work performance and productivity) were measured at baseline and 3-months via postal questionnaires. Intention-to-treat analysis comprised multiple regression modeling with adjustment for missing response predictors, minimization variables and baseline values. Results: Twenty-three employees attended one or more T-CBT sessions. T-CBT was associated with medium-large effects sizes on clinical outcomes (0.63-0.77) and work productivity scores (0.75-0.88). Twenty-one patients failed to return 3-month primary outcome data. Non-respondents were more likely to be male and more severely ill. Conclusion: Delivery of T-CBT in an occupational context is feasible with evidence of potential effect. Larger-scale trials are warranted. These studies demand assertive outreach or telephone-based assessment strategies in order to maximize participant recruitment and follow-up.

Beecham J et al 2010 Cost and impact of a quality improvement programme in mental health services *Journal of Health Services Research and Policy*. 2010;15:69-75

<http://dx.doi.org/10.1258/jhsrp.2009.009005>

Objective: To estimate the cost and impact of a centrally-driven quality improvement initiative in four UK mental health communities. Methods: Total costs in year 1 were identified using documentation, a staff survey, semi-structured interviews and discussion groups. Few outcome data were collected within the programme so thematic analysis was used to identify the programme's impact within its five broad underlying principles. Results: The survey had a 40% response. Total costs ranged between £164,000 and £458,000 per site, plus staff time spent on workstreams. There was a very hazy view of the resources absorbed and poor recording of expenditure and activity. The initiative generated little demonstrable improvements in service quality but some participants reported changes in attitudes. Conclusions: Given the difficult contexts, short time-scales and capacity constraints, the programme's lack of impact is not surprising. It may, however, represent a worthwhile investment in cultural change which might facilitate improvements in how services are delivered.

Cape J, Whittington, C, and Bower, P. (2010) What is the role of consultation-liaison psychiatry in the management of depression in primary care? A systematic review and meta-analysis. *General Hospital Psychiatry* . Available online 11/03/2010

[doi:10.1016/j.genhosppsy.2010.02.003](https://doi.org/10.1016/j.genhosppsy.2010.02.003)

Objective To assess the effectiveness of consultation-liaison services, involving mental health professionals working to advise and support primary care professionals in the management of depression. **Methods** Studies of consultation-liaison for depression in primary care were identified from a systematic search of electronic databases, augmented by identification of papers from reference lists, published reviews and from hand searching. Data on study quality, intervention characteristics and outcomes were extracted by two reviewers, and outcome data were meta-analyzed. **Results** Five studies met the criteria. There was no significant effect of consultation-liaison on antidepressant use (risk ratio 1.23, 95% CI 0.91 to 1.66) or depression outcomes in the short-term (standardized mean difference -0.04, 95% CI -0.21 to 0.14) or long-term (standardized mean difference 0.06, 95% CI -0.13 to 0.26). **Conclusions** Evidence concerning consultation-liaison for depression in primary care remains limited, but the existing studies do not suggest it is more effective than usual care. Further research is required to explore the mechanisms by which consultation-liaison might be made more effective, including the potential role of consultation-liaison in combination with other models of care, and in other patient populations

Castelo, Milena Sampaio, et al Validity of the Brazilian version of the Geriatric Depression Scale (GDS) among primary care patients. *International Psychogeriatrics* 22(01), 109-113. 2010.

<http://dx.doi.org/10.1017/S1041610209991219>

<http://pmid.us/19883523>

Background: The aim of the present study was to determine the validity of the Brazilian version of the Geriatric Depression Scale (GDS) with 30 (GDS-30), 15 (GDS-15), 10 (GDS-10), 4 (GDS-4) and 1 (GDS-1) items and to calculate the optimum cutoff points for identifying depression among elderly primary care subjects. **Methods:** A cross-sectional study was carried out involving 220 elderly patients recruited from four primary care clinics in northeastern Brazil. The following measurements were obtained: sociodemographic variables, Katz scale of independence in activities of daily living, and the GDS with 30, 15, 10, 4 and 1 item(s). A psychiatrist blinded to the results of the GDS applied the mood module of the Structured Clinical Interview for the DSM-IV for the diagnosis of major depressive episodes as the **Results:** The use of the cut-off point of 10/11 for the GDS-30 produced sensitivity and specificity rates of 92.0% (95% CI: 7085), respectively. The positive predictive value (PPV) and the negative predictive value (NPV) were 49% and 98%, respectively. The optimum cut-off point for the GDS-15 was 4/5, at which sensitivity was 87% (95% CI: 7191), PPV was 51% and NPV was 97%. At the cut-off point of 3/4 the sensitivity, specificity, PPV and NPV for the GDS-10 were 76% (95% CI: 6087), 46% (95% CI: 3397%), respectively. The optimum cut-off point for the GDS-4 was 0/1, at which sensitivity was 84% (95% CI: 6891%); PPV was 41% and NPV was 96%. For the GDS-1, sensitivity was 47%, specificity was 96%; PPV was 69% and NPV was 90%. **Conclusions:** The GDS-30, GDS-15, GDS-10 and GDS-4

proved to be good screening instruments for depression in primary care clinics in Brazil, whereas the GDS-1 failed to perform adequately

Dickinson R et al 2010 Long-term prescribing of antidepressants in the older population: a qualitative study. *British Journal of General Practice* 2010 Apr;60(573):e144-55.

<http://dx.doi.org/10.3399/bjgp10X483913>

<http://pmid.us/20353660>

Background: High rates of long-term antidepressant prescribing have been identified in the older population. Aims: To explore the attitudes of older patients and their GPs to taking long-term antidepressant therapy, and their accounts of the influences on long-term antidepressant use. Design of study: Qualitative study using in-depth semi-structured interviews. Setting: One primary care trust in North Bradford. Method: Thirty-six patients aged > or =75 years and 10 GPs were interviewed. Patients were sampled to ensure diversity in age, sex, antidepressant type, and home circumstances. Results: Participants perceived significant benefits and expressed little apprehension about taking long-term antidepressants, despite being aware of the psychological and social factors involved in onset and persistence of depression. Barriers to discontinuation were identified following four themes: pessimism about the course and curability of depression; negative expectations and experiences of ageing; medicine discontinuation perceived by patients as a threat to stability; and passive (therapeutic momentum) and active (therapeutic maintenance) decisions to accept the continuing need for medication. Conclusion: There is concern at a public health level about high rates of long-term antidepressant prescribing, but no evidence was found of a drive for change either from the patients or the doctors interviewed. Any apprehension was more than balanced by attitudes and behaviours supporting continuation. These findings will need to be incorporated into the planning of interventions aimed at reducing long-term antidepressant prescribing in older people.

Hackley, B et al Managing Mental Health Conditions in Primary Care Settings. *Journal of Midwifery & Women's Health* 55(1), 9-19. 2001. 2010.

<http://dx.doi.org/10.1016/j.jmwh.2009.06.004>

<http://pmid.us/20129225>

Depression is one of the most commonly encountered conditions in women's health, but many providers lack the knowledge and skills needed to identify and manage depression in primary care settings. This article discusses strategies that can improve the identification and treatment of depression. In addition, it describes how these strategies were incorporated into an urban inner-city health center. These strategies used in this

setting can be adapted for use in either comprehensive health care centers or in practices providing primarily obstetric and gynecologic services

Hegerl U et al 2010 Effects of pharmacotherapy and psychotherapy in depressed primary –care patients: a randomized, controlled trial including a patients' choice arm *The International Journal of Neuropsychopharmacology* (2010), 13:31-44

<http://dx.doi.org/10.1017/S1461145709000224>

Mild depressive syndromes are highly prevalent among primary -carepatients. Evidence-based treatment recommendations need to be derived directly from this diagnostically heterogeneous group. The primary aim was to assess the efficacy of sertraline and cognitive-behavioural group therapy for treatment of depressed primary -carepatients, the secondary aim was to evaluate if receiving treatment according to free choice is associated with a better outcome than randomization to a particular treatment. We conducted a randomized, placebo-controlled, single-centre, 10-wk trial with five arms: sertraline (flexible dosages up to 200 mg/d) ($n=83$); placebo ($n=83$); manual-guided cognitive-behavioural group therapy (one individual session and nine group sessions per 90 min) ($n=61$); guided self-help group (control condition, $n=59$); and treatment with sertraline or cognitive-behavioural group therapy according to patients' choice ($n=82$). From 1099 consecutively screened adult patients, 368 formed the intent-to-treat population with milder forms of depression. Primary outcome was a global efficacy measure combining z-converted Hamilton Depression Rating Scale and clinician-rated Inventory for Depressive Symptomatology scores. Sertraline was superior to placebo ($p=0.03$). Outcome for guided self-help groups was worse compared to cognitive-behavioural group therapy ($p=0.002$) and compared to all other treatment arms including pill placebo (secondary analyses). Outcome in the patients' choice arm was similar to that in the sertraline and cognitive-behavioural group therapy. Overall, sertraline is efficacious in primary –care patients with milder forms of depression. The superiority of cognitive-behavioural group therapy over guided self-help groups might partly be explained by ‘nocebo’ effects of the latter

Iliffe, S et al Evidence-based interventions in dementia: A pragmatic cluster-randomised trial of an educational intervention to promote earlier recognition and response to dementia in primary care (EVIDEM-ED). *Trials* 11(1), 13. 2010.

<http://www.trialsjournal.com/content/11/1/13>

<http://pmid.us/20146803>

Background: The National Dementia Strategy seeks to enhance general practitioners' diagnostic and management skills in dementia. Early diagnosis in dementia within primary care is important as this allows those with dementia and their family care

networks to engage with support services and plan for the future. There is, however, evidence that dementia remains under-detected and sub-optimally managed in general practice. An earlier unblinded, cluster randomised controlled study tested the effectiveness of educational interventions in improving detection rates and management of dementia in primary care. In this original trial, a computer decision support system and practice-based educational workshops were effective in improving rates of detecting dementia although not in changing clinical management. The challenge therefore is to find methods of changing clinical management. Our aim in this new trial is to test a customised educational intervention developed for general practice, promoting both earlier diagnosis and concordance with management guidelines. Design/method: The customised educational intervention combines practice-based workshops and electronic support material. Its effectiveness will be tested in an unblinded cluster randomised controlled trial with a pre-post intervention design, with two arms; normal care versus the educational intervention. Twenty primary care practices have been recruited with the aim of gaining 200 patient participants. We will examine whether the intervention is effective, pragmatic and feasible within the primary care setting. Our primary outcome measure is an increase in the proportion of patients with dementia who receive at least two dementia-specific management reviews per year. We will also examine important secondary outcomes such as practice concordance with management guidelines and benefits to patients and carers in terms of quality of life and carer strain. Discussion: The EVIDEM-ED trial builds on the earlier study but the intervention is different in that it is specifically customised to the educational needs of each practice. If this trial is successful it could have implications for the implementation of the National Dementia Strategy.

McGarry, H et al 2010 Managing depression in a changing primary mental healthcare system : comparison of two snapshots of Australian GPs' treatment and referral patterns. *Mental Health in Family Medicine* 2010; 6 (2): 75-83

Background: Significant government spending has resulted in substantial changes to the Australian primary mental healthcare system. Initially producing the Better Outcomes in Mental Health Care (BOiMHC) initiative, this has been replaced by the Better Access to Mental Health Care programme, which allows all general practitioners (GPs) to refer patients for allied psychological health care under Medicare. Aim: To examine changes in patient management and referral for care following the BOiMHC initiative. Method: Comparison of results of a 2006 postal survey of Australian GPs examining self-reported management of patients with depression with a similar survey conducted in 2001-2002, prior to the BOiMHC initiative. Results: One hundred and thirty-three (33 per cent) GPs responded. The main self-reported strategies for managing patients with depression were similar to the previous study: supportive counselling and medication. No significant difference was found in rates of self-reported formal training in psychological treatments. Significantly higher rates of referral for psychological treatments were reported in 2006 than in 2002. Small trends towards higher reported referral for and reported use of psychological treatments by GPs registered for the BOiMHC initiative were noted when compared with those who were not registered. Conclusion: While GPs' main reported strategies for managing patients with depression were unchanged, reported referral for psychological therapies was significantly higher in 2006, possibly reflecting the impact of

changes to the primary mental healthcare system. Ongoing rigorous evaluation of further changes to the primary mental healthcare system are needed to determine whether they deliver effective, evidence-based care, and thus to inform future programmes

Mcgregor, Joanna, et al 2010 The Health Informatics Trial Enhancement Project (HITE): Using routinely collected primary care data to identify potential participants for a depression trial. *Trials* 11(1), 39. 2010.

<http://dx.doi.org/10.1186/1745-6215-11-39>

<http://www.trialsjournal.com/content/11/1/39>

<http://pmid.us/20398303>

Background: Recruitment to clinical trials can be challenging. We identified anonymous potential participants to an existing pragmatic randomised controlled depression trial to assess the feasibility of using routinely collected data to identify potential trial participants. We discuss the strengths and limitations of this approach, assess its potential value, report challenges and ethical issues encountered. Methods: Swansea University's Health Information Research Unit's Secure Anonymised Information Linkage (SAIL) database of routinely collected health records was interrogated, using Structured Query Language (SQL). Read codes were used to create an algorithm of inclusion/exclusion criteria with which to identify suitable anonymous participants. Two independent clinicians rated the eligibility of the potential participants' identified. Inter-rater reliability was assessed using the kappa statistic and inter-class correlation. Results: The study population (N=37263) comprised all adults registered at five general practices in Swansea UK. Using the algorithm 867 anonymous potential participants were identified. The sensitivity and specificity results > 0.9 suggested a high degree of accuracy from the algorithm. The inter-rater reliability results indicated strong agreement between the confirming raters. The Intra Class Correlation Coefficient (Cronbach's Alpha) > 0.9 , suggested excellent agreement and Kappa coefficient > 0.8 ; almost perfect agreement. Conclusions: This proof of concept study showed that routinely collected primary care data can be used to identify potential participants for a pragmatic randomised controlled trial of folate augmentation of antidepressant therapy for the treatment of depression. Further work will be needed to assess generalisability to other conditions and settings and the inclusion of this approach to support Electronic Enhanced Recruitment (EER)

Maidment, Ian D.; Parmentier, Henk; 2009 Medication error in mental health : implications for primary care. *Mental Health in Family Medicine* 2009; 6 (4): 203-207

Medication errors are associated with significant morbidity and people with mental health problems may be particularly susceptible to medication errors due to various factors. Primary care has a key role in improving medication safety in this vulnerable population.

The complexity of services, involving primary and secondary care and social services, and potential training issues may increase error rates, with physical medicines representing a particular risk. Service users may be cognitively impaired and fail to identify an error placing additional responsibilities on clinicians. The potential role of carers in error prevention and medication safety requires further elaboration. A potential lack of trust between service users and clinicians may impair honest communication about medication issues leading to errors. There is a need for detailed research within this field

Mead N et al 2010 Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. *British Journal of Psychiatry*. 2010 Feb;196(2):96-101.

<http://dx.doi.org/10.1192/bjp.bp.109.064089>

<http://pmid.us/20118451>

Background: High rates of emotional distress and depressive symptoms in the community can reflect difficult life events and social circumstances. There is a need for appropriate, low-cost, non-medical interventions for many individuals. Befriending is an emotional support intervention commonly offered by the voluntary sector. Aims: To examine the effectiveness of befriending in the treatment of emotional distress and depressive symptoms. Method: Systematic review of randomised trials of interventions focused on providing emotional support to individuals in the community. Results: Compared with usual care or no treatment, befriending had a modest but significant effect on depressive symptoms in the short term (standardised mean difference SMD = -0.27, 95% CI -0.48 to -0.06, nine studies) and long term (SMD = -0.18, 95% CI -0.32 to -0.05, five studies). ConclusionS: Befriending has a modest effect on depressive symptoms and emotional distress in varied patient groups. Further exploration of active ingredients, appropriate target populations and optimal methods of delivery is required.

Palmer V 2010 Diverse voices, simple desires: a conceptual design for primary care to respond to depression and related disorders. *Family Practice* 2010 Apr 8. [Epub ahead of print]

<http://dx.doi.org/10.1093/fampra/cmq016>

<http://pmid.us/20378630>

Background: The World Health Organization and the World Organization of Family Doctors have called for 'doable' and 'limited' tasks to integrate mental health into primary care. Little information is provided about tasks GPs can undertake outside of guidelines that suggest to prescribe medication and refer to specialists. Objectives: The reorder study aimed to gather diverse patient and community perspectives to inform the development of an effective system of depression care. Method: Five hundred and

seventy-six patients completed computer-assisted telephone interviews. Two hundred and seventy-six community stakeholders completed a modified two round Delphi. Responses were analysed to identify tasks and these were synthesised into a conceptual design. Results: Fifteen core tasks were identified, 5 were agreed upon and a further 10 identified by each group but not agreed upon. Listen, understand and empathize, provide thorough and competent diagnosis and management, follow-up and monitor patients, be accessible and do not rush appointments and provide holistic approach and tailor care to individual needs were agreed on. Other tasks included: develop plans with patients, assess for severity and suicide risk, account for social factors, be well trained in depression care and offer a range of treatment options, appropriate and timely referral, support and reassurance, educate patients about depression, prescribe appropriately and manage medication and be positive and encouraging. Conclusions: The tasks form the basis of a conceptual design for developing a primary care response to depression. They fit within three domains of care: the relational, competency and systems domains. This illustrates tasks for GPs beyond prescription and referral.

Poutanen O et al 2010 The validity of the Depression Scale (DEPS) to assess the severity of depression in primary care patients. *Family Practice*. 2010 Jun 16. [Epub ahead of print]

<http://dx.doi.org/10.1093/fampra/cmq040>

<http://pmid.us/20554653>

Background: There is a need for a simple depression questionnaire also capable of assessing the severity of depression. The Depression Scale (DEPS), has been a very popular self-rating depression questionnaire in Finland for >15 years. Objective: Our aim was to examine whether the DEPS has the ability to differentiate clearly defined levels of depression in primary care patients. Methods: Primary care patients aged 18-64 years completed a postal questionnaire including the DEPS. All screen-positive subjects and every 10th screen-negative subject were invited for interview using the Present State Examination (PSE) as the gold standard. Complete DEPS score was available for 410 patients. Descriptive statistics of the DEPS in the six diagnostic PSE classes were computed. Four of the PSE classes were selected for further analyses of depression severity. Receiver Operating Characteristic curves, sensitivity, specificity, ideal cut-off points and area under the curve were calculated. The ability of the DEPS to differentiate levels of functioning was also evaluated. RESULTS: The DEPS identified three groups of patients: those with no psychiatric symptoms, those with some depressive symptoms and those with clinical depression. The margins between the levels were thin: the ideal cut-off point for clinical depression was 11/12 and for any level of depression 9/10. The DEPS was also able to differentiate three levels of functioning. Conclusions: The DEPS has some ability to identify severity of depression in primary care patients. Further research with larger unscreened material is called for.

Reddy P et al Identification of depression in diabetes: the efficacy of PHQ-9 and HADS-D *British Journal of General Practice*, Volume 60, Number 575, June 2010 , pp. e239-e245(7)

<http://dx.doi.org/10.3399/bjgp10X502128>

<http://pmid.us/20529487>

Background Clinical guidelines advise screening for depression in patients with diabetes. The Patient Health Questionnaire (PHQ-9) and the depression subscale of the Hospital Anxiety and Depression Scale (HADS-D) are commonly used in primary care. Aim To compare the efficacy of HADS-D and PHQ-9 in identifying moderate to severe depression among primary care patients with type 2 diabetes. Design of study Self-report postal survey, clinical records assessed by GPs. Setting Seven metropolitan and rural general practices in Victoria, Australia. Method Postal questionnaires were sent to all patients with diabetes on the registers of seven practices in Victoria. A total of 561 completed postal questionnaires were returned, giving a response rate 47%. Surveys included demographic information, and history of diabetes and depression. Participants completed both the PHQ-9 and HADS-D. Clinical data from patient records included glycosylated hemoglobin (HbA1c) levels and medications. Results The proportion of the total sample completing HADS-D was 96.8% compared with 82.4% for PHQ-9. Level of education was unrelated to responses on the HADS-D but was related to completion of the PHQ-9. Using complete data ($n = 456$) from both measures, 40 responders showed HADS-D scores in the moderate to severe range, compared with 103 cases identified by PHQ-9. Only 35 cases were classified in the moderate to severe category by both the PHQ-9 and HADS-D. Items with the highest proportions of positive responses on the PHQ-9 were related to tiredness and sleeping problems and, on the HADS-D, feeling slowed down. Conclusion It may be that the items contributing to the higher prevalence of moderate to severe depression using the PHQ-9 are due to diabetes-related symptoms or sleep disorders.

Romera I et al 2010 Generalized anxiety disorder, with or without co-morbid major depressive disorder, in primary care: Prevalence of painful somatic symptoms, functioning and health status. *Journal of Affective Disorders* 2010 Jun 11. [Epub ahead of print]

<http://dx.doi.org/10.1016/j.jad.2010.05.009>

<http://pmid.us/2054181>

Background: Painful physical symptoms (PPS) have received little attention in patients with generalized anxiety disorder (GAD). The objective of the present study was to assess the prevalence of PPS in patients with GAD vs patients with GAD and co-morbid major depressive disorder (MDD) and a control group (patients neither with GAD nor

MDD). Methods: This is a cross-sectional, multi-center, epidemiological study, in primary care. Patients were screened for GAD (HADS-A), followed by a diagnosis confirmation (MINI). Patients were considered to have PPS when VAS overall pain score >30. Functioning and health status was assessed (SDS, EUROQoL-5D). Relationships between the presence of PPS and functioning and health status was analyzed (ANCOVA models). Results were adjusted for confounding factors. Results: Of 7152 patients, 1546 (22%) screened positive for GAD, 981 (14%) had confirmed GAD diagnosis, of whom 559 (8%) had GAD with co-morbid MDD and 422 (6%) had GAD alone. Of the 5292 (74%) patients screened negative for GAD, 336 (5%) were confirmed as controls. PPS in patients with GAD were twice as prevalent as in the control group: 59.0% vs. 28.3%; $p < 0.001$. The presence of co-morbid MDD was associated with a significantly higher prevalence of PPS: 78.0% vs. 59.0%; $p < 0.001$. PPS were significantly associated with functioning and health status impairment ($p < 0.001$) both in GAD alone and in GAD and co-morbid MDD compared with controls. LIMITATIONS: Results do not prove causal relationships. Conclusions: Our results support the clinical relevance of PPS in patients suffering from GAD; therefore they need to be considered when evaluating the patient.

Toner R et al 2010 Do general practitioners adhere to NICE guidelines for depression? Systematic Questionnaire Survey *Primary Health Care Research & Development* (2010), 11:123-131 doi:

<http://dx.doi.org/10.1017/S1463423609990363>

Background Guidelines may improve clinical outcomes for depression, but whether they are followed in primary care is uncertain. Aim To assess general practitioners (GPs') adherence to the National Institute for Health and Clinical Excellence (NICE) guidelines for managing depression in adults (2004). Design of study Anonymized Questionnaire Survey. Setting Thirty-eight partnerships within one primary care trust in England. Method Focused questionnaire incorporating measurable criteria, posted to GPs in May 2007. Results The response rate was 67% (143/215 GPs). GPs followed NICE guidelines when screening for depression in patients with physical illness, using selective serotonin reuptake inhibitor antidepressants appropriately and referring to counselling and secondary care. However, 48% GPs did not screen patients with a history of depression, 44% discontinued medication too soon and 38% avoided prescribing for 'understandable' moderate depression. GPs identified poor access to cognitive behaviour therapy (CBT) as the greatest barrier to implementing guidelines. Only 41% personally used CBT. Adherence to NICE guidelines was significantly higher for GPs trained in psychiatry and in younger GPs, but was not associated with gender, practice size, possessing the Membership of the Royal College of General Practitioners or reading guidelines. Less than half (38%) of the GPs rated NICE as having a moderate or substantial impact upon their clinical management. The Quality and Outcomes Framework (QOF) had more influence than NICE guidelines upon detection and recording of care, especially in larger practices. Conclusion Training more cognitive

behaviour therapists, making psychiatry experience mandatory for future GPs and focusing QOF incentives upon treatment outcomes as well as screening may improve adherence to NICE depression guidelines.

QUALITY

den Boer-Wolters, Dianne, et al 2010 Frequent attendance of primary care out-of-hours services in The Netherlands: characteristics of patients and presented morbidity. *Family Practice* 27(2), 129-134. 1-4-2010.

<http://dx.doi.org/10.1093/fampra/cmp103>

<http://pmid.us/20032165>

Background. Over the last years, a system of regional general practices was developed in The Netherlands, responsible for the primary care out-of-hours services (OHS). As in daytime, frequent attendance of the OHS increases workload and the health care; detailed description of the background of frequent attendance is required to develop interventions aiming at reduction. Objectives. To assess the characteristics of the frequent attenders (FAs) and the presented morbidity during their consultations and to study the persistence of frequent attendance. Methods. We performed a retrospective descriptive 1-year database investigation of all patient contacts (n = 44 953) made in 2007 with the OHS de Gelderse Vallei'. We analysed characteristics of normal attender, FA and very frequent attender (VFA) and compared the reason for encounter, GP diagnoses, psychiatric co-morbidities and management during their 2007 consultations. Results. VFAs, constituting 1% of the attenders and 7.7% of the total number of contacts, more often reported agitation as reason for encounter. The prevalence of psychiatric diagnosis in the VFA group (15.3%) was significantly higher than in other groups. Reassurance was the most frequent prevalent management action in each group. The prevalence of chronic diseases and psychological problems was higher in the VFA groups. Conclusions. Frequent attendance puts severe pressure on OHS resources. Much of the frequent attendance can be explained by the increased incidence of chronic diseases and psychiatric co-morbidity

Delgado A et al 2010 The role of expectations in preferences of patients for a female or male general practitioner. *Patient Education and Counseling* . 2010 Apr 3. [Epub ahead of print]

<http://dx.doi.org/10.1016/j.pec.2010.02.028>

<http://pmid.us/20371157>

Objective: To determine, for five health problems, whether preference for a male or female general practitioner (GP) is related to patient gender, GP gender and/or patient expectations of GP behaviour. Methods: Cross-sectional study in 14 health centres in Spain, administering a questionnaire to 360 patients. Outcome variables were: preference for male GP, female GP or no preference in consultations for five hypothetical health problems. Results: Mean age was 47.3+/-16.5 years, 51% were female. Preference was more frequently expressed by females. Odds ratios (ORs) for a woman preferring a female to male GP ranged from 3 to 508, according to the hypothetical problem, and ORs for a patient with female GP preferring a female GP ranged from 2.8 to 9.1. Patient gender and GP gender had no interactive effect on preferences. Expectations of GP behaviour were related to preferences, except for chest pain. Higher expectations of communication or technical care were associated with greater preference for female or male GP, respectively. Conclusions: Patient gender and current GP gender are related to preferences in five hypothetical clinical situations and expectations of GP behaviour to preferences in four of them. Practice implications: Educational strategies are needed to adjust clinical encounters to patients' preferences.

Doran T, Roland M 2010 Lessons from major initiatives to improve primary care in the United kingdom. *Health Affairs (Millwood)*. 2010 May;29(5):1023-9.

<http://dx.doi.org/10.1377/hlthaff.2010.0069>

<http://pmid.us/20439901>

Primary care in the United Kingdom faced a crisis in 2000. General practitioners (GPs) complained of low morale, long hours, and low pay. The quality of care delivered to patients, meanwhile, was highly variable. The U.K. government responded with a program of quality improvement initiatives, a substantial increase in funding, and an ambitious pay-for-performance scheme that introduced publicly reported quality-of-care targets. Following these reforms, GPs' income and morale increased, the number of working hours declined, and the quality of care improved. The reforms, however, presented a serious challenge to medical professionalism, and the long-term effects on patient outcomes remain uncertain.

Frostholm, L et al 2010 Which is more important for outcome: the physician's or the patient's understanding of a health problem? A 2-year follow-up study in primary care. *General Hospital Psychiatry* 32(1), 1-8. 2010.

<http://dx.doi.org/10.1016/j.genhosppsych.2009.08.004>

<http://pmid.us/20114122>

Objective We sought to examine (1) whether the patients' and the family physicians' (FPs') beliefs about the nature of a health problem predict health outcomes and (2) whether the FPs were aware of their patients' beliefs. **Methods** A 2-year follow-up study of 38 FPs and 1131 patients presenting with well-defined physical disease (n=922) or medically unexplained symptoms (MUS) (n=209) according to the FPs was conducted. Before the consultation, patients categorized their health problem as being either physical or both physical and psychological. After the consultation, the FPs judged their patients' understanding of the health problem. Outcome measures were (1) patient satisfaction (seven-item Patient Satisfaction Consultation Questionnaire), (2) self-perceived mental and physical health (component summaries of the Medical Outcome Study's Short Form: SF-36) and (3) health care use extracted from patient registers. **Main results** Patients with MUS according to the FPs and patients who believed that the nature of their health problem was both physical and psychological had higher health care use and worse self-rated health than patients in cases where both the FP and the patient had a physical understanding. Patients presenting MUS were more dissatisfied with the consultation than patients with well-defined physical disease. Overall, the FPs' perceptions of their patients' understanding were accurate in 82% of the consultations, but when the patients had a both physical and psychological understanding of their health problem, the FPs were right in only 26% of the consultations. **Conclusions** Both FPs' diagnoses and patients' beliefs predict important health outcomes such as patient satisfaction, use of health care and self-rated health

Gandjour, Afschin; 2010 Investment in quality improvement : how to maximize the return. *Health Economics* 2010; 19 (1): 31-42 (January 2010)

<http://dx.doi.org/10.1002/hec.1449>

<http://pmid.us/19212939>

Today, one of the most pressing concerns of health-care policymakers in industrialized countries are deficits in the quality of health care. This paper presents a decision program that addresses the question in which disease areas and at what intensity to invest in quality improvement (QI) in order to maximize population health. The decision program considers both a budget constraint as well as time constraints of educators and health professionals to participate in educational activities. The calculations of the model are based on a single assumption which is that more intense quality efforts lead to larger QIs, but with diminishing returns. This assumption has been validated by previous studies. All other relationships described by the model are deduced from this assumption. The model uses data from QI trials published in the literature. Thus, it is able to assess how the vast number of published QI strategies compare in terms of their value.

Helitzer, D et al 2010 A randomized controlled trial of communication training with primary care providers to improve patient-centeredness and health risk communication. *Patient Education and Counseling* In Press, Corrected Proof.

<http://dx.doi.org/10.1016/j.pec.2010.01.021>

<http://pmid.us/20219315>

Objective To determine the efficacy and effectiveness of training to improve primary care providers' patient-centered communication skills and proficiency in discussing their patients' health risks. **Methods** Twenty-eight primary care providers participated in a baseline simulated patient interaction and were subsequently randomized into intervention and control groups. Intervention providers participated in training focused on patient-centered communication about behavioral risk factors. Immediate efficacy of training was evaluated by comparing the two groups. Over the next 3 years, all providers participated in two more sets of interactions with patients. Longer term effectiveness was assessed using the interaction data collected at 6 and 18 months post-training. **Results** The intervention providers significantly improved in patient-centered communication and communication proficiencies immediately post-training and at both follow-up time points. **Conclusions** This study suggests that the brief training produced significant and large differences in the intervention group providers which persisted 2 years after the training. **Practice implications** The results of this study suggest that primary care providers can be trained to achieve and maintain gains in patient-centered communication, communication skills and discussion of adverse childhood events as root causes of chronic disease

Lester H et al 2010 The impact of removing financial incentives from clinical quality indicators: longitudinal analysis of four Kaiser Permanente indicators. *British Medical Journal* 2010 May 11;340:c1898.

<http://dx.doi.org/10.1136/bmj.c1898>.

<http://pmid.us/2046033>

Objective: To evaluate the effect of financial incentives on four clinical quality indicators common to pay for performance plans in the United Kingdom and at Kaiser Permanente in California. **Design:** Longitudinal analysis. **Setting:** 35 medical facilities of Kaiser Permanente Northern California, 1997-2007. **Participants:** 2 523 659 adult members of Kaiser Permanente Northern California. **Main outcomes measures** Yearly assessment of patient level glycaemic control (HbA(1c) <8%), screening for diabetic retinopathy, control of hypertension (systolic blood pressure <140 mm Hg), and screening for cervical cancer. **Results:** Incentives for two indicators-screening for diabetic retinopathy and for cervical cancer-were removed during the study period. During the five consecutive years when financial incentives were attached to screening for diabetic retinopathy (1999-2003), the rate rose from 84.9% to 88.1%. This was followed by four years without incentives when the rate fell year on year to 80.5%. During the two initial years when financial incentives were attached to cervical cancer screening (1999-2000), the screening rate rose slightly, from 77.4% to 78.0%. During the next five years when financial incentives were removed, screening rates fell year on year to 74.3%. Incentives

were then reattached for two years (2006-7) and screening rates began to increase. Across the 35 facilities, the removal of incentives was associated with a decrease in performance of about 3% per year on average for screening for diabetic retinopathy and about 1.6% per year for cervical cancer screening. Conclusion: Policy makers and clinicians should be aware that removing facility directed financial incentives from clinical indicators may mean that performance levels decline.

Masotti M et al 2010 Adverse events experienced by homecare patients: a scoping review of the literature *International Journal for Quality in Health Care* 22: 115-125

<http://dx.doi.org/10.1093/intqhc/mzq003>.

<http://pmid.us/20147333>

Purpose. The paper summarizes the results of a scoping review that focused on the occurrence of adverse events experienced by homecare patients. Data sources. The literature search covered published and grey literature between 1998 and 2007. Databases searched included: MEDLINE, EMBASE, CINAHL and EBM REVIEWS including the Cochrane Library, AGELINE, the National Patient Safety Foundation Bibliography, Agency for Healthcare Research and Quality and the Patient Safety Net bibliography. Study selection. Papers included research studies, review articles, policy papers, opinion articles and legal briefs. Inclusion criteria were: (i) homecare directed services provided in the home by healthcare professionals or caregivers; (ii) addressed a characteristic relevant to patient experienced adverse events (e.g. occurrences, rates, definitions, prevention or outcomes); and (iii) were in English. Data extraction. A pool of 1007 articles was reduced to 168 after analysis. Data were charted according to six categories: definitions, rates, causes, consequences, interventions and policy. Results. Eight categories emerged: adverse drug events, line-related, technology-related, infections and urinary catheters, wounds, falls, studies reporting multiple rates and other. Reported overall rates of adverse events ranged from 3.5 to 15.1% with higher rates for specific types. Few intervention studies were found. Adverse events were commonly associated with communication problems. Policy suggestions included the need to improve assessments, monitoring, education, coordination and communication. Conclusion. A standardized definition of adverse events in the homecare setting is needed. Prospective cohort studies are needed to improve estimates and intervention studies should be undertaken to reduce the risk that homecare patients will experience adverse events.

Rahmqvist M, Bara AC 2010 Patient characteristics and quality dimensions related to patient satisfaction *International Journal for Quality in Health Care* 22; 86-92

<http://dx.doi.org/10.1093/intqhc/mzq009>.

<http://pmid.us/20133477>

Objective. To examine the relation of respondents' characteristics, and perceived quality dimensions of health care to overall patient satisfaction in out-patient hospital care. Design. A questionnaire concerning the perceived quality of health care sent to patients in out-patient medical care. **Setting.** All medical centres in Östergötland County, Sweden, during a period in 2007. Participants. Seven thousand two hundred and forty-five patients aged 20 or older responded to the survey and provided their own ratings of the care. Main outcome measure. Global patient satisfaction as the overall rating of the encounter at the medical centre. The relation between respondent characteristics, quality dimensions and global satisfaction was examined using linear regression. Results. Younger patients in emergency care were the least satisfied group (54%) and older patients with excellent health status were the most satisfied group (90%). Patients with perceived better health status and those with less education were more satisfied than those with more education or poorer health status. The two dimensions most strongly positively associated with global satisfaction were receiving the expected medical help and being treated well by the doctor. To wait at the reception without getting information correlated negatively to patient satisfaction, and participation in the medical decision-making correlated positively. Conclusions. By using a complete patient population, including all types of medical specialities, we have identified a set of common respondent characteristics and quality dimensions that are related to global satisfaction in out-patient hospital care.

Reeves D et al 2010 How to identify when a performance indicator has run its course *British Medical Journal* 2010;340:c1717

<http://dx.doi.org/10.1136/bmj.c1717>

<http://pmid.us/20371570>

Increasing numbers of countries are using indicators to evaluate the quality of clinical care, with some linking payment to achievement.¹ For performance frameworks to remain effective the indicators need to be regularly reviewed. The frameworks cannot cover all clinical areas, and achievement on chosen indicators will eventually reach a ceiling beyond which further improvement is not feasible.^{2 3} However, there has been little work on how to select indicators for replacement. The Department of Health decided in 2008 that it would regularly replace indicators in the national primary care pay for performance scheme, the Quality and Outcomes Framework,⁴ making a rigorous approach to removal a priority. We draw on our previous work on pay for performance^{5 6}

and our current work advising the National Institute for Health and Clinical Excellence (NICE) on the Quality and Outcomes Framework to suggest what should be considered when planning to remove indicators from a clinical performance .

Sequist TD 2010 Reliability of Medical Group and Physician Performance Measurement in the Primary Care Setting. *Medical Care*. 2010 Apr 23. [Epub ahead of print]

<http://dx.doi.org/10.1097/MLR.0b013e3181d5690f>

<http://pmid.us/20421826>

Background:: Performance reporting is increasingly focused on physician practice sites and individual physicians. Objective:: To assess the reliability of performance measurement for practice sites and individual physicians. RESEARCH DESIGN:: We used data collected across multiple payers as part of a statewide measurement collaborative to evaluate the observed measure reliability and sample size requirements to achieve acceptable reliability of 4 Health Care Effectiveness Data and Information Set measures of preventive care and 10 Health Care Effectiveness Data and Information Set measures of chronic care across 334 practice sites. We conducted a parallel set of physician-level analyses using data across 118 primary physicians practicing within a large multispecialty group. Measures:: Observed reliabilities and estimated sample size requirements to achieve reliability ≥ 0.70 . Results:: At the practice site level, sample sizes required to achieve a reliability of 0.70 were less than 200 patients per site for all 4 measures of preventive care, all 4 process measures of diabetes care, and 2 outcomes measures of diabetes care. Larger samples were required to achieve reliability for cholesterol screening in the presence of cardiovascular disease ($n = 249$) and use of appropriate asthma medications ($n = 351$). At the physician level, less than 200 patients were required for all 4 measures of preventive care, but for many chronic care measures the samples of patients available per physician were not sufficient to achieve a reliability of 0.70. CONCLUSION:: In a multipayer collaborative, sample sizes were adequate to reliably assess clinical process and outcome measures at the practice site level. For individual physicians, sample sizes proved adequate to reliably measure preventive care, but may not be feasible for chronic care assessment.

Starfield B 2010 Reinventing primary care: lessons from Canada for the United States. *Health Affairs* (Millwood). 2010 May;29(5):1030-6.

<http://dx.doi.org/10.1377/hlthaff.2010.0002>

<http://pmid.us/2043990>

Canada is, in many respects, culturally and economically similar to the United States, and until relatively recently, the two countries had similar health systems. However, since passage of the Canada Health Act in the 1970s, that nation's health statistics have become increasingly superior. Although the costs of Canada's health system are high by international standards, they are much lower than U.S. costs. This paper describes several factors likely to be responsible for Canada's better health at lower cost: universal financial coverage through a so-called single payer; features conducive to a strong primary care infrastructure; and provincial autonomy under general principles set by national law.

Vrijhoef, H et al 2009 Quality of integrated chronic care measured by patient survey : identification, selection and application of most appropriate instruments. *Health Expectations* 2009; 12 (4): 417-429 (December 2009)

<http://dx.doi.org/10.1111/j.1369-7625.2009.00557.x>

<http://pmid.us/19709315>

Objective: To identify the most appropriate generic instrument to measure experience and/or satisfaction of people receiving integrated chronic care. Background: Health care is becoming more user-centred and, as a result, the experience of users of care and evaluation of their experience and/or satisfaction is taken more seriously. It is unclear to what extent existing instruments are appropriate in measuring the experience and/or satisfaction of people using integrated chronic care. Methods: Instruments were identified by means of a systematic literature review. Appropriateness of instruments was analysed on seven criteria. The two most promising instruments were translated into Dutch, if necessary, and administered to a convenience sample of 109 people with a chronic illness. Data derived from respondents were analysed statistically. Focus-group interviews were conducted to assess the semantic and technical equivalence as well as opinions of people about the applicability and relevance of the translated instruments. Results: From 37 instruments identified, the Patients' Assessment of Care for chronic Conditions (PACIC) and the short form of the Patient Satisfaction Questionnaire III (PSQ-18) were selected as most promising instruments. Both instruments produced similar median scores across people with different chronic conditions. The overall PACIC and its subscales and the overall PSQ-18 were highly internally consistent, but not the PSQ-18 subscales. Overall, the PACIC demonstrated better psychometric

characteristics. PACIC and PSQ-18 scores were found to be moderately correlated. Whereas more respondents preferred the PSQ-18, focus-group participants regarded the PACIC to be more applicable and relevant. The technical and semantic equivalence of both instruments were sufficient. Conclusions: Because of its psychometric characteristics, perceived applicability and relevance, the PACIC is the most appropriate instrument to measure the experience of people receiving integrated chronic care

Walker S et al 2010 Value for money and the Quality and Outcomes Framework in primary care in the UK NHS. *British Journal of General Practice* 2010 May;60(574):213-20

<http://dx.doi.org/10.3399/bjgp10X501859>

<http://pmid.us/20423576>

Background: The Quality and Outcomes Framework (QOF) is a pioneering attempt to improve the quality of primary care in the UK through the use of financial rewards. Despite its achievements, there are concerns that the QOF may offer poor value for money. Aim: To assess the cost-effectiveness of QOF payments. DESIGN OF STUDY: Economic analysis. Setting: England, UK. Method: Cost-effectiveness evidence was identified for a subset of nine QOF indicators with a direct therapeutic impact. These data were then applied to an analytic framework to determine the conditions under which QOF payments would be cost-effective. This framework was constructed to assess the cost-effectiveness of QOF payments by modelling the incentive structure using cost-effectiveness thresholds of 20 000 and 30 000 UK pounds per quality-adjusted life year (QALY) gained, to represent good value to the NHS. It used 2004/2005 data on the QOF performance of all English primary care practices. Results: Average indicator payments ranged from 0.63 to 40.61 UK pounds per patient, and the percentage of eligible patients treated ranged from 63% to 90%. The proportional changes required for QOF payments to be cost-effective varied widely between the indicators. Although most indicators required only a fraction of a 1% change to be cost-effective, for some indicators improvements in performance of around 20% were needed. Conclusion: For most indicators that can be assessed, QOF incentive payments are likely to be a cost-effective use of resources for a high proportion of primary care practices, even if the QOF achieves only modest improvements in care. However, only a small subset of the indicators has been considered, and no account has been taken of the costs of administering the QOF scheme.

Wynne-Jones, G., et al 2010. "Sickness certification and the GP: what really happens in practice?". *Family Practice* 27: 344-350.

<http://dix.doi.org/10.3109/02813431003696189>

<http://pmid.us/20334576>

Background. GPs typically sanction absence from work by issuing sickness certificates. There has been some debate recently about changing the way sickness certificates are issued and by whom. However, without understanding GPs' certification practices, their requirements in terms of training and education and how they feel the certification process should or should not be changed, measures aimed at improving the system are unlikely to succeed. **Objective.** To investigate and describe British GPs' sickness certification practices. **Methods.** A cross-sectional nationwide postal survey of 2154 UK GPs was conducted. GPs were asked about perceived certification practices, training in sickness certification, their opinions about the certification process and potential to improve the system. **Results.** Adjusted response was 42% (n = 878). GPs do ask about a patient's work situation but lack training in sickness certification. GPs would like to maintain their role in sickness certification but felt there was scope for other health professionals to issue some sickness certificates. GPs report more frequent sickness certification for mental health and musculoskeletal conditions compared to any other condition. **Conclusions.** This study has highlighted the main issues that GPs face during a consultation where sickness certification is a possible outcome. Lack of training in certification was a recurrent theme. However, GPs felt there was scope to improve training and recommendations were made as to how this might be achieved. The survey has highlighted that GPs feel there are opportunities to improve the system and that other health professionals may play a role in the certification process

RESEARCH AND DEVELOPMENT

Adler, Rhodes, Vasiliadis, Athanasia, and Bickell, Nina. The relationship between continuity and patient satisfaction: a systematic review. *Family Practice* 27(2), 171-178.

<http://dx.doi.org/10.1093/fampra/cmp099>

<http://pmid.us/20053674>

Background. Continuity between doctors and patients likely affects patient satisfaction. **Objective.** To assess the current evidence on the relationship between continuity and patient satisfaction. **Methods.** Systematic review of studies of adults in general, family, or internal medicine practices with ongoing, direct, face-to-face contact with their physician. Measures of the relationship between continuity and patient satisfaction were examined. **Results.** A MEDLINE search covering 1984-2007 and a Cumulative Index to Nursing

and Allied Health Literature search covering 1981-2007 identified 263 relevant studies and 12 studies met inclusion criteria. There were 12 different continuity measures and 9 different satisfaction measures. Conclusions. Continuity has a variable effect on patient satisfaction

Castle N et al 2010 Assessment of the speed and ease of insertion of three supraglottic airway devices by paramedics: a manikin study. *Emergency Medicine Journal* 2010 Jun 1. [Epub ahead of print]

<http://dx.doi.org/10.1136/emj.2009.084343>

<http://pmid.us/20515910>

Background Control of the airway is a priority during cardiopulmonary resuscitation and/or following a failed intubation attempt. Supraglottic airway devices provide more effective airway management than bag-valve-mask-ventilation (BVMV) and can be effectively used by non-anaesthetists. Methods 36 paramedic students were timed to ascertain how long it took them to place an Igel, laryngeal mask airway (LMA) or laryngeal tube airway (LTA) into a manikin. Following insertion, students were interviewed to see which device they preferred and why. Results The Igel was consistently the fastest airway device, taking a mean of 12.3 s (95% CI 11.5 to 13.1) to insert, the LTA took a mean time of 22.4 s (95% CI 20.3 to 24.5) and the LMA 33.8 s (95% CI 30.9 to 36.7). 63% of students would choose the Igel as their preferred intermediate airway device, stating ease of use and speed of insertion as the primary reasons. Conclusion The ease and speed at which a supraglottic airway can be inserted means that it is a viable alternative to the use of the BVMV.

Davies, Stephen; 2010 Setting the research agenda for health services management practice : who decides? *Evidence & Policy* 2010; 6 (1): 103-113 (January 2010)

<http://dx.doi.org/10.1332/174426410X483033>

The value of research to society depends not only on its intrinsic quality but also on topic selection. Because it is difficult to assess objectively the value of topic selection, research funders develop transparent processes for research needs assessment and prioritisation. In this paper, these processes are analysed for one publicly funded research commissioner in England, paying attention to the positioning of the programme within national institutions and with discussion of some historical antecedents. The dynamics between interest groups with a stake in the programme are identified. Different strategies for balancing stakeholder interests are described and their relative merits discussed. The conclusion is that no one strategy can be effective in isolation and a mixed approach is needed.

Elwyn O et al 2010 Identifying and prioritizing uncertainties: patient and clinician engagement in the identification of research questions. *Journal of Evaluation in Clinical Practice* , 2010 May 5. [Epub ahead of print]

<http://dx.doi.org/10.1111/j.1365-2753.2009.01262.x>

<http://pmid.us/2048274>

Background To arrive at an agreed, prioritized ranking of treatment uncertainties in asthma that need further research, by developing a collaboration of patients, carers and clinicians, facilitated by the James Lind Alliance Working Partnership between Asthma UK and the British Thoracic Society. **Methods** A four-step procedure: (1) establish a collaborative Working Partnership; (2) identify and collect treatment uncertainties by using a patient survey and analysing existing systematic reviews, clinical guidelines and query-answering services; (3) categorize uncertainties; and (4) convene a workshop using a nominal group process to establish a ranked prioritization of treatment uncertainties in asthma. **Findings** Agreement and rankings were reached for 10 treatment uncertainties. The highest was given to the uncertainty surrounding the adverse effects of inhaled and oral steroids. The top three priorities dealt with clinical management issues, where uncertainties still exist, namely concerns about the side effects of inhaled and oral steroids, how to manage asthma when other illnesses exist or how to rely on personal decisions in an ever-changing illness (self-management). **Interpretation** The key outcome is the generation of a prioritized list of treatment uncertainties in asthma, agreed by a collaboration of patients and health professionals, to inform the commissioning of new research. Such a large number of patient-identified treatment uncertainties had not previously been identified in the literature, an indication perhaps that asthma self-management is a neglected research area. Whether the results have an influence of research funding decisions is not yet known.

Grant MJ Booth A A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Info Libr J.* 2009 Jun;26(2):91-108.

<http://dx.doi.org/10.1111/j.1471-1842.2009.00848.x>

<http://pmid.us/19490148>

Background and objectives: The expansion of evidence-based practice across sectors has lead to an increasing variety of review types. However, the diversity of terminology used means that the full potential of these review types may be lost amongst a confusion of indistinct and misapplied terms. The objective of this study is to provide descriptive insight into the most common types of reviews, with illustrative examples from health and health information domains. **Methods:** Following scoping searches, an examination was made of the vocabulary associated with the literature of review and synthesis (literary warrant). A simple analytical framework -- Search, Appraisal, Synthesis and Analysis (SALSA) -- was used to examine the main review types. **Results:** Fourteen review types and associated methodologies were analysed against the SALSA

framework, illustrating the inputs and processes of each review type. A description of the key characteristics is given, together with perceived strengths and weaknesses. A limited number of review types are currently utilized within the health information domain. Conclusions: Few review types possess prescribed and explicit methodologies and many fall short of being mutually exclusive. Notwithstanding such limitations, this typology provides a valuable reference point for those commissioning, conducting, supporting or interpreting reviews, both within health information and the wider health care domain.

Graffy J, et al 2010 . Trials within trials? Researcher, funder and ethical perspectives on the practicality and acceptability of nesting trials of recruitment methods in existing primary care trials. *BMC Medical Research Methodology* 2010;10:38.

<http://pmid.us/20433728>

<http://www.biomedcentral.com/1471-2288/10/38>

Background: Trials frequently encounter difficulties in recruitment, but evidence on effective recruitment methods in primary care is sparse. A robust test of recruitment methods involves comparing alternative methods using a randomized trial, 'nested' in an ongoing 'host' trial. There are potential scientific, logistical and ethical obstacles to such studies. Methods: Telephone interviews were undertaken with four groups of stakeholders (funders, principal investigators, trial managers and ethics committee chairs) to explore their views on the practicality and acceptability of undertaking nested trials of recruitment methods. These semi-structured interviews were transcribed and analysed thematically. Results: Twenty people were interviewed. Respondents were familiar with recruitment difficulties in primary care and recognised the case for 'nested' studies to build an evidence base on effective recruitment strategies. However, enthusiasm for this global aim was tempered by the challenges of implementation. Challenges for host studies included increasing complexity and management burden; compatibility between the host and nested study; and the impact of the nested study on trial design and relationships with collaborators. For nested recruitment studies, there were concerns that host study investigators might have strong preferences, limiting the nested study investigators' control over their research, and also concerns about sample size which might limit statistical power. Nested studies needed to be compatible with the main trial and should be planned from the outset. Good communication and adequate resources were seen as important. Conclusions: Although research on recruitment was welcomed in principle, the issue of which study had control of key decisions emerged as critical. To address this concern, it appeared important to align the interests of both host and nested studies and to reduce the burden of hosting a recruitment trial. These findings should prove useful in devising a programme of research involving nested studies of recruitment interventions

Howe, A et al 2010 Public involvement in health research: a case study of one NHS project over 5 years *Primary Health Care Research & Development* (2010), 11:17-28

<http://dx.doi.org/10.1017/S1463423609990405>

background Public involvement, both in the National Health Service (NHS) and in clinical research, is promoted as an important democratic principle. The declared aims are to reduce professional autocracy and allow a broader ownership of the research agenda; also to improve the design of, and recruitment and retention of patients to, clinical studies. There have been a number of national initiatives in the UK to improve public input to clinical research activities, but very few reports of effective and sustainable partnerships over time. This study reports the evaluation of one example, which is embedded in the NHS and university partnerships in the Norfolk area of England. Objectives Evaluate:

- Putting principles into practice of public involvement in research over a 5 year period for one specific project (Patient and Public Involvement in Research).
- How the model contributes to, and impacts upon, all stages of the research process.
- Attitudes of the research community and lay volunteers to their mutual experiences of public involvement.
- Key factors and strengths of this project, and areas for improvement.

Methods A mixed methods approach related to the 5 years from start of 2003 to end of 2007. This used descriptive statistics of volunteer activity, interviews with key stakeholders (13), questionnaires (53% response rate), and focus group with 10 volunteers to explore emergent themes. We analysed findings using a policy framework approach. Results About 47 of the original 55 volunteers remained on the panel after 5 years. All have undertaken training, 38% have been involved in the full range of research activities offered, and 75% have attended at least one research project meeting. Some are active in governance, ethics, and advisory committees. Both the research community and the volunteers are very positive about the project. The researchers find it provides well prepared personnel, and gives a speedy and efficient way of fulfilling the expectations of funders for lay input. The volunteers find it gives them important opportunities to influence the quality of research and thus support improvements in patient care. Areas for improvement include increasing social diversity among the volunteers, and improving feedback on input from volunteers, without which volunteers tend to lose confidence and motivation. Conclusion Long-term sustainable and valuable public input to research is possible. Key factors are committing resources, embedding the service in the infrastructure of a research consortium, and ongoing responsiveness by NHS staff and researchers. Additional activity to recruit and support access may be needed to attract people from a broad range of sociodemographic backgrounds. Some volunteers want more involvement than this model currently of

Kelly, M. 2010. "The role of theory in qualitative health research" *Family Practice* 27: 285-290.

<http://dx.doi.org/10.1093/fampra/cmp077>

<http://pmid.us/19875746>

The role of theory in qualitative research is often underplayed but it is relevant to the quality of such research in three main ways. Theory influences research design, including decisions about what to research and the development of research questions. Theory underpins methodology and has implications for how data are analyzed and interpreted. Finally, theory about a particular health issue may be developed, contributing to what is already known about the topic that is the focus of the study. This paper will critically consider the role of theory in qualitative primary care research in relation to these three areas. Different approaches to qualitative research will be drawn upon in order to illustrate the ways in which theory might variably inform qualitative research, namely generic qualitative research, grounded theory and discourse analysis. The aim is to describe and discuss key issues and provide practical guidance so that researchers are more aware of the role theory has to play and the importance of being explicit about how theory affects design, analysis and the quality of qualitative research

Kirkham J et al 2010 The impact of outcome reporting bias in randomised controlled trials on a cohort of systematic reviews *British Medical Journal* 15/02/1010 2010;340:c365

<http://dx.doi.org/10.1136/bmj.c365>

<http://pmid.us/20156912>

Objective To examine the prevalence of outcome reporting bias—the selection for publication of a subset of the original recorded outcome variables on the basis of the results—and its impact on Cochrane reviews. **Design** A nine point classification system for missing outcome data in randomised trials was developed and applied to the trials assessed in a large, unselected cohort of Cochrane systematic reviews. Researchers who conducted the trials were contacted and the reason sought for the non-reporting of data. A sensitivity analysis was undertaken to assess the impact of outcome reporting bias on reviews that included a single meta-analysis of the review primary outcome. **Results** More than half (157/283 (55%)) the reviews did not include full data for the review primary outcome of interest from all eligible trials. The median amount of review outcome data missing for any reason was 10%, whereas 50% or more of the potential data were missing in 70 (25%) reviews. It was clear from the publications for 155 (6%) of the 2486 assessable trials that the researchers had measured and analysed the review primary outcome but did not report or only partially reported the results. For reports that did not mention the review primary outcome, our classification regarding the presence of outcome reporting bias was shown to have a sensitivity of 88% (95% CI 65% to 100%)

and specificity of 80% (95% CI 69% to 90%) on the basis of responses from 62 trialists. A third of Cochrane reviews (96/283 (34%)) contained at least one trial with high suspicion of outcome reporting bias for the review primary outcome. In a sensitivity analysis undertaken for 81 reviews with a single meta-analysis of the primary outcome of interest, the treatment effect estimate was reduced by 20% or more in 19 (23%). Of the 42 meta-analyses with a statistically significant result only, eight (19%) became non-significant after adjustment for outcome reporting bias and 11 (26%) would have overestimated the treatment effect by 20% or more. Conclusions Outcome reporting bias is an under-recognised problem that affects the conclusions in a substantial proportion of Cochrane reviews. Individuals conducting systematic reviews need to address explicitly the issue of missing outcome data for their review to be considered a reliable source of evidence. Extra care is required during data extraction, reviewers should identify when a trial reports that an outcome was measured but no results were reported or events observed, and contact with trialists should be encouraged.

Kringos, Dionne, et al 2010. The breadth of primary care: a systematic literature review of its core dimensions. *BMC Health Services Research* 10(1), 65. 2010.

<http://www.biomedcentral.com/1472-6963/10/65>

<http://pmid.us/20226084>

<http://dx.doi.org/10.1186/1472-6963-10-65>

Background: Even though there is general agreement that primary care is the linchpin of effective health care delivery, to date no efforts have been made to systematically review the scientific evidence supporting this supposition. The aim of this study was to examine the breadth of primary care by identifying its core dimensions and to assess the evidence for their interrelations and their relevance to outcomes at (primary) health system level. Methods: A systematic review of the primary care literature was carried out, restricted to English language journals reporting original research or systematic reviews. Studies published between 2003 and July 2008 were searched in MEDLINE, Embase, Cochrane Library, CINAHL, King's Fund Database, IDEAS Database, and EconLit. Results: Eighty-five studies were identified. This review was able to provide insight in the complexity of primary care as a multidimensional system, by identifying ten core dimensions that constitute a primary care system. The structure of a primary care system consists of three dimensions: 1. governance; 2. economic conditions; and 3. workforce development. The primary care process is determined by four dimensions: 4. access; 5. continuity of care; 6. coordination of care; and 7. comprehensiveness of care. The outcome of a primary care system includes three dimensions: 8. quality of care; 9. efficiency care; and 10. equity in health. There is a considerable evidence base showing that primary care contributes through its dimensions to overall health system performance and health. Conclusions: A primary care system can be defined and approached as a multidimensional system contributing to overall health system performance and health

McAneney H et al 2010 Translating evidence into practice: A shared priority in public health? *Social Science and Medicine* Volume 70, Issue 10, May 2010, Pages 1492-1500

<http://dx.doi.org/10.1016/j.socscimed.2010.01.038>

<http://pmid.us/20207462>

Translational and transdisciplinary research is needed to tackle complex public health problems. This article has three aims. Firstly, to determine how academics and non-academics (practitioners, policy makers and community workers) identified with the goals of the UKCRC Centre of Excellence for Public Health in Northern Ireland and how their attitudes varied in terms of knowledge brokerage and translation. Secondly, to map and analyse the network structure of the public health sector and the placement of the Centre within this. Thirdly, to aggregate responses from members of the network by work setting to construct the trans-sectoral network and devise the Root Mean Sum of Squares to determine the quality and potential value of connections across this network. The analysis was based on data collected from 98 individuals who attended the launch of the Centre in June 2008. Analysis of participant expectations and personal goals suggests that the academic members of the network were more likely to expect the work of the Centre to produce new knowledge than non-academics, but less likely to expect the Centre to generate health interventions and influence health policy. Academics were also less strongly oriented than non-academics to knowledge transfer as a personal goal, though more confident that research findings would be diffused beyond the immediate network. A central core of five nodes is crucial to the overall configuration of the regional public health network in Northern Ireland, with the Centre being well placed to exert influence within this. Though the overall network structure is fairly robust, the connections between some component parts of the network – such as academics and the third sector – are unidirectional. Identifying these differences and core network structure is key to translational and transdisciplinary research. Though exemplified in a regional study, these techniques are generalisable and applicable to many networks of interest: public health, interdisciplinary research or organisational involvement and stakeholder linkage.

Monteserin, R., et al 2010. Effectiveness of a geriatric intervention in primary care: a randomized clinical trial. *Family Practice* 27: 239-245.

<http://dx.doi.org/10.1093/fampra/cmp101>

<http://pmid.us/20053673>

Objective. To assess the effectiveness of an intervention after comprehensive geriatric assessment (CGA) in reducing morbidity and mortality in patients over 74 years in primary care. Methods. Randomized controlled trial with 18 months of follow-up. Patients in the control group (CG) followed usual care. Patients in the intervention group (IG) were classified as at risk or non-risk of frailty based on the CGA. Patients at non-risk of frailty in the IG were provided with recommendations about healthy habits and

adherence to treatment in group sessions, while patients at risk of frailty were visited individually by a geriatrician. Results. Six hundred and twenty patients were randomized to the IG (49.7%) or to the CG (50.3%), 83.2% completed follow-up. Cox's proportional hazards model showed as covariates the study group (hazard ratio [HR] 0.58; 95% confidence interval [CI] 0.28-1.22), risk of frailty (HR 1.33; 95% CI 0.71-2.51) and the interaction between both (HR 3.08; 95% CI 1.22-7.78). Forty-nine percent of the patients in the IG and 43% in the CG were at risk of frailty at baseline. At the end of the study, 27.9% of the IG and 13.5% of the CG had reversed their initial at risk of frailty status (P = 0.027). Multivariate predictors of reversible risk of frailty were younger age, not being at risk of depression, low consumption of medications and the intervention itself. Conclusions. A specific intervention in patients over 74 years attended in primary care reduces morbidity and mortality in patients at risk of frailty and increases the proportion of patients that reversed their initial status at risk of frailty

Rodríguez, Charo and Pozzebon, Marlei. The implementation evaluation of primary care groups of practice: a focus on organizational identity. *BMC Family Practice* 11(1), 15. 2010.

<http://www.biomedcentral.com/1471-2296/11/15>

<http://pmid.us/20175911>

Background: Since 2002 the Health Ministry of Québec (Canada) has been implementing a primary care organizational innovation called 'family medicine groups'. This is occurring in a political context in which the reorganization of primary care is considered necessary to improve health care system performance. More specifically, the purpose of this reform has been to overcome systemic deficiencies in terms of accessibility and continuity of care. This paper examines the first years of implementation of the family medicine group program, with a focus on the emergence of the organizational identity of one of the pilot groups located in the urban area of Montreal. Methods: An in-depth longitudinal case study was conducted over two and a half years. Face to face individual interviews with key informants from the family medicine group under study were conducted over the research period considered. Data was gathered through observations and documentary analysis. The data was analyzed using temporal bracketing and Fairclough's three-dimensional critical discourse analytical techniques. Results: Three different phases were identified over the period under study. During the first phase, which corresponded to the official start-up of the family medicine group program, new resources and staff were only available at the end of the period, and no changes occurred in medical practices. Power struggles between physicians and nurses characterized the second phase, resulting in a very difficult integration of advanced nurse practitioners into the group. Indeed, the last phase was portrayed by initial collaborative practices associated with a sensegiving process prompted by a new family medicine group director. Conclusions: The creation of a primary care team is a very challenging

process that goes beyond the normative policy definitions of who is on the team or what the team has to do. To fulfil expectations of quality improvement through team-based care, health care professionals who are required to work together need shared time/space contexts to communicate; to overcome interprofessional and interpersonal conflicts; and to make sense of and define who they collectively are and what they do as a clinical team

Schwartz, S and Meyer, I H. 2010 Mental health disparities research: The impact of within and between group analyses on tests of social stress hypotheses. *Social Science & Medicine* 70(8), 1111-1118. 2010.

<http://dx.doi.org/10.1016/j.socscimed.2009.11.032>

<http://pmid.us/20100631>

Social stress models are the predominant theoretical frame for studies of the relationship between social statuses and mental health ([Dressler et al., 2005] and [Horwitz, 1999]). These models propose that prejudice, discrimination and related social ills exert an added burden on socially disadvantaged populations (populations subjected to stigma, prejudice and discrimination) that can generate mental health problems. Researchers have used a variety of methodological approaches to study this hypothesis. In this paper we argue that researchers have not paid sufficient attention to the implications of this methodological variability, particularly the distinction between studies of within-group and studies of between-groups variation, in interpreting empirical tests of social stress theory. To fully evaluate the evidence, we need to carefully consider the convergence and divergence of results across diverse methodologies

Williams, B et al 2010 Developing a longitudinal database of routinely recorded primary care consultations linked to service use and outcome data. *Social Science & Medicine* 70(3), 473-478. 2010.

<http://dx.doi.org/10.1016/j.socscimed.2009.10.025>

<http://pmid.us/19896255>

The primary care consultation provides access to the majority of health care services and is central to obtaining diagnoses, treatment and ongoing management of long-term conditions. This paper reports the findings of an interdisciplinary feasibility study to explore the benefits and practical, technical and ethical challenges (and solutions) of creating a longitudinal database of recorded GP consultations in Tayside, Scotland which could be linked to existing routine data on intermediate and long-term health outcomes. After consultation we attempted to recruit and audio-record the consultations of all patients attending three general practices over a two week period. Background patient data, and patient and staff experiences of participation were also collected. Eventually, two practices participated with 77% of patients approached agreeing to participate. The

findings suggest that the perceived integrity of the consultation was preserved. The overwhelming majority of patients believed that recording was worthwhile and did not feel it impacted on communication or the treatment they received; 93% indicated they would be willing to have subsequent consultations recorded and 81% would recommend participation to a friend. Staff had similar beliefs but raised concerns about potential increases in workload, confidentiality issues and ease of software use. We conclude that practice participation could be increased by providing safeguards on data use, financial reward, integrated recording software, and procedures to lessen the impact on workload. The resulting Scottish Clinical Interactions Project (SCIP) would provide the largest and most detailed longitudinal insight into real world medical consultations in the world, permitting the linking of consultation events and practices to subsequent outcomes and behaviours

SELF MANAGEMENT

Blakeman T et al 2010 Bringing self-management into clinical view: a qualitative study of long-term condition management in primary care consultations. *Chronic Illness* 2010 May 5. [Epub ahead of print]

<http://dx.doi.org/10.1177/1742395309358333>

<http://pmid.us/20444765>

Objectives: To understand social processes underpinning support for self-management of long-term conditions in primary care. Methods: Comparative analysis of observational and interview data concerning the management of long-term conditions in UK primary-care consultations. Analysis of recordings of primary care consultations (n = 86) was conducted in conjunction with analysis of semi-structured interviews with health professionals (n = 17) and patients (n = 12) living with a long-term condition. Results: A key finding was the infrequency with which self-management topics became legitimate objects for discussion in consultations. Analysis suggested that the maintenance of self-other relations was a prime objective for both patients and professionals, and the introduction of self-management topics threatened this process. Technology and the division of labour among primary-care professionals reinforced this tension. Discussion: In order for self-management support to become embedded and integrated into primary care, interventions concerning long-term condition management need to take into account this tension underpinning care.

Dunn K et al 2010 Recall of medication use, self-care activities and pain intensity: a comparison of daily diaries and self-report questionnaires among low back pain patients *Primary Health Care Research & Development* (2010), 11:93-102

<http://dx.doi.org/10.1017/S1463423609990296>

Aim We aimed to compare recalled information on medication use, self-care activities and pain intensity among primary care low back pain consulters with diary records of the same events. **Background** Concerns are often expressed regarding the validity of recalled information about past experience of health events such as pain or its treatment. Comparing with information collected using daily diaries is one method of validating recalled findings. **Methods** Patients completed diaries recording their medication use, self-care activities and pain intensity each day for two weeks. Immediately following this period, patients completed questionnaires asking for recall of their medication use, self-care activities and least, worst, usual and current pain for the previous two weeks. The recalled information obtained from the questionnaires was compared with data from the daily diaries using intraclass correlation coefficients (ICC) and κ , with one-sided 95% confidence intervals. **Findings** All 29 participants returned 11 or more diaries. Validity of questionnaire-based recall for medication use and self-care activities was good, with everyone who reported use in the diaries also reporting this on the questionnaires (both $\kappa = 1.0$). However, some specific medications (eg, diclofenac) were over-reported in the questionnaires, and some self-care activities (eg, exercises) were under-reported. Combinations of pain intensity ratings were more accurate than single ratings; the mean of the recalled least, usual and current pain intensities was closest to the diary ratings (ICC 0.94, mean difference 0.13). The generalisability of these findings to other settings, recall periods and patient groups remains to be established.

Wearden AJ et al 2010 Nurse led, home based self help treatment for patients in primary care with chronic fatigue syndrome: randomised controlled trial. *British Medical Journal* . 2010 Apr 23;340:c1777.

<http://dx.doi.org/10.1136/bmj.c1777>.

<http://pmid.us/20418251>

Objective: To evaluate the effectiveness of home delivered pragmatic rehabilitation-a programme of gradually increasing activity designed collaboratively by the patient and the therapist-and supportive listening-an approach based on non-directive counselling-for patients in primary care with chronic fatigue syndrome/myalgic encephalomyelitis or encephalitis (CFS/ME). **DesigN:** Single blind, randomised, controlled trial. **SETTING:**

186 general practices across the north west of England between February 2005 and May 2007. Participants: 296 patients aged 18 or over with CFS/ME (median illness duration seven years) diagnosed using the Oxford criteria. Interventions: Participants were randomly allocated to pragmatic rehabilitation, supportive listening, or general practitioner treatment as usual. Both therapies were delivered at home in 10 sessions over 18 weeks by one of three adult specialty general nurses who had received four months' training, including supervised practice, in each of the interventions. GP treatment as usual was unconstrained except that patients were not to be referred for systematic psychological therapies during the treatment period. Main outcome measures The primary clinical outcomes were fatigue and physical functioning at the end of treatment (20 weeks) and 70 weeks from recruitment compared with GP treatment as usual. Lower fatigue scores and higher physical functioning scores denote better outcomes. Results: A total of 257 (87%) of the 296 patients who entered the trial were assessed at 70 weeks, the primary outcome point. Analysis was on an intention to treat basis, with robust treatment effects estimated after adjustment for missing data using probability weights. Immediately after treatment (at 20 weeks), patients allocated to pragmatic rehabilitation (n=95) had significantly improved fatigue (effect estimate -1.18, 95% confidence interval -2.18 to -0.18; P=0.021) but not physical functioning (-0.18, 95% CI -5.88 to +5.52; P=0.950) compared with patients allocated to treatment as usual (n=100). At one year after finishing treatment (70 weeks), there were no statistically significant differences in fatigue or physical functioning between patients allocated to pragmatic rehabilitation and those on treatment as usual (-1.00, 95% CI -2.10 to +0.11; P=0.076 and +2.57, 95% CI 3.90 to +9.03; P=0.435). At 20 weeks, patients allocated to supportive listening (n=101) had poorer physical functioning than those allocated to treatment as usual (-7.54, 95% CI -12.76 to -2.33; P=0.005) and no difference in fatigue. At 70 weeks, patients allocated to supportive listening did not differ significantly from those allocated to treatment as usual on either primary outcome. Conclusions: For patients with CFS/ME in primary care, pragmatic rehabilitation delivered by trained nurse therapists improves fatigue in the short term compared with unconstrained GP treatment as usual, but the effect is small and not statistically significant at one year follow-up. Supportive listening delivered by trained nurse therapists is not an effective treatment for CFS/ME.

SERVICE ORGANISATION AND DELIVERY

Kruk, M et al 2010. The contribution of primary care to health and health systems in low- and middle-income countries: A critical review of major primary care initiatives. *Social Science & Medicine* 70(6), 904-911. 2010.

<http://dx.doi.org/10.1016/j.socscimed.2009.11.025>

<http://pmid.us/20089341>

It has been 30 years since the Declaration of Alma Ata. During that time, primary care has been the central strategy for expanding health services in many low- and middle-income countries. The recent global calls to redouble support for primary care highlighted it as a pathway to reaching the health Millennium Development Goals. In this systematic review we described and assessed the contributions of major primary care initiatives implemented in low- and middle-income countries in the past 30 years to a broad range of health system goals. The scope of the programs reviewed was substantial, with several interventions implemented on a national scale. We found that the majority of primary care programs had multiple components from health service delivery to financing reform to building community demand for health care. Although given this integration and the variable quality of the available research it was difficult to attribute effects to the primary care component alone, we found that primary care-focused health initiatives in low- and middle-income countries have improved access to health care, including among the poor, at reasonably low cost. There is also evidence that primary care programs have reduced child mortality and, in some cases, wealth-based disparities in mortality. Lastly, primary care has proven to be an effective platform for health system strengthening in several countries. Future research should focus on understanding how to optimize the delivery of primary care to improve health and achieve other health system objectives (e.g., responsiveness, efficiency) and to what extent models of care can be exported to different settings

Sambrook, Sally; 2010 Critical pedagogy in a health service management development programme : can 'critically thinking' managers change the NHS management culture? *Journal of Health Organization and Management* 2009; 23 (6): 656-671

<http://pmid.us/20020598>

Purpose – Management development programmes available to NHS managers focus on a performance orientation and sustain a culture of managerial and medical domination. This paper aims to question whether it is possible to consider NHS management development from a critical (empowerment culture) perspective. Features of the critical management studies approach (CMS) are identified. A new MSc is evaluated against these characteristics, examining the teaching and learning processes and students' perceptions of the programme. The aim is to develop critical thinkers who can return to their organizations and challenge existing power structures and practices to change local cultures and enhance health services. Design/methodology/approach: Empirical research employed anonymous student questionnaires and a focus group. Findings: Student evaluations suggest the MSc can deliver a critical pedagogy and help managers understand issues of power and empowerment, challenge dominant cultures, innovate and effect small, local changes in the NHS culture. Research Limitations/implications: There is a need to continue evaluating the programme and include other stakeholders. Longitudinal research should assess the impact of the managers' changed values, attitudes and behaviours on colleagues, clients and the local cultures. Practical implications: The paper identifies some of the tensions of developing “critical” health service managers, and the problems they encounter back in the “uncritical” NHS context, as well as some of

the challenges in “facilitating” a critical curriculum. It questions the ethics of developing (or not) a critical perspective in a local context unfamiliar with CMS. Originality/value: Management development in the NHS largely ignores critical pedagogy. This paper makes a small and unique contribution to understanding how developing “critically thinking” managers can challenge the dominant culture. However, the limitations of such a small-scale study and ethical implications are noted.

Finn, Rachael, Learmonth, Mark, Reedy, Patrick. 2010 Some unintended effects of teamwork in healthcare. *Social Science & Medicine* 70(8), 1148-1154. 2010.

<http://dx.doi.org/10.1016/j.socscimed.2009.12.025>

<http://pmid.us/20137845>

Teamwork has been emphasised as a key feature of health service reform, essential for safe, efficient and patient-centred care. Bringing together literatures from the sociology of healthcare and organizational theory, we examine how the teamwork phenomenon plays out in practice. Drawing upon material from two ethnographic studies, conducted in an operating theatre and a medical-records department in separate UK NHS hospitals, we explore some of the discursive teamwork practices of healthcare staff. Our analysis presents a very different picture from the normative, evangelistic promotion of teamwork within much management and health policy writing. We reveal how the ambiguity of teamwork opens up opportunities for a complex, diverse range of responses to the managerial discourse among diverse occupational groups, mobilizing the discourse to enact identity in different ways. We highlight how teamwork discourse can be instrumentally co-opted in the reproduction of the very occupational divisions it is designed to ameliorate, or simply ignored as irrelevant when compared to more attractive forms of collective identity. These responses challenge both those who believe that teamwork is a solution to problems in healthcare, as well as those concerned about the oppressive effects of pervasive managerialism

SOCIAL CAPITAL

D'Hombries, B.; Rocco, L.; Suhrcke, M.; 2010 Does social capital determine health? : evidence from eight transition countries. *Health Economics* 2010; 19 (1): 56-74 (January 2010)

<http://dx.doi.org/10.1002/hec.1445>

<http://pmid.us/19301350>

There is growing interest in the role of social relationships in explaining patterns of health. We contribute to this debate by investigating the impact of social capital on self-reported health for eight countries from the Commonwealth of Independent States. We rely on three indicators of social capital at the individual level (trust, participation in local organisations, social isolation) and employ alternative procedures to estimate consistently the impact of social capital on health. The three social capital indicators are choice variables and are hence, by definition, endogenously determined. We attempt to circumvent the endogeneity problems by using instrumental variable estimates. Our results show that the individual degree of trust is positively and significantly correlated with health, this being true with least squares estimators as well as when relying on instrumental variable estimators with (and without) community fixed effects. Similarly, social isolation is negatively and significantly associated with health, irrespective of the procedure of estimation. On the other hand, the effect of being a member of a Putnamesque organisation is more ambiguous and usually not significantly related to health

WORKFORCE

Kowalski C et al 2010 Burnout in nurses - the relationship between social capital in hospitals and emotional exhaustion. *Journal of Clinical Nursing* _ 2010 Apr 1. [Epub ahead of print]

<http://dx.doi.org/10.1111/j.1365-2702.2009.02989.x>

<http://pmid.us/20384668>

Aims. The aim of this study is to examine the relationship between a hospital's social capital, individual decision latitude, workload and emotional exhaustion in nurses, controlling for age, sex, years of professional experience and job tenure. **Background.** In western countries between 15-45% of nurses working in hospitals suffer from burnout, characterised by emotional exhaustion, depersonalisation and decreased personal performance. The prevention of burnout constitutes a great challenge to those responsible for the health care system, not least because burnout may cause increasing turnover rates in nurses and lead to medical mistakes. **Design.** Survey. **Method.** A questionnaire was mailed to 1325 nurses working at four hospitals in east and west Germany in 2002. Nine hundred and fifty nine nurses responded (response rate: 72.4%). **Results.** Logistic regression identified three significant predictors of emotional exhaustion in nurses: workload (OR: 4.523, CI: 3.230-6.333) was positively associated with emotional exhaustion. Decision latitude (OR: 0.376, CI: 0.254-0.557) and social capital in the hospitals (OR: 0.549, CI: 0.403-0.746) were negatively associated with emotional

exhaustion. Emotional exhaustion was not affected by age, sex, years of professional experience and job tenure. Nagelkerke's Pseudo R(2) was 0.225. Conclusions. The findings underline the importance of social capital and organisational development in hospital management. Relevance to clinical practice. Efforts to create a good working atmosphere with readiness to provide mutual support and the pursuit of joint values in a hospital, the reduction of workload and increased decision latitude may prevent the development of emotional exhaustion in nurses.

Petrova M et al 2010 Benefits and challenges of employing health care assistants in general practice: a qualitative study of GPs' and practice nurses' perspectives. *Family Practice* 2010 Mar 17. [Epub ahead of print]

<http://dx.doi.org/10.1093/fampra/cmq011>

<http://pmid.us/20237109>

Background: Estimates suggest that over half of general practices in England currently employ a health care assistant (HCA) but there is little evidence of their impact, effectiveness and acceptability to patients and primary care team members. Objectives: To explore the role of HCAs in general practice and the benefits and challenges associated with their employment. Methods: Semi-structured interviews were performed with 6 GPs and 13 practice nurses as part of a larger qualitative study that also included HCAs. Interviewees were from 16 general practices from two Primary Care Trusts in the West Midlands. Transcripts were analyzed using thematic and framework analysis. Results: HCAs were seen as a valuable addition to the primary care team. They were reported to accelerate, rather than extend services, allow more appropriate use of nurses' skills and enable cost containment. Their training and supervision were felt as time intensive, demanding of time and commitment. Patient safety was raised as a concern, although no specific experience of it being compromised was reported. Nurses recognized the usefulness of HCAs, helped to make the role work, but were often anxious about the impact on their own roles and professional identity. Patients were perceived as being generally neutral or positive. Conclusion: Cost-effectiveness, patient safety, quality of care, potentially contested role boundaries and patient attitudes are among the issues that policy-makers, commissioners and those responsible for workforce development and training need to consider in relation to HCAs in general practice. There is also a need for more in-depth evaluation of this role.

Rizq, Rosemary, et al 2010 Reflective voices: primary care mental health workers? experiences in training and practice. *Primary Health Care Research & Development* 11(01), 72-86. 2010.

<http://dx.doi.org/10.1017/S1463423609990375>

Background The role of the primary care mental health worker (PCMHW) in providing self-help and signposting to people referred for mild-moderate anxiety and depression is currently being complemented by low-intensity workers training under the government written reflective papers provides a qualitative exploration of issues and concerns raised by PCMHWs during a fortnightly reflective practice group. Results Themes emerging from participants; written accounts highlight: difficulties in applying academic and skills training to the real-life world of clinical practice; difficulties in managing issues of risk and complexity; role confusion; and the need for a visible and coherent career structure .Conclusions The study highlights the psychological impact on PCMHWs of managing complex client referrals. This is discussed in the context of the high volume case turnover anticipated by IAPT training curricula. Implications for the training and education of IAPT low-intensity workers are briefly considered

Wilberforce, N., Wilberforce, K., and ubrey-Bassler, F. K. 2010. "Post-traumatic stress disorder in physicians from an underserviced area". *Family Practice* 27: 339-343.

<http://dx.doi.org/10.1093/fampra/cmq002>

<http://pmid.us/20200091>

Background. Studies suggest a high prevalence of mental illness in physicians. The rate of post-traumatic stress disorder (PTSD) has been examined in physicians exposed to traumatic circumstances and physicians in training but never in physicians in regular practice. Objective. To estimate the prevalence of PTSD in physicians practicing in a predominantly rural and remote and medically underserviced region of Canada. Methods. The PTSD Checklist-Civilian Version (PCL-C) was mailed to all 331 physicians in Northwestern Ontario, Canada. A PCL-C score of ≥ 50 was used to define probable PTSD and ≥ 30 defined possible PTSD. Additional comments and demographic information were also requested. Results. Completed questionnaires were received from 159 physicians (48%). The prevalence of probable PTSD was 4.4%. No differences between demographic groups were observed for probable PTSD, but possible PTSD was more frequent in males than females (47.3% versus 20.4%, chi-square = 10.59, P = 0.001). Mean scores were also higher for males than for females (30.4 versus 25.4, 95% confidence interval for the difference: 1.4-8.5, P = 0.006). Respondents identified overwork, insufficient resources and relationships with colleagues and patients as common stressors. Conclusions. Results suggest a high rate of PTSD in Northwestern Ontario physicians. The prevalence of possible PTSD and mean PCL-C scores are higher in men than in women in this region, which may relate to differences in practice characteristics and the opportunity for exposure to traumatic events

Wright, D , Ricketts TC. 2010 The road to efficiency? Re-examining the impact of the primary care physician workforce on health care utilization rates. *Social Science & Medicine* Epub ahead of print 20/3/2010

<http://dx.doi.org/10.1016/j.socscimed.2010.02.043>

<http://pmid.us/20385438>

Research suggests that primary care physicians may help to control health care costs by encouraging more efficient service use. However, most studies do not account for data aggregation effects that can significantly affect the direction and magnitude of findings. To re-examine the association between the proportion of primary care physicians and health care utilization rates in an area, and investigate the potential impact of aggregating data to different geographic levels on these observed associations, we estimate four distinct cross-sectional multivariate regression models to predict health care utilization at the county level and the metropolitan statistical area (MSA) level using data from 2007. Our study focuses on health care utilization in the United States using inpatient admissions, outpatient visits, emergency room visits, and total (both inpatient and outpatient) surgeries as dependent variables in separate regressions. The key independent variable is the proportion of primary care physicians in the area. Several community-level control variables are also included. We find that a higher proportion of primary care physicians in the area's physician supply is associated with a decreased number of inpatient admissions at the MSA level, but not the county level, and a decreased number of emergency room visits at the county level, but not the MSA level. Outpatient visits and total surgeries are not associated with the proportion of primary care physicians. From our findings we are able to conclude that there is some evidence that a higher concentration of primary care physicians is associated with a decrease in health care utilization, but these findings depend on the level of aggregation. Investigators should be aware of the implications of aggregating data and acknowledge any resultant limitations