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March – April 2009

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ACCESS TO CARE

Cooper,L., et al (2009). A randomized controlled trial of interventions to enhance patient-physician partnership, patient adherence and high blood pressure control among ethnic minorities and poor persons: study protocol *Implementation Science*, 4(1), 7.

<http://dx.doi.org/10.1186/1748-5908-4-7>

<http://www.implementationscience.com/content/4/1/7>

<http://pmid.us/19228414>

Background: Disparities in health and healthcare are extensively documented across clinical conditions, settings, and dimensions of healthcare quality. In particular, studies show that ethnic minorities and persons with low socioeconomic status receive poorer quality of interpersonal or patient-centered care than whites and persons with higher socioeconomic status. Strong evidence links patient-centered care to improvements in patient adherence and health outcomes; therefore, interventions that enhance this dimension of care are promising strategies to improve adherence and overcome disparities in outcomes for ethnic minorities and poor persons. Objective: This paper describes the design of the Patient-Physician Partnership (Triple P) Study. The goal of the study is to compare the relative effectiveness of the patient and physician intensive interventions, separately, and in combination with one another, with the effectiveness of minimal interventions. The main hypothesis is that patients in the intensive intervention groups will have better adherence to appointments, medication and lifestyle recommendations at 3 months and 12 months than patients in minimal intervention groups. The study also examines other process and outcome measures including patient-physician communication behaviors, patient ratings of care, health service utilization, and blood pressure control. Methods: A total of 50 primary care physicians and 279 of their ethnic minority or poor patients with hypertension were recruited into a randomized controlled trial with a two by two factorial design. The study used a patient-centered, culturally tailored, education and activation intervention for patients with active follow-up delivered by a community health worker in the clinic. It also included a computerized, self-study communication skills training program for physicians, delivered via an interactive CD-ROM, with tailored feedback to address their individual communication skills needs. Conclusion: The Triple P study will provide new knowledge about how to improve patient adherence, quality of care, and cardiovascular outcomes and how to reduce disparities in care and outcomes of ethnic minority and poor persons with hypertension

Fotaki,M. (2009). Are all consumers the same? Choice in health, social care and education in England and elsewhere. *Public Money & Management*, 29(2), 87-94.

<http://dx.doi.org/10.1080/09540960902767956>

The reliance on consumer choice to drive improvements in public services is at the centre of policy debates in the UK and elsewhere. However, the discourse of consumerism occurs in the midst of a quagmire as to whether users of public services can legitimately be considered as customers, citizens or co-producers, while the existing evidence on how far they assume the role of public service consumers is largely ignored. This article discusses research on users' attitudes to choice in health, education and social services in the UK, the European Union and the USA. Provision of public services is rarely about acquiring products for pure consumption, but more about providers and users jointly addressing essential social and human needs. The author argues for an alternative conception of public service provision going beyond the limitations of consumerism, although some users are more likely to choose certain public services over others (for example schools rather than health services). However, the evidence presented disproves the view that users of public services will act as discerning consumers in the market-place

Goddard, M (2006). Access to health care services: an English policy perspective. *Health Economics, Policy and Law*, Online 30/01/2009

<http://dx.doi.org/10.1017/S174413310900485X>

<http://pmid.us/19187570>

The English government has given a commitment to improving access to health care services for particular groups perceived as being under-served, or served inappropriately, by existing services. In this article four examples of policies aimed at improving access are considered: enhancing the supply of services to under-served areas, changing the organization of services, setting targets to improve access, and empowering people to make choices. Policies aimed at improving access will work only if they address the source of inequities, which means identifying the key barriers to access and these barriers are unlikely to be uniform across sectors, services, and groups of people. Evidence on the success of these four types of intervention in terms of influencing access and equity of access is discussed, borrowing some concepts from the sociological literature that enable us to understand the importance of how barriers to access may arise for different services and different population groups. It is clear that some policies may not work as well as we would hope, or may even exacerbate inequities of access, because they fail to recognize the source of the particular barriers faced by some groups

Hugenholtz, M., Broer, C., & van Daalen R. (2009). Apprehensive parents: a qualitative study of parents seeking immediate primary care for their children. *British Journal of General Practice* 59 (560), 173-179.

<http://dx.doi.org/10.3399/bjgp09X394996>

<http://pmid.us/19275833>

Background: Children are more frequent users of out-of-hours primary care than other age groups, although their medical problems are less urgent. Aim: To gain insight into the health-seeking behaviour of parents who ask for immediate medical attention for their children. Design of study: Qualitative analysis of interviews and telephone calls. Setting: A general practice out-of-hours cooperative that caters for approximately 300,000 people in The Netherlands. Method: A semi-structured interview was conducted with 27 parents who had consulted their own GP or an out-of-hours facility for primary care because they wanted urgent medical attention for their child who was sick. Forty-four telephone calls from parents seeking medical care for a child were analysed. Results: Recognising symptoms in a child started with the observation of a deviation from the child's normal appearance or behaviour. Parents decided to contact medical services when they felt they lost control of the situation. Most parents consulted because they wanted to rule out or prevent serious disease, not because of the condition itself; not wanting to take a risk with their child was an important motivation. In an attempt to rule out serious disease at home, parents also attempted diagnostic procedures they had copied from professionals. Conclusion: Worry of parents and their health-seeking behaviour can be seen as an expression of the central role of risk regulation in modern society. Doctors need to realise their own contribution to the way parents want to rule out serious disease in their children. Improving parents' knowledge will not solve the problem of inappropriate use of out-of-hours facilities

Knight,A.W. (2009). Learning from four years of collaborative access work in Australia. *Quality in Primary Care*, 17(1), 71-74.

<http://pmid.us/19281677>

Background: Through the three years of the first phase of the Australian Primary Care Collaborative there was considerable adaptation of the work to improve access translated from the UK to the Australian environment. Changes in four areas are described. Methods and results: Measures: 'third available appointment' was retained as a measure of delay. A patient satisfaction survey was revised and a new measure added looking at unmet demand. Team: requests from practices resulted in the production of a set of 'team principles' designed to help practices build capacity for improvement in their teams. Name: the name of the topic seemed to be a barrier for some practices. After much thought, the name of the improvement topic was changed from 'Better Access' to 'Access and Care Redesign'. The product: the content of the access topic was revised. Change ideas were divided into 'foundation work', which all practices were expected to do to improve access to care for patients. Once this was completed, practices were encouraged to select a 'pathway' which best suited their situation. Conclusion: Four possible changes are offered for consideration to those planning to do access work with general practices based on the learning from the Australian Primary Care Collaborative

Ratcliffe,J., et al (2009). Examining the attitudes and preferences of health care decision-makers in relation to access, equity and cost-effectiveness: A discrete choice experiment. *Health Policy*, 90(1), 45-57.

<http://dx.doi.org/10.1016/j.healthpol.2008.09.001>

<http://pmid.us/18937994>

Objectives To describe the views of health care decision-makers and providers operating in the UK National Health Service (NHS) concerning the concepts of cost-effectiveness, equity and access through a series of attitudinal questions; to evaluate the preferences of health care providers in relation to each of these concepts using a discrete choice experiment (DCE); to assess the impact of prior completion of an attitude questionnaire on preferences elicited through a DCE. **Method** Three versions of a DCE questionnaire were developed with and without a series of attitudinal questions and randomly distributed to 1456 health care decision-makers and providers. The questionnaire sought to elicit their preferences between the competing objectives of cost-effectiveness, equity and access within the context of different hypothetical, specialist treatment programmes for cardiovascular disease. **Results** The response rate was 26%. Female respondents exhibited a stronger preference than males for reducing health inequalities by targeting the worst off (Wald test, $P < 0.001$). Primary Care Trusts (PCTs), Strategic Health Authorities (SHA) or Department of Health (DoH) staff were also more likely than hospital managers to favour programmes that targeted the worst off (Wald test, $P < 0.001$ in each case). Those who were clinically trained and currently in a clinical post had a stronger preference for programmes with shorter waiting times compared to those in a managerial or non-clinical posts, who exhibited stronger preferences for equity. Completion of a series of attitudinal questions prior to completing the DCE task resulted in a lower proportion of dominant responses and an increased willingness to make trade-offs between attributes

CHRONIC ILLNESS

Amsberg,S., et al (2009). A cognitive behavior therapy-based intervention among poorly controlled adult type 1 diabetes patients-A randomized controlled trial. *Patient Education and Counseling* Online 16/03/2009

<http://dx.doi.org/10.1016/j.pec.2009.01.015>

<http://pmid.us/19297117>

Objective: To examine the impact of a Cognitive Behavior Therapy (CBT)-based intervention on HbA(1c), self-care behaviors and psychosocial factors among poorly controlled adult type 1 diabetes patients. Methods: Ninety-four type 1 diabetes patients were randomly assigned to either an intervention group or a control group. The intervention was based on CBT and was mainly delivered in group format, but individual sessions were also included. All subjects were provided with a continuous glucose monitoring system (CGMS) during two 3-day periods. HbA(1c), self-care behaviors and psychosocial factors were measured up to 48 weeks. Results: Significant differences were observed with respect to HbA(1c) ($P<0.05$), well-being ($P<0.05$), diabetes-related distress ($P<0.01$), frequency of blood glucose testing ($P<0.05$), avoidance of hypoglycemia ($P<0.01$), perceived stress ($P<0.05$), anxiety ($P<0.05$) and depression ($P<0.05$), all of which showed greater improvement in the intervention group compared with the control group. A significant difference ($P<0.05$) was registered with respect to non-severe hypoglycemia, which yielded a higher score in the intervention group. Conclusion: This CBT-based intervention appears to be a promising approach to diabetes self-management. PRactice implications: Diabetes care may benefit from applying tools commonly used in CBT. For further scientific evaluation in clinical practice, there is a need for specially educated diabetes care teams, trained in the current approach, as well as cooperation between diabetes care teams and psychologists trained in CBT

Baksi, A.K. (2009). Experiences in peer-to-peer training in diabetes mellitus: challenges and implications. *Family Practice Advanced Access* published online 3/02/2009

<http://dx.doi.org/10.1093/fampra/cmp014>

<http://pmid.us/19258442>

This paper briefly describes the functions of peer advisers in diabetes (PADs) and their training. The formal process used in the assessment of the peer advisers at the completion of the training courses is also stated. The findings of a recent randomized controlled trial to study the effectiveness of peer advisers in delivering a programme of education on self-management are also described. The experience gained after the completion of four courses for the training of peer advisers, in addition to a review of the literature, forms the basis for discussion of the subject of peer-to-peer support activities in diabetes. PADs are effective in the provision of one-to-one psychosocial support and advice on self-management. They are also effective as committee members and advocates for diabetes. More recently, they have been shown to be effective as teachers on self-management to their peers with diabetes. With the imminent explosion in the number of people with diabetes, there will be increased need for psychosocial support and in the requirement for the provision of education on self-management. It is unlikely that health services would be given sufficient resources to cope with this. Society should identify alternative

resources. People with diabetes and their close carers are the obvious choice, and we need to commence their training now. The implications for primary care are discussed

Brennan,C., Harkins,V., & Perry,I.J. (2008). Management of diabetes in primary care: A structured-care approach. *The European Journal of General Practice*, 14(3), 117-122.

<http://dx.doi.org/10.1080/13814780802689154>

Background: In the Irish Midland Health Service Executive (HSE) Diabetes Structured Care Project, additional resources were targeted at general practice in the absence of a local hospital-based specialized diabetes unit. Objective: We assessed the performance of the Midland HSE Diabetes Structured Care programme in 2003, bench-marked against Primary Care Trust (PCT) data from the 2003/2004 National Diabetes Audit for England. Methods: Data on 947 patients (72% of eligible patients) from all 20 general practices participating in the structured-care programme were collected retrospectively over a 12-month period. The data included demographic and clinical variables as well as key process-of-care and intermediate outcome indicators used in the National Diabetes Audit for England. Results: The level of recording of process-of-care measures was near or above the upper quartile for PCTs in England. The proportion of patients with HbA_{1c} concentrations at target levels (<6.5%) in the Midlands HSE project (26.8%) was virtually identical to the upper quartile level for PCTs in England (27.4%). The proportion of patients reaching target total cholesterol levels (<5.0 mmol/l) (54.6%) was close to the mean for PCTs in England (56.6%), and performance with regard to target blood pressure levels was equally poor in both the Midlands HSE (18.0%) and in PCTs in England (20.8%). Conclusion: Primary-care-led structured care, with relatively limited but well-focused investment, can achieve quality of care for patients with diabetes, comparable to international best practice.

Caiata,Z.M., & Schulz,P.J. (2009). Self-management of chronic low back pain: An exploration of the impact of a patient-centered website. *Patient Education and Counseling Online* 23/03/2009

<http://dx.doi.org/10.1016/j.pec.2009.01.016>

<http://pmid.us/19321286>

Objective: This paper examines from a qualitative approach the role of a patient-centered website - named "Oneself" - on patients' chronic low back pain self-management attitudes and behaviors in the Italian part of Switzerland. Methods: In-depth interviews have been conducted with a purposive and convenient sample of 18 chronic low back pain sufferers who had used Oneself during 6 months. Data collection and analysis were driven by grounded theory. Results: Reported positive effects of the use of Oneself on self-management attitudes and behaviors include self-comprehension, improvement of argumentative abilities, orientation, development of self-confidence and maintenance of a

high level of attention. In some cases, participants affirm to have experienced negative effects such as confusion and discouragement. The individual's previous awareness of cLBP and level of self-management plays a main role in the way people use the website and in its impact. Based on this criterium, a typology of four patterns of use is drawn. Conclusion: Patient-centered websites are useful for enhancing self-management of chronic low back pain. However, individuals take advantage of this means differently, based on their stage of advancement in the self-management process. Practice implications: Information and supports provided online should be tailored according to people's stage of advancement

Cowie,L., et al (2009). Experience of continuity of care of patients with multiple long-term conditions in England. *Journal of Health Services Research and Policy*, 14(2), 82-87.

<http://dx.doi.org/10.1258/jhsrp.2009.008111>

<http://pmid.us/19299261>

Objectives: To examine patients' experiences of continuity of care in the context of different long-term conditions and models of care, and to explore implications for the future organization care of long-term conditions. Methods: Qualitative semi-structured interviews were carried out with 33 patients recruited from seven general practices in South London. Patients were selected who had one or more of the following long-term conditions: arthritis, coronary heart disease, stroke, hypercholesterolaemia, hypertension, diabetes mellitus or chronic obstructive pulmonary disease. Results: Multiple morbidity was frequent and experiences of continuity were framed within patients' wider experiences of health care rather than the context of a particular diagnosis. Positive experiences of relational continuity were strongly associated with long-term GP-led or specialist-led care. Management continuity was experienced in the context of shared care in terms of transitions between professionals or organizations. Access and flexibility issues were identified as important barriers or facilitators of continuity. Conclusions: Across a range of long-term conditions, patients' experiences of health care can be understood in terms of nuanced understandings of relational and management continuity. Continuity experiences, meanings and expectations, as well as barriers and facilitators, are influenced by the model of care rather than type of condition

Dobscha,S.K., et al (2009). Collaborative care for chronic pain in primary care: a cluster randomized trial. *JAMA*, 301(12), 1242-1252.

<http://dx.doi.org/10.1001/jama.2009.377>

<http://pmid.us/19318652>

Context: Chronic pain is common in primary care patients and is associated with distress, disability, and increased health care use. Objective: To assess whether a collaborative intervention can improve chronic pain-related outcomes, including comorbid depression severity, in a Department of Veterans Affairs primary care setting. Design, setting, and

participants: Cluster randomized controlled trial of a collaborative care assistance with pain treatment intervention vs treatment as usual at 5 primary care clinics of 1 Department of Veterans Affairs Medical Center. Forty-two primary care clinicians were randomized to the assistance with pain treatment intervention group or the treatment as usual group. The 401 patients had musculoskeletal pain diagnoses, moderate or greater pain intensity, and disability lasting 12 weeks or longer and were assigned to the same treatment groups as their clinicians. Recruitment occurred from January 2006 to January 2007 and follow-up concluded in January 2008. Intervention: Assistance with pain treatment included a 2-session clinician education program, patient assessment, education and activation, symptom monitoring, feedback and recommendations to clinicians, and facilitation of specialty care. Main outcome measures: Changes over 12 months in pain-related disability (Roland-Morris Disability Questionnaire, range of 0-24), pain intensity (Chronic Pain Grade [CPG] Pain Intensity subscale, range of 0-100), and depression (Patient Health Questionnaire 9 [PHQ-9], range of 0-27), measured as beta coefficients (difference in slopes in points per month). RESULTS: Intervention patients had a mean (SD) of 10.6 (4.5) contacts with the assistance with pain treatment team. Compared with the patients receiving treatment as usual, intervention patients showed greater improvements in pain-related disability (Roland-Morris Disability Questionnaire beta, -0.101 [95% confidence interval {CI}, -0.163 to -0.040]; P = .004 and CPG Pain Intensity subscale beta, -0.270 [95% CI, -0.480 to -0.061]; P = .01). Among patients with baseline depression (PHQ-9 score > or = 10), there was greater improvement in depression severity in patients receiving the intervention compared with patients receiving treatment as usual (PHQ-9 beta, -0.177 [95% CI, -0.295 to -0.060]; P = .003). The differences in scores between baseline and 12 months for the assistance with pain treatment intervention group and the treatment as usual group, respectively, were -1.4 vs -0.2 for the Roland-Morris Disability Questionnaire, -4.7 vs -0.6 for the CPG Pain Intensity subscale, and -3.7 vs -1.2 for PHQ-9. Conclusion: The assistance with pain treatment collaborative intervention resulted in modest but statistically significant improvement in a variety of outcome measures.

Fharm,E., Rolandsson,O., & Johansson,E.E. (2009). 'Aiming for the stars'--GPs' dilemmas in the prevention of cardiovascular disease in type 2 diabetes patients: focus group interviews. *Family Practice* Advanced Access published online 10/02/2009

<http://dx.doi.org/10.1093/fampra/cmp002>

<http://pmid.us/19208737>

Background. Studies have revealed low adherence to guidelines for treatment of diabetes and cardiovascular risk factors. Objective. To explore GPs' experiences regarding treatment practice in type 2 diabetes with specific focus on the prevention of cardiovascular disease. Methods. Fourteen experienced GPs from nine health care centres with group practices were interviewed in focus groups. The interviews were digitally recorded, transcribed verbatim and analysed by qualitative content analysis. Results. The overall theme was dilemmas' in GPs' treatment practice for type 2 diabetes patients. Five

main dilemma categories were identified. First, the GPs were hesitant about labelling someone who feels healthy as ill. Second, regarding communicating a diabetes diagnosis and its consequences; should the patient be frightened or comforted? Third, the GPs experienced uncertainty in their role; were they to take responsibility for the care or not? Fourth, the GPs expressed a conflict between lifestyle changes and drug treatment. Fifth, the GPs described difficulties in integrating science into reality. Conclusions. The five dilemmas in the GPs' approach to diabetes patients and the treatment of their cardiovascular risk were related to the GPs' professional role and communication with the patient. To consider these dilemmas in educational efforts is probably essential to achieve improved diabetes care and guideline adherence

Fisher, E.B., et al (2009). Cross-cultural and international adaptation of peer support for diabetes management. *Family Practice Advanced Access* published online 10/03/2009

<http://dx.doi.org/10.1093/fampra/cmp013>

<http://pmid.us/19276176>

Peer support may improve self-management among the millions of people with diabetes around the world. A major challenge to international promotion of peer support is allowing for tailoring to population, cultural, health system and other features of specific settings, while also ensuring congruence with standards for what peer support entails. One strategy to address this challenge was used in the Robert Wood Johnson Foundation Diabetes Initiative. Key functions of self-management--Resources and Supports for Self-Management--were identified. Individual programmes were then encouraged to implement these resources and support in ways that were feasible in their settings and responsive to the needs and perspectives of those they serve. Extending this to peer support, three Key functions are (i) assistance in managing and living with diabetes in daily life; (ii) social and emotional support and (iii) linkage to clinical care. International promotion may be advanced by emphasizing these key functions and then encouraging local variation in the specific ways they are addressed. Similarly, evaluation of the general benefits of peer support across several individual programmes may rest on measurement of implementation of the key functions, participants' reports of receipt of them and common end points. Challenges to promoting peer support include integrating peers amidst others in the health care system, harmonizing peers with family and other social networks, maintaining the engagement of peer supporters and those they assist and preventing training, quality improvement and professionalism from distorting the fundamental benefits of support from a peer

Gonzalez, E.L.M., et al (2009). Trends in the prevalence and incidence of diabetes in the UK: 1996-2005. *Journal of Epidemiology and Community Health*, 63(4), 332-336.

<http://dx.doi.org/10.1136/jech.2008.080382>

<http://pmid.us/19240084>

Background To estimate the incidence and prevalence of type 1 and type 2 diabetes in the UK general population from 1996 to 2005. **Methods** Using The Health Improvement Network database, patients with type 1 or type 2 diabetes were identified who were 10-79 years old between 1996 and 2005. Prevalent cases (n = 49 999) were separated from incident cases (n = 42 642; type 1 = 1256, type 2 = 41 386). Data were collected on treatment patterns in incident cases, and on body mass index in prevalent and incident cases. **Results** Diabetes prevalence increased from 2.8% in 1996 to 4.3% in 2005. The incidence of diabetes in the UK increased from 2.71 (2.58-2.85)/1000 person-years in 1996 to 4.42 (4.32-4.53)/1000 person-years in 2005. The incidence of type 1 diabetes remained relatively constant throughout the study period; however, the incidence of type 2 diabetes increased from 2.60 (2.47-2.74)/1000 person-years in 1996 to 4.31 (4.21-4.42)/1000 person-years in 2005. Between 1996 and 2005, the proportion of individuals newly diagnosed with type 2 diabetes who were obese increased from 46% to 56%. Treatment with metformin increased across the study period, while treatment with sulphonylureas decreased. **Conclusions** The prevalence and incidence of type 2 diabetes have increased in the UK over the past decade. This might be primarily explained by the changes in obesity prevalence. Also, there was a change in drug treatment pattern from sulphonylureas to metformin

Grant, J., et al (2009). Gender-specific epidemiology of diabetes: a representative cross-sectional study. *International Journal for Equity in Health*, 8(1), 6.

<http://dx.doi.org/10.1186/1475-9276-8-6>

<http://www.equityhealthj.com/content/8/1/6>

<http://pmid.us/19284598>

Background: Diabetes and its associated complications are part of a chronic disease global epidemic that presents a public health challenge. Epidemiologists examining health differences between men and women are being challenged to recognise the biological and social constructions behind the terms 'sex' and/or 'gender', together with social epidemiology principles and the life course approach. This paper examines the epidemiology of a population with diabetes from the north-west metropolitan region of South Australia. **Methods:** Data were used from a sub-population with diabetes (n=263), from 4060 adults aged 18 years and over living in the north-west suburbs of Adelaide, South Australia. Eligible respondents were asked to participate in a telephone interview, a self-report questionnaire and a biomedical examination. Diabetes (undiagnosed and diagnosed) was determined using self-reported information and a fasting blood test administered to participants. Data were analysed using SPSS (Version 10.0) and EpiInfo (Version 6.0). **Results:** Factors associated with diabetes for both men and women were being aged 40 years and over, and having a low gross annual household income, obesity and a family history of diabetes. In addition, being an ex-smoker and having low

cholesterol levels were associated with diabetes among men. Among women, having a high waist-hip ratio, high blood pressure and reporting a previous cardiovascular event or mental health problem were associated with diabetes. Conclusions: The results found that men and women with diabetes face different challenges in the management of their condition. Public health implications include a need for quality surveillance data, including epidemiological life course, social, behavioural, genetic and environmental factors. This will enrich the evidence base for health promotion professionals and allow policy makers to draw inferences and conclusions for interventions and planning purposes

Gress,S., et al (2009). Co-ordination and management of chronic conditions in Europe: the role of primary care - position paper of the European Forum for Primary Care. *Quality in Primary Care*, 17(1), 75-86.

<http://pmid.us/19281678>

Healthcare systems in Europe struggle with inadequate co-ordination of care for people with chronic conditions. Moreover, there is a considerable evidence gap in the treatment of chronic conditions, lack of self-management, variation in quality of care, lack of preventive care, increasing costs for chronic care, and inefficient use of resources. In order to overcome these problems, several approaches to improve the management and co-ordination of chronic conditions have been developed in European healthcare systems. These approaches endeavour to improve self-management support for patients, develop clinical information systems and change the organisation of health care. Changes in the delivery system design and the development of decision support systems are less common. Almost as a rule, the link between healthcare services and community resources and policies is missing. Most importantly, the integration between the six components of the chronic care model remains an important challenge for the future. We find that the position of primary care in healthcare systems is an important factor for the development and implementation of new approaches to manage and coordinate chronic conditions. Our analysis supports the notion that countries with a strong primary care system tend to develop more comprehensive models to manage and co-ordinate chronic conditions

Ham,C. (2009). Chronic care in the English National Health Service: progress and challenges. *Health Affairs* , 28(1), 190-201.

<http://dx.doi.org/10.1377/hlthaff.28.1.190>

<http://pmid.us/19124870>

One of the aims of the English National Health Service (NHS) reform program has been to give higher priority to chronic care. Chronic care policy has focused on self-management, disease management, and case management, alongside a number of related initiatives. A start has been made in implementing these initiatives, and some are beginning to demonstrate benefits, like the new pay-for-performance contract for family

physicians. However, investment in the chronic care policy has been modest, and the emphasis on case management appears to have been misplaced, when it is the cumulative effect of different interventions that is likely to have the greatest impact

Heisler, M. (2009). Different models to mobilize peer support to improve diabetes self-management and clinical outcomes: evidence, logistics, evaluation considerations and needs for future research. *Family Practice Online* 17/03/2009

<http://dx.doi.org/10.1093/fampra/cmp003>

<http://pmid.us/19293400>

Much of diabetes care needs to be carried out by patients between office visits with their health care providers. Yet, many patients face difficulties carrying out these tasks. In addition, many adults with diabetes cannot count on effective support from their families and friends to help them with their self-management. Peer support programmes are a promising approach to enhance social and emotional support, assist patients in daily management and living with diabetes and promote linkages to clinical care. This background paper provides a brief overview of different approaches to mobilize peer support for diabetes self-management support, discusses evidence to date on the effectiveness of each of these models, highlights logistical and evaluation issues for each model and concludes with a discussion of directions for future research in this area

Hippisley-Cox, J., et al . (2009). Predicting risk of type 2 diabetes in England and Wales: prospective derivation and validation of QDScore. *British Medical Journal* 338 b880 Online 17/03/2009

<http://dx.doi.org/10.1136/bmj.b880>

<http://pmid.us/19297312>

Objective: To develop and validate a new diabetes risk algorithm (the QDScore) for estimating 10 year risk of acquiring diagnosed type 2 diabetes over a 10 year time period in an ethnically and socioeconomically diverse population. Design: Prospective open cohort study using routinely collected data from 355 general practices in England and Wales to develop the score and from 176 separate practices to validate the score. Participants: 2 540 753 patients aged 25-79 in the derivation cohort, who contributed 16 436 135 person years of observation and of whom 78 081 had an incident diagnosis of type 2 diabetes; 1 232 832 patients (7 643 037 person years) in the validation cohort, with 37 535 incident cases of type 2 diabetes. Outcome measures: A Cox proportional hazards model was used to estimate effects of risk factors in the derivation cohort and to derive a risk equation in men and women. The predictive variables examined and included in the final model were self assigned ethnicity, age, sex, body mass index, smoking status, family history of diabetes, Townsend deprivation score, treated hypertension, cardiovascular disease, and current use of corticosteroids; the outcome of interest was incident diabetes recorded in general practice records. Measures of calibration and discrimination were calculated in the validation cohort. RESULTS: A fourfold to fivefold

variation in risk of type 2 diabetes existed between different ethnic groups. Compared with the white reference group, the adjusted hazard ratio was 4.07 (95% confidence interval 3.24 to 5.11) for Bangladeshi women, 4.53 (3.67 to 5.59) for Bangladeshi men, 2.15 (1.84 to 2.52) for Pakistani women, and 2.54 (2.20 to 2.93) for Pakistani men. Pakistani and Bangladeshi men had significantly higher hazard ratios than Indian men. Black African men and Chinese women had an increased risk compared with the corresponding white reference group. In the validation dataset, the model explained 51.53% (95% confidence interval 50.90 to 52.16) of the variation in women and 48.16% (47.52 to 48.80) of that in men. The risk score showed good discrimination, with a D statistic of 2.11 (95% confidence interval 2.08 to 2.14) in women and 1.97 (1.95 to 2.00) in men. The model was well calibrated. Conclusions: The QDScore is the first risk prediction algorithm to estimate the 10 year risk of diabetes on the basis of a prospective cohort study and including both social deprivation and ethnicity. The algorithm does not need laboratory tests and can be used in clinical settings and also by the public through a simple web calculator (www.qdscore.org)

Mann,E., et al (2009). Impact of an informed choice invitation on uptake of screening for diabetes in primary care (DICISION): trial protocol. *BMC Public Health*, 9(1), 63.

<http://dx.doi.org/10.1186/1471-2458-9-63>

<http://www.biomedcentral.com/1471-2458/9/63>

<http://pmid.us/19232112>

Background: Screening invitations have traditionally been brief, providing information only about population benefits. Presenting information about the limited individual benefits and potential harms of screening to inform choice may reduce attendance, particularly in the more socially deprived. At the same time, amongst those who attend, it might increase motivation to change behavior to reduce risks. This trial assesses the impact on attendance and motivation to change behavior of an invitation that facilitates informed choices about participating in diabetes screening in general practice. Three hypotheses are tested: 1. Attendance at screening for diabetes is lower following an informed choice compared with a standard invitation. 2. There is an interaction between the type of invitation and social deprivation: attendance following an informed choice compared with a standard invitation is lower in those who are more rather than less socially deprived. 3. Amongst those who attend for screening, intentions to change behavior to reduce risks of complications in those subsequently diagnosed with diabetes are stronger following an informed choice invitation compared with a standard invitation. Methods: 1500 people aged 40-69 years without known diabetes but at high risk are identified from four general practice registers in the east of England. 1200 participants are randomized by households to receive one of two invitations to attend for diabetes screening at their general practices. The intervention invitation is designed to facilitate informed choices, and comprises detailed information and a decision aid. A comparison

invitation is based on those currently in use. Screening involves a finger-prick blood glucose test. The primary outcome is attendance for diabetes screening. The secondary outcome is intention to change health related behaviors in those attenders diagnosed with diabetes. A sample size of 1200 ensures 90% power to detect a 10% difference in attendance between arms, and in an estimated 780 attenders, 80% power to detect a 0.2 sd difference in intention between arms. Discussion: The DICISION trial is a rigorous pragmatic denominator based clinical trial of an informed choice invitation to diabetes screening, which addresses some key limitations of previous trials

Olbort,R., et al (2009). Doctors' assistants' views of case management to improve chronic heart failure care in general practice: a qualitative study. *Journal of Advanced Nursing* 65(4), 799-808.

<http://dx.doi.org/10.1111/j.1365-2648.2008.04934.x>

<http://pmid.us/19228240>

Aim: This paper is a report of a study to explore the views, concerns and experiences of doctors' assistants of case management for patients with chronic heart failure, while experiencing the new role of being a case manager within the Heidelberg Integrated Case Management trial. Background: Case management is being investigated as part of a randomised controlled trial aiming to improve care for patients with chronic systolic heart failure. In a complex, multifaceted intervention, trained doctors' assistants (equivalent to a nursing role) adopted new tasks using standardised case management involving telephone monitoring, home visits and diagnostic screening. Method: In April 2007, 3 months after implementation of the intervention programme, 27 doctors' assistants participated in four focus group interviews discussing their views on, and experiences of, case management. Thematic analysis of the data was undertaken. Findings: Participants believed that the most positive factors in case management were about interaction with patients, including opportunities for identifying disease and psychosocial problems. However, barriers included lack of time allocated to perform case management in addition to their normal role and poor cooperation within the practice team. According to the doctors' assistants, the routine implementation of case management was acceptable, feasible and effective in improving the management of patients with chronic systolic heart failure. Conclusion: Case management enhanced the role of doctors' assistants, leading to increased awareness of the perspective of patients with chronic disease. In the wider international primary care practice nursing context, the orchestrated delegation of tasks using specific case management may be a promising strategy for improving the quality of care of chronically ill patients and enabling patient self-management

Shackelton,R., et al (2009). Does the culture of a medical practice affect the clinical management of diabetes by primary care providers? *Journal of Health Services Research and Policy*, 14(2), 96-103.

<http://dx.doi.org/10.1258/jhsrp.2009.008124>

<http://pmid.us/19299263>

Objectives: The financing and organization of primary care in the United States has changed dramatically in recent decades. Primary care physicians have shifted from solo practice to larger group practices. The culture of a medical practice is thought to have an important influence on physician behavior. This study examines the effects of practice culture and organizational structure (while controlling for patient and physician characteristics) on the quality of physician decision-making. Methods: Data were obtained from a balanced factorial experiment which employed a clinically authentic video-taped scenario of diabetes with emerging peripheral neuropathy. Results: Our findings show that several key practice culture variables significantly influence clinical decision-making with respect to diabetes. Practice culture may contribute more to whether essential examinations are performed than patient or physician variables or the structural characteristics of clinical organizations. Conclusions: Attention is beginning to focus on physician behavior in the context of different organizational environments. This study provides additional support for the suggestion that organization-level interventions (especially focused on practice culture) may offer an opportunity to reduce health care disparities and improve the quality of care

Simmons,D., et al (2009). The New Zealand experience in peer support interventions among people with diabetes. *Family Practice Advanced Access* published online 2/03/2009

<http://dx.doi.org/10.1093/fampra/cmp012>

<http://pmid.us/19254967>

Background. Peer-to-peer support has the potential to assist people with diabetes, or at risk of diabetes. Objective. To review the development of diabetes peer support initiatives in New Zealand. Methods. A systematic review of diabetes peer support publications from New Zealand, supplemented by unpublished records from Diabetes New Zealand (DNZ, the national diabetes patient organization) and the two major regional initiatives in South Auckland and Waikato. Results. DNZ, which has 40 societies and 71 diabetes support groups, delivers a range of services to members and non-members. The membership is mainly older European New Zealanders with diabetes, with some Maori and associated societies for Pacific and Youth. While demand exists, no quantitative evaluation of health impact by these organizations has been undertaken. Other peer support groups have developed in South Auckland and Northland. Common themes that emerge relate to leadership, organization and balancing the different needs of people with diabetes at different stages (e.g. newly diagnosed versus others) and with different personal needs. In South Auckland and the Waikato, lay educators have been trained to provide 1:1 and group sessions for people with, or at high risk of, diabetes. A range of training, management, funding and organizational barriers existed in the implementation of these lay educator programmes. Conclusions. Peer-to-peer support and education programmes in diabetes have been considered useful in New Zealand. Knowledge regarding training, management and organization is nearing a level, which would allow formal evaluation of a strategy for both the prevention of diabetes and in supporting people with diabetes

COMMISSIONING

Martin, G.P. (2009). Whose health, whose care, whose say? Some comments on public involvement in new NHS commissioning arrangements. *Critical Public Health*, 19(1), 123-132.

<http://dx.doi.org/10.1080/09581590802385672>

<http://pmid.us>

Recent health policy in England has demanded greater involvement of patients and the public in the commissioning of health and social care services. Public involvement is seen as a means of driving up service quality, reducing health inequalities and achieving value in commissioning decisions. This paper presents a summary and analysis of the forms that public involvement in commissioning are to take, along with empirical analysis from a qualitative study of service-user involvement. It is argued that the diversity of constituencies covered by the notion of 'public involvement', and the breadth of aims that public involvement is expected to achieve, require careful disaggregation. Public involvement in commissioning may encompass a variety of interest groups, whose inputs may include population needs assessment, evaluation of service quality, advocacy of the interests of a particular patient group or service, or a combination of all of these. Each of these roles may be legitimate, but there are significant tensions between them. The extent to which the structures for public involvement proposed recognize these possible tensions is arguably limited. Notably, new Local Involvement Networks (LINKs), which will feed into commissioning decisions, are set as the arbiters of these different interests, a demanding role which will require considerable skill, tenacity and robustness if it is to be fulfilled effectively

COMORBIDITY

May, H.T., et al (2009). Depression after coronary artery disease is associated with heart failure. *Journal of the American College of Cardiology*, 53 (16), 1440-1447.

<http://dx.doi.org/10.1016/j.jacc.2009.01.036>

<http://pmid.us/19371828>

Objectives: The purpose of this study was to evaluate the influence of post-coronary artery disease (CAD) depression diagnosis on heart failure (HF) incidence.
BACKGROUND: Depression has been shown to be a risk factor for poor outcomes

among CAD patients. However, little is known about the influence of depression on HF development in CAD patients. Methods: Patients (n = 13,708) without a diagnosis of HF and depression (International Classification of Diseases-Ninth Revision [ICD-9] codes: 296.2 to 296.36 and 311) and who were not prescribed antidepressant medication (ADM) at the time of CAD diagnosis ($\geq 70\%$ stenosis) were studied. For those with available medication records (n = 7,719), patients subsequently diagnosed with depression were stratified by use of ADM. Patients were followed until HF diagnosis (physician-diagnosed or ICD-9 code: 428) or death. Results were analyzed by Cox proportional hazards regression models. Results: A total of 1,377 patients (10.0%) had a post-CAD clinical depression diagnosis. The incidence of HF among those without a post-CAD depression diagnosis was 3.6 per 100 compared with 16.4 per 100 for those with a post-CAD depression diagnosis. Depression was associated with an increased risk for HF incidence (adjusted hazard ratio [HR]: 1.50, $p < 0.0001$). Results were similar among those with available follow-up medication information (vs. no depression: depression without ADM use [HR: 1.68, $p < 0.0001$]; depression with ADM use [HR: 2.00, $p < 0.0001$]). No difference was found between depressed patients with and without ADM treatment (HR: 0.84, $p = 0.24$). Conclusions: Depression diagnosis was shown to be associated with an increased incidence of HF after CAD diagnosis, regardless of ADM treatment. This finding suggests the need to further study the effect of depression on HF risk among CAD patients

GOVERNANCE

Litva,A., et al (2009). Lay perceptions of the desired role and type of user involvement in clinical governance. *Health Expectations*, 12(1), 81-91

<http://dx.doi.org/10.1111/j.1369-7625.2008.00530.x>

<http://pmid.us/19250154>

Objective: The aim of this paper is to explore variations in lay perceptions of user involvement in clinical governance. Context: The English National Health Service has sought to build a dependable health service through enhanced effectiveness, responsiveness and consistency. Clinical governance, a policy for improving service quality, is a key pillar of these reforms. It is a statutory duty of primary care organizations to ensure that users are involved in all service planning and decision making, including clinical governance. Yet surveys indicated that user involvement in clinical governance was underdeveloped and underutilized. Design: Focus groups were conducted with different types of lay people to explore their perceptions around public involvement in different aspects of clinical governance policy. Results: Content analysis of the transcripts reveals that different groups of lay people varied in their desired role

perspective and preferred type of involvement in different aspects of clinical governance policy. Drawing upon existing models of user involvement, we identified three role perspectives that lay people could take in user involvement - consumer, advocate and citizen. We compared our findings regarding the desired type of involvement with existing models of user involvement, and identified a new type of involvement, overseeing, that is relevant to clinical governance policy. Conclusions: These findings suggest that to facilitate user involvement in clinical governance, it would be necessary to use different strategies to accommodate the differing role perspectives and types of involvement desired by different groups of lay people

HEALTH ECONOMICS

Greener,I., & Mannion,R. (2009). Patient choice in the NHS: what is the effect of choice policies on patients and relationships in health economies? *Public Money & Management*, 29 (2), 95-100.

<http://dx.doi.org/10.1080/09540960902767972>

Policy-makers are increasingly advocating market-based reforms to increase choices for service users and therefore to drive improvement through competition. This article assesses this approach in a hospital trust where there is plenty of scope for patients to choose providers and so for reforms based on a market logic to work. The market had very little impact on the hospital's activities, but demands from the Department of Health and the strategic health authority for the hospital to become more market-oriented were creating the potential for significant dysfunctional consequences

Mannion,R., & Street,A. (2009). Managing activity and expenditure in the new NHS market. *Public Money & Management*, 29(1), 27-34.

<http://dx.doi.org/10.1080/09540960802617335>

The English National Health Service is introducing “Payment by Results” so that hospitals are paid according to the activity they undertake. This should encourage hospitals to increase activity but perhaps to unaffordable levels. Drawing on interviews with NHS staff and documentary evidence, the authors examine local strategies to manage activity and NHS expenditure. These alone cannot be relied upon to control expenditure, and payments themselves should be modified

McDonald, R., & Roland, M. (2009). Pay for performance in primary care in England and California: comparison of unintended consequences. *Annals of Family Medicine* 7(2), 121-127.

<http://dx.doi.org/10.1370/afm.946>

<http://pmid.us/19273866>

Purpose: We undertook an in-depth exploration of the unintended consequences of pay-for-performance programs in England and California. Methods: We interviewed primary care physicians in California (20) and England (20) and compared unintended consequences in each setting. Interview recordings were transcribed verbatim and subjected to thematic analysis. Results: Unintended consequences reported by physicians varied according to the incentive program. English physicians were much more likely to report that the program changed the nature of the office visit. This change was linked to a larger number of performance measures and heavy reliance on electronic medical records, with computer prompts to facilitate the delivery of performance measures. Californian physicians were more likely to express resentment about pay for performance and appeared less motivated to act on financial incentives, even in the program with the highest rewards. The inability of Californian physicians to exclude individual patients from performance calculations caused frustration, and some physicians reported such undesirable behaviors as forced disenrollment of noncompliant patients. English physicians are assessed using data extracted from their own medical records, whereas in California assessment mostly relies on data collected by multiple third parties that may have different quality targets. Assessing performance based on these data contributes to feelings of resentment, lack of understanding, and lack of ownership reported by Californian physicians. Conclusions: Our study findings suggest that unintended consequences of incentive programs relate to the way in which these programs are designed and implemented. Although unintended, these consequences are not necessarily unpredictable. When designing incentive schemes, more attention needs to be paid to factors likely to produce unintended consequences

Rutten, M., & Reed, G. (2009). A comparative analysis of some policy options to reduce rationing in the UK's NHS: Lessons from a general equilibrium model incorporating positive health effects. *Journal of Health Economics*, 28(1), 221-233.

<http://dx.doi.org/10.1016/j.jhealeco.2008.10.002>

<http://pmid.us/19062116>

This paper seeks to determine the macro-economic impacts of changes in health care provision. The resource allocation issues have been explored in theory, by applying the Rybczynski theorem, and empirically, using a computable general equilibrium (CGE) model for the UK with a detailed health component. From the theory, changes in non-health outputs are shown to depend on factor-bias and scale effects, the net effects generally being indeterminate. From the applied model, a rise in the National Health

Service (NHS) budget is shown to yield overall welfare gains, which fall by two-thirds assuming health care-specific factors. A nominally equivalent migration policy yields even higher welfare gains

Weeks,W.B., Wallace,T.A., & Wallace,A.E. (2009). How do race and sex affect the earnings of primary care physicians? *Health Affairs (Millwood)*, 28(2), 557-566.

<http://dx.doi.org/10.1377/hlthaff.28.2.557>

<http://pmid.us/19276016>

To explore the connection between primary care physicians' race and sex and their annual incomes, we used restricted versions of Community Tracking Study Physician Surveys administered in 1998-99, 2001-02, and 2004-05. Compared to white male primary care physicians, we inconsistently found lower yearly incomes for their black male peers but consistently found significantly lower incomes for their female peers of any race, after differences in work effort, physician characteristics, and practice characteristics were adjusted for. Sex-based differences persisted over time. Our findings suggest that addressing the underlying causes of sex-based income differences should be a priority for health professional organizations, particularly as more women enter the physician workforce

HEALTH INEQUALITIES

Brown,D., & Leyland,A.H. (2009). Population mobility, deprivation and self-reported limiting long-term illness in small areas across Scotland. *Health & Place*, 15(1), 37-44.

<http://dx.doi.org/10.1016/j.healthplace.2008.01.009>

This study investigates population mobility and its relationship with area level deprivation and health. Based on UK movement in the year preceding the 2001 census, small areas in Scotland were classified as being one of the following population types; decreasing, increasing or stable (with high or low turnover). In the most deprived areas, illness rates for those under 65 were significantly lower in stable populations with low turnover than in other areas of comparable deprivation. Decreasing populations in deprived areas had significantly highest illness rates overall. Leaving those in poor health behind may lead to artifactual increases in area based health inequalities

Carter, K.N., et al . (2009). What is the association between wealth and mental health? *Journal of Epidemiology and Community Health*, 63(3), 221-226.

<http://dx.doi.org/10.1136/jech.2008.079483>

<http://pmid.us/19028729>

Background: Socioeconomic inequalities in mental health have been shown in a number of populations. This study aims to investigate the association between asset wealth and psychological distress in New Zealand and whether it is independent of other socioeconomic measures and baseline health status. Methods: Data for this study were from the first three waves of the Survey of Families, Income and Employment (SoFIE) conducted in New Zealand (2002-2004/05) (n = 15 340). The Kessler-10 was used as a measure of psychological distress. The association of quintiles of wealth with psychological distress was investigated using logistic regression, controlling for confounders, socioeconomic variables and prior health status. Results: The odds ratio (OR) of reporting high psychological distress were greater in the lowest wealth quintile compared with the highest (OR 3.06, 95% CI 2.68 to 3.50). Adjusting for age and sex did not alter the relationship; however, adjusting for income and area deprivation attenuated the OR to 1.73 (95% CI 1.48 to 2.04). Further controlling for baseline health status reduced the OR to 1.45 (95% CI 1.23 to 1.71), although the confidence interval still excluded the null. Conclusions: Inequalities in wealth are strongly associated with psychological distress, over and above other confounding demographic variables and baseline health status. Much, but not all, of that association is confounded by adult socioeconomic position. This suggests that policy measures to improve asset wealth, through savings and home ownership, may have positive health implications and help to reduce health inequalities

Mooney, G (2006). Is it not time for health economists to rethink equity and access? *Health Economics, Policy and Law*, Online 4/02/2009

<http://dx.doi.org/10.1017/S1744133109004848>

<http://pmid.us/19192324>

This article considers two key issues in health economics regarding the question of equity. First, why have health economists not resolved better the issue of what are equity and access? Second, the paper draws attention to the relative lack of analyses of equity concerns outside of health care. The question of whose values should prevail in equity is also addressed. On the first issue, there is an obsession with quantification in economics with the result that in analysing equity, in practice often has been substituted for . The problem of defining access has thereby been by-passed. This has taken the pressure off trying to research access per se. Second, what is meant by equity and access are in part culturally determined. The continued efforts of health economists to treat equity as some universal construct are misplaced. The lack of effort on the part of health economists to

look at equity more broadly than health care equity is concerning. Certainly, to be pursued in practice, equity in both health and health care need a shift in resources, which will be opposed by those who exercise power over decision making in health care and in society more generally. Currently health economists jury in Perth, Australia is used to exemplify this point. It is concluded that the often all too simplistic equity goals adopted in health economics (and sometimes public health discourse) need to be challenged. For health economists, there is a need for more of us to get involved in the issues around inequalities, class and power and the impact of these on health

Priest N (2009) et al Engaging policy makers in action on socially determined health inequities: developing evidence-informed cameos. *Evidence & Policy*, 5(1), 71-83.

<http://dx.doi.org/10.1332/174426409X395411>

This article describes an innovative knowledge translation project involving researchers and key stakeholders commissioned by the World Health Organization (WHO) for the Commission on Social Determinants of Health (CSDH). The project aimed to develop 'cameo' reports of evidence-based policies and interventions addressing social determinants of health, intended for use by leaders and advocates, as well as policy and programme decision makers, to advance global action. The iterative process of developing the framework and content of the cameos, in the context of a limited evidence base, is described, and a number of issues related to the integration of multiple sources of evidence for knowledge translation action are identified.

Smith,N.R., Kelly,Y.J., & Nazroo,J.Y. (2009). Intergenerational continuities of ethnic inequalities in general health in England. *Journal of Epidemiology and Community Health*, 63(3), 253-258.

<http://dx.doi.org/10.1136/jech.2008.077495>

<http://pmid.us/19074925>

Background: Previous research strongly suggests that ethnic minority groups are more likely to suffer a poorer health profile compared with the overall population, although it is not clear whether these inequalities persist over generations. This study aimed to establish the degree to which ethnic inequalities in health are transmitted from the first to the second generation, and to determine the extent to which intergenerational changes in socioeconomic status and health behaviours might explain any variation that exists. Methods: Data from the 1999 and 2004 Health Surveys for England assessed the prevalence of fair/poor general health across first (n = 4492) and second (n = 5729) generations of six ethnic minority populations. A white population was selected as reference (n = 18 407). The risk of fair/poor general health was estimated by applying logistic regression models and stepwise inclusion of demographic, socioeconomic and behavioural variables. Generational movement relative to the white baseline was assessed for all ethnic groups adjusted for age and sex. Results: No significant differences in levels

of reported fair/poor general health were observed between generations. After adjusting for improved socioeconomic position, the second generation became more likely to report worse health, whereas adjusting for differences in health behaviours had no effect. The Bangladeshi population showed significant intergenerational improvement in general health relative to the white reference, showing a reduction in the odds ratio (95% CI) from 2.75 (2.14 to 3.56) for the first generation to 1.58 (1.17 to 2.13) in the second generation. Conclusion: Ethnic minorities in England report consistent rates of fair/poor general health across generations, despite the health benefits resulting from upward social mobility. These health inequalities are unaffected by changes in health behaviours. Understanding these intergenerational pathways will have important public health policy implications as the migrant population not only ages, but also reproduces

Ward,P.R. (2009). The relevance of equity in health care for primary care: creating and sustaining a 'fair go, for a fair innings'. *Quality in Primary Care*, 17(1), 49-54.

<http://pmid.us/19281674>

This paper provides an 'equity lens' through which practitioners, policy makers and researchers can measure and monitor the equity of healthcare services provided. An argument is put forward which shows that services need to be assessed in terms of inequities, as opposed to the more often used terms of inequalities or disparities. This is not just a semantic argument, rather it is based on the foundations that service provision should be socially just. The paper then outlines some of the key domains involved in measuring the equity of health care - access, need and utilisation. The paper concludes with some of the reasons for the current equity problems in healthcare services and suggestions for ways forward in terms of developing more equitable healthcare services

MEDICINES MANAGEMENT

Fattore,G., et al Social network analysis in primary care: The impact of interactions on prescribing behaviour. *Health Policy*, Online 7/04/2009

<http://dx.doi.org/10.1016/j.healthpol.2009.03.005>

Objectives In many healthcare systems of affluent countries, general practitioners (GPs) are encouraged to work in collaborative arrangements to increase patients' accessibility and the quality of care. There are two lines of thought regarding the ways in which belonging to a network can affect GP behaviour: (1) the social capital framework posits that, through relationships, individuals acquire resources, such as information, that allow them to perform better; and (2) the social influence framework sees relationships as avenues through which individual actors influence other individuals and through which

behavioural norms are developed and enforced. The objective of this study is to provide an evaluation of the effects of GP network organisation on their prescribing behaviour. Methods We used administrative data from a Local Health Authority (LHA) in Italy concerning GPs organisation and prescriptions. Results We found that GPs working in a collaborative arrangement have a similar prescribing behaviour while we did not find a significant relationship between the centrality of a GP and her capability to meet LHA's targets. Conclusions Our data support the conclusion that, in the case of GP collaboration initiatives, the social influence mechanism is more relevant than the social capital mechanism

Millar, J., et al (2009). Does a system of instalment dispensing for newly prescribed medicines save NHS costs? Results from a feasibility study. *Family Practice* Advanced Access published online 6/01/2009

<http://dx.doi.org/10.1093/fampra/cmn100>

<http://pmid.us/19126830>

Background. In view of the increasing cost of general practice of drug prescribing, it is important to look at ways of reducing drug wastage and thereby improve the cost-effectiveness of prescribing. Objective. To determine the costs and cost savings to the NHS of instalment dispensing for newly prescribed medicines and to quantify the extra costs incurred by patients. Methods. Patients were randomized to receive either a normal (n = 103) or an instalment (n = 101) prescription. Results. The difference between prescribed and dispensed drug costs in the intervention group was {pound}0.98 per patient (95% confidence interval {pound}0.14- {pound}1.82), giving a 7% reduction in drug costs. The costs of the additional pharmacy time required to implement the intervention was calculated to be {pound}5.02 per patient. Conclusions. Introduction of a system of instalment dispensing produced savings in the general practice of drugs bill, but these were not large enough to offset additional costs for pharmacists

Sondergaard, J., et al (2009). Impact of pharmaceutical representative visits on GPs' drug preferences. *Family Practice* Online 8/03/2009

<http://dx.doi.org/10.1093/fampra/cmp010>.

<http://pmid.us/19273463>

Background. Pharmaceutical representative visits are believed to have substantial impact, but the effects on prescribing patterns have not been systematically evaluated. Objective. This study investigates how pharmaceutical sales representative visits influenced physicians' company-specific drug preferences and prevalence of steroid prescribing. Methods. Observational cohort study in Funen County, Denmark, including 165 general practices visited 832 times by pharmaceutical representatives and 54 080 patients treated with asthma drugs. Visits were conducted from 2001 to 2003. Our main outcome

measures were (i) company-specific drug preferences measured as the proportion of dispensings of the promoted drug among all dispensings of fixed combinations of inhaled corticosteroid and long-acting β_2 -agonists and (ii) the proportion of patients receiving repeated β_2 -agonist dispensings who were treated with inhaled steroids. Results. The first visit had a statistically significant effect on the GPs' drug preference in favour of the marketed drug [odds ratio (OR), 2.39; 95% confidence interval (CI), 1.72-3.32]. The effect on drug preference increased further after the second visit (OR, 1.51; 95% CI, 1.19-1.93), while there was no significant change after the third visit (OR, 1.06; 95% CI, 0.94-1.20). Pharmaceutical sales representative visits did not influence the overall treatment pattern with inhaled steroids (OR, 1.01; 95% CI, 0.97-1.06). Conclusions. Pharmaceutical sales representative visits markedly increased the market share of the promoted drug, but only the two first visits had significant impact. Visits had no significant impact on GPs' overall prescribing of inhaled steroids

MENTAL HEALTH

Beattie,A., Shaw,A., Kaur,S., & Kessler,D. (2009). Primary-care patients' expectations and experiences of online cognitive behavioural therapy for depression: a qualitative study. *Health Expectations* , 12(1), 45-59.

<http://dx.doi.org/10.1111/j.1369-7625.2008.00531.x>

<http://pmid.us/19250152>

Objective To explore expectations and experiences of online cognitive behavioural therapy (CBT) among primary-care patients with depression, focusing on how this mode of delivery impacts upon the therapeutic experience. **Design** Qualitative study, using repeat semi-structured interviews with patients before and after therapy. The study was conducted in parallel with a randomized controlled trial examining the effectiveness and cost-effectiveness of online CBT for patients with depression. **Participants** Twenty-four patients with depression recruited from five general practices in southwest England, who were offered up to 10 sessions of CBT, delivered via the internet by a psychologist. **Results** Most participants accessed the therapy from their home computer and found this to be a major advantage, in terms of convenience and fitting therapy into their daily routine, with any technical problems quickly resolved. Two key themes regarding expectations and experiences of online CBT were: developing a virtual relationship with a therapist, and the process of communicating thoughts and emotions via an online medium. Online CBT seems to be acceptable to, and experienced as helpful by, certain subgroups of patients with depression, particularly those who are familiar with computers, feel comfortable with writing their feelings down, enjoy the opportunities to review and reflect that written (or typed) communication offers are attracted to the 'anonymity' of an online therapeutic relationship and are open to the proactive requirements of CBT itself. However, on-line CBT may feed into the vulnerability of

depressed people to negative thoughts, given the absence of visual cues and the immediate response of face-to-face interaction. Conclusions Online CBT has the potential to enhance care for patients with depression who are open to engaging in 'talking' (or typing) therapies as part of their treatment. If online CBT is to be provided via the NHS, it is important to establish patient preferences regarding this mode of delivery and ensure that referral practices are appropriately targeted. The results of our main trial will provide evidence regarding the effectiveness and cost-effectiveness of receiving therapy via this modality

Cronin,E., et al (2009). A tale of two systems: perceptions of primary care for depression in London and Melbourne. *Family Practice* Online 5/03/2009

<http://dx.doi.org/10.1093/fampra/cmp017>

<http://pmid.us/19264839>

Background: Depression represents a major and growing disease burden. About 90% of depressed patients are treated solely in primary care, yet there are system-related barriers to primary care for people with depression in the UK and Australia, countries which have different health care arrangements. Objectives: The aim was to explore the views of GPs and patients in London and Melbourne about primary care system features which support or hinder best care for mild-to-moderate depression. The study differentiated between policy and reality 'on the ground'. Methods: Two round Delphi technique methodology with four panels: GPs and patients in London and GPs and patients in Melbourne, to elicit views on the extent to which system features were reflected in policy, reflected in reality and were of value for best care. Results: Four themes were generated: system and financing, responsibility and continuity, consultations and primary care team. Patient-centred care, having sufficient time during a consultation, and the GP-patient relationship extending over time were rated highly by all panels. Panellists differentiated between policy and reality on a number of features. Conclusions: The Australian system does not guarantee continuity of care with practitioner or practice but patients took steps to see the same doctor for depression. There was a difference in the way London and Melbourne panels responded to finance-related statements. There was a tendency for panellists to value aspects of their own system and to fail to see possibilities of other systems

Dowrick,C., et al (2009) Patients' and doctors' views on depression severity questionnaires incentivised in UK quality and outcomes framework: qualitative study. *BMJ*, 338 b663. Online 19/03/2009

<http://dx.doi.org/10.1136/bmj.b663>

<http://pmid.us/19299474>

Objective: To gain understanding of general practitioners' and patients' opinions of the routine introduction of standardised measures of severity of depression through the UK general practice quality and outcomes framework. Design: Semistructured qualitative interview study, with purposive sampling and constant comparative analysis. Participants: 34 general practitioners and 24 patients. Setting: 38 general practices in

three sites in England: Southampton, Liverpool, and Norfolk. Results: Patients generally favoured the measures of severity for depression, whereas general practitioners were generally cautious about the validity and utility of such measures and sceptical about the motives behind their introduction. Both general practitioners and patients considered that assessments of severity should be seen as one aspect of holistic care. General practitioners considered their practical wisdom and clinical judgment ("phronesis") to be more important than objective assessments and were concerned that the assessments reduced the human element of the consultation. Patients were more positive about the questionnaires, seeing them as an efficient and structured supplement to medical judgment and as evidence that general practitioners were taking their problems seriously through a full assessment. General practitioners and patients were aware of the potential for manipulation of indicators: for economic reasons for doctors and for patients to avoid stigma or achieve desired outcomes. Conclusions: Despite general practitioners' caution about measures of severity for depression, these may benefit primary care consultations by increasing patients' confidence that general practitioners are correct in their diagnosis and are making systematic efforts to assess and manage their mental health problems. Further education of primary care staff may optimise the use and interpretation of depression questionnaires

Harkness,E.F., & Bower,P.J. (2009). On-site mental health workers delivering psychological therapy and psychosocial interventions to patients in primary care: effects on the professional practice of primary care providers. *Cochrane Database Syst.Rev.*(1), CD000532.

<http://dx.doi.org/10.1002/14651858.CD000532.pub2>

<http://pmid.us/19160181>

Background: Mental health problems are common in primary care and mental health workers (MHWs) are increasingly working in this setting delivering psychological therapy and psychosocial interventions to patients. In addition to treating patients directly, the introduction of on-site MHWs represents an organisational change that may lead to changes in the clinical behaviour of primary care providers (PCPs). Objectives: To assess the effects of on-site MHWs delivering psychological therapy and psychosocial interventions in primary care on the clinical behaviour of primary care providers (PCPs). Search strategy: The following sources were searched in 1998: the Cochrane Effective Practice and Organisation of Care Group Specialised Register, the Cochrane Controlled Trials Register, MEDLINE, EMBASE, PsycINFO, Counsellit, NPCRDC skill-mix in primary care bibliography, and reference lists of articles. Additional searches were conducted in February 2007 using the following sources: MEDLINE, EMBASE, PsycINFO, CINAHL, and Cochrane Central Register of Clinical Trials (CENTRAL) (The Cochrane Library). Selection criteria: Randomised trials, controlled before and after studies, and interrupted time series analyses of MHWs working alongside PCPs in primary care settings. The outcomes included objective measures of PCP behaviours such as consultation rates, prescribing, and referral. DATA Collection and analysis: Two review authors independently extracted data and assessed study quality. Main results:

Forty-two studies were included in the review. There was evidence that MHWs caused significant reductions in PCP consultations (standardised mean difference -0.17, 95% CI -0.30 to -0.05), psychotropic prescribing (relative risk 0.67, 95% CI 0.56 to 0.79), prescribing costs (standardised mean difference -0.22, 95% CI -0.38 to -0.07), and rates of mental health referral (relative risk 0.13, 95% CI 0.09 to 0.20) for the patients they were seeing. In controlled before and after studies, the addition of MHWs to a practice did not affect prescribing behaviour towards the wider practice population and there was no consistent pattern to the impact on referrals in the wider patient population. Authors' conclusions: This review provides some evidence that MHWs working in primary care to deliver psychological therapy and psychosocial interventions cause a significant reduction in PCP behaviours such as consultations, prescribing, and referrals to specialist care. However, the changes are modest in magnitude, inconsistent, do not generalise to the wider patient population, and their clinical or economic significance is unclear

Haller, D.M., et al (2009). The identification of young people's emotional distress: a study in primary care. *British Journal of General Practice* 59(560), e61-e70.

<http://dx.doi.org/10.3399/bjgp09X419510>

<http://pmid.us/19275825>

Background: Primary care is a key step in young people's pathway to mental health care. Despite the high prevalence of mental disorder in this age group, little is known about the factors that determine the identification of young people's mental disorder in primary care. AIM: To provide a detailed description of the factors associated with both 'correct' and 'excessive' identification of youth mental disorder in primary care. Design of the study: Cross-sectional study. Setting: Twenty-six randomly selected general practices in Victoria, Australia. Method: Consecutive young people (16-24 years) were interviewed before their consultation, using a semi-structured interview. They completed Kessler's scale of emotional distress (K10). GPs completed a questionnaire after the consultation. Multinomial logistic regression was used to examine the factors associated with GP identification of mental disorder in those with high and low probability of disorder on the K10. Results: Altogether, 450/501 (90%) of approached young people participated; 36.1% (95% confidence interval [CI] = 32.3 to 40.2%) had high probability of mental disorder on the K10. Young people's perception that they had a mental illness was highly associated with GP identification (odds ratio [OR] = 62.6, 95% CI = 22.8 to 172.0). Other significantly associated factors were: patient fears (OR = 2.4, 95% CI = 1.1 to 5.1), frequent consultations (OR = 3.0, 95% CI = 1.0 to 8.4), days out of role (OR = 2.7, 95% CI = 1.2 to 5.7), and continuity of care (OR = 3.4, 95% CI = 1.6 to 6.9). The latter two were also associated with 'over-identification' of young people who had low probability of mental disorder. gp characteristics were not associated with identification. Conclusion: These findings provide guidance for GPs in their clinical work and training. They should also inform the further development of mental health literacy programmes in the community

Kendrick,T., et al (2009). Management of depression in UK general practice in relation to scores on depression severity questionnaires: analysis of medical record data. *BMJ*, 338 b750 Online 19/03/2009

<http://dx.doi.org/10.1136/bmj.b750>

<http://pmid.us/19299475>

Objective: To determine if general practitioner rates of antidepressant drug prescribing and referrals to specialist services for depression vary in line with patients' scores on depression severity questionnaires. DESIGN: Analysis of anonymised medical record data. Setting: 38 general practices in three sites-Southampton, Liverpool, and Norfolk. Data reviewed Records for 2294 patients assessed with severity questionnaires for depression between April 2006 and March 2007 inclusive. Main outcome measures: Rates of prescribing of antidepressants and referrals to specialist mental health or social services. Results: 1658 patients were assessed with the 9 item patient health questionnaire (PHQ-9), 584 with the depression subscale of the hospital anxiety and depression scale (HADS), and 52 with the Beck depression inventory, 2nd edition (BDI-II). Overall, 79.1% of patients assessed with either PHQ-9 or HADS received a prescription for an antidepressant, and 22.8% were referred to specialist services. Prescriptions and referrals were significantly associated with higher severity scores. However, overall rates of treatment and referral were similar for patients assessed with either measure despite the fact that, with PHQ-9, 83.5% of patients were classified as moderately to severely depressed and in need of treatment, whereas only 55.6% of patients were so classified with HADS. Rates of treatment were lower for older patients and for patients with comorbid physical illness (including coronary heart disease and diabetes) despite the fact that screening for depression among such patients is encouraged in the quality and outcomes framework. Conclusions General practitioners do not decide on drug treatment or referral for depression on the basis of questionnaire scores alone, but also take account of other factors such as age and physical illness. The two most widely used severity questionnaires perform inconsistently in practice, suggesting that changing the recommended threshold scores for intervention might make the measures more valid, more consistent with practitioners' clinical judgment, and more acceptable to practitioners as a way of classifying patients

Koopmans,B., et al . (2009). Depressive symptoms are associated with physical inactivity in patients with type 2 diabetes. The DIAZOB Primary Care Diabetes study. *Family Practice* Online 25/03/2009

<http://dx.doi.org/10.1093/fampra/cmp016>.

<http://pmid.us/19321598>

Background. Depression is a common complication of type 2 diabetes, associated with poor disease outcomes such as impaired glycaemic control, cardiovascular disease and increased mortality. The mechanisms behind these associations are unclear. Depression might contribute to poor disease outcomes through decreased physical activity. Objective.

To test whether type 2 diabetes patients with elevated depression scores are more often physically inactive. Methods. Demographic features, clinical factors, level of physical inactivity and depressive symptoms were assessed in 2646 primary care patients with type 2 diabetes. Sequential multiple logistic regression analyses [odds ratio, 95% confidence interval (CI)] were performed to test the association between depressive symptoms and physical inactivity. Results. About 48% of the respondents were physically inactive. Elevated depressive symptoms were found in 14% of the respondents. After adjustment for potential confounders, the odds for being physically inactive were almost doubled in depressed patients with type 2 diabetes 1.74 (95% CI 1.32-2.31). Conclusions. Presence of depressive symptoms almost doubles the likelihood of physical inactivity in patients with type 2 diabetes. Longitudinal studies are needed to investigate whether physical inactivity forms the link between depression and poor disease outcomes

Lindamer,L., et al (2009). Establishing an implementation network: lessons learned from community-based participatory research. *Implementation Science*, 4(1), 17. Online 31/03/2009

<http://dx.doi.org/10.1186/1748-5908-4-17>

<http://www.implementationscience.com/content/4/1/17>

<http://pmid.us/19335915>

Background :Implementation of evidence-based mental health assessment and intervention in community public health practice is a high priority for multiple stakeholders. Academic-community partnerships can assist in the translation of efficacious treatments into community settings; yet, little is known about the processes by which these collaborations are developed. In this paper, we discuss our application of community-based participatory research (CBPR) approach to implementation and present six lessons we have learned from the establishment of an academic-community partnership. Methods: With older adults with psychosis as a focus, we have developed a partnership between a university research center and a public mental health service system based on CBPR. The long-term goal of the partnership is to collaboratively establish an evidence-based implementation network that is sustainable within the public mental healthcare system. Results: In building a sustainable partnership, we found that the following lessons were instrumental: changing attitudes; sharing staff; expecting obstacles and formalizing solutions; monitoring and evaluating; adapting and adjusting; taking advantage of emerging opportunities. Some of these lessons were previously known principles that were modified as the result of the CBPR process, while some lessons derived directly from the interactive process of forming the partnership. Conclusions: The process of forming of academic-public partnerships is challenging and time consuming, yet crucial for the development and implementation of state-of-the-art approaches to assessment and interventions to improve the functioning and quality of life for persons with serious mental illnesses. These partnerships provide necessary organizational support to facilitate the translation of clinical research into community practice benefiting consumers, researchers, and providers

Mavaddat,N., Lester,H.E., & Tait,L. (2009). Development of a patient experience questionnaire for primary care mental health. *Quality and Safety in Health Care*, 18(2), 147-152.

<http://dx.doi.org/10.1136/qshc.2007.023143>

<http://pmid.us/19342531>

Introduction: There are no validated measures available for use in assessing patients' views of the quality of primary care mental healthcare at practice level. Methods: The Patient Experience Questionnaire was developed through an initial information-gathering phase with focus groups followed by questionnaire development and validation with patients in nine general practices in the West Midlands. Statistical analyses were performed to test the internal consistency, validity and reliability of the questionnaire. Results: Fifty-six patients participated in focus groups, and 241 patients completed the questionnaire. The 20-item questionnaire had good internal consistency (Cronbach alpha = 0.94) and test-retest reliability ($r = 0.859$; $p = 0.01$). Discussion: The Patient Experience Questionnaire appears to be a valid and reliable instrument, able to assess patients' views of the quality of primary care mental healthcare at practice level

Menchetti, M., et al (2009). Recognition and treatment of depression in primary care: Effect of patients' presentation and frequency of consultation. *Journal of Psychosomatic Research* 66(4), 335-341.

<http://dx.doi.org/10.1016/j.jpsychores.2008.10.008>

<http://pmid.us/19302892>

Objective: Primary care physicians (PCPs) are expected to recognize depression and appropriately prescribe antidepressants. This article investigated the single and combined effects of different patient presentations and frequency of visits on detection and antidepressant use. Methods: Data came from an Italian nationwide survey on depressive disorders in primary care, involving 191 PCPs and 1910 attenders. Two hundred fifty patients suffering from major or subthreshold depression were compared in relation to their presentation (psychological, physical, and pain) and frequency of visits (low and high). Results: Recognition of depression significantly varied according to both presentation and frequency of visits. When compared to patients with psychological complaints, the odds ratios for nonrecognition of depression were higher for patients presenting with physical symptoms [2.3; 95% confidence interval (CI)=1.1-5.3] and with pain (4.1; 95% CI=1.6-9.9). Subjects who rarely attended the practice were 2.3 times less likely to receive a diagnosis of depression, compared with those having a high frequency of visits (95% CI=1.2-4.6). Similarly, patients presenting with physical symptoms or with pain and those with a low frequency of visits were rarely treated with antidepressants.

The combination of physical or pain presentation with low frequency of visits further increased the risk for nonrecognition, which was sixfold that of the reference category. Conclusions: Some subgroups of depressed patients still run a high risk of having their depression unrecognized by the PCP. Screening for depression among patients presenting with pain might be useful in order to improve recognition and management

Patten,S., et al (2009). The effect of major depression on participation in preventive health care activities. *BMC Public Health*, 9(1), 87.

<http://dx.doi.org/10.1186/1471-2458-9-87>

<http://www.biomedcentral.com/1471-2458/9/87>

<http://pmid.us/19320983>

Background: The objective of this study was to determine whether major depressive episodes (MDE) contribute to a lower rate of participation in three prevention activities: blood pressure checks, mammograms and Pap tests. Methods: The data source for this study was the Canadian National Population Health Survey (NPHS), a longitudinal study that started in 1994 and has subsequently re-interviewed its participants every two years. The NPHS included a short form version of the Composite International Diagnostic Interview (CIDI-SF) to assess past year MDE and also collected data on participation in preventive activities. Initially, we examined whether respondents with MDE in a particular year were less likely to participate in screening during that same year. In order to assess whether MDE negatively altered the pattern of participation, those successfully screened at the baseline interview in 1994 were identified and divided into cohorts depending on their MDE status. Proportional hazard models were used to quantify the effect of MDE on subsequent participation in screening. Results :No effect of MDE on participation in the three preventive activities was identified either in the cross-sectional or longitudinal analysis. Adjustment for a set of relevant covariates did not alter this result. Conclusions: Whereas MDE might be expected to reduce the frequency of participation in screening activities, no evidence for this was found in the current analysis. Since people with MDE may contact the health system more frequently, this may offset any tendency of the illness itself to reduce participation in screening

Pilgrim,D., Rogers,A., & Bentall,R. (2009). The centrality of personal relationships in the creation and amelioration of mental health problems: the current interdisciplinary case. *Health (London)*, 13(2), 235-254.

<http://dx.doi.org/10.1177/1363459308099686>

<http://pmid.us/19228830>

An interdisciplinary case is made for the centrality of personal relationships in the creation and amelioration of mental health problems. Taking the work of John Bowlby as a starting point, the article summarizes accumulating evidence from the past 50 years about the link between childhood adversity and adult mental health problems. Evidence is also reviewed about contemporary interpersonal impacts on adult mental health from

natural social settings and in professional therapy. These empirical summaries are then discussed in the context of dominant trends in professional knowledge about bio-determinism within psychiatry and the emphasis upon models and techniques in professional and political advocates of the psychological therapies. It is concluded that the latter trends are diverting us from policies, which properly concede the importance of relationships for improving the mental health of the population

Pontin,E., et al (2009). Enhanced relapse prevention for bipolar disorder: a qualitative investigation of value perceived for service users and care coordinators. *Implementation Science* 4 4.

<http://dx.doi.org/10.1186/1748-5908-4-4>

<http://www.implementationscience.com/content/4/1/4>

<http://pmid.us/19203373>

Background: Enhanced relapse prevention (ERP) is a psychological intervention delivered by mental health professionals to help individuals with bipolar disorder (BD) recognise and manage early warning signs for mania and depression. ERP has an emerging evidence base and is recommended as good practice for mental health professionals. However, without highly perceived value to both those receiving (services users) or delivering it (health professionals), implementation will not occur. The aim of this study is to determine what values of ERP are perceived by service users (SUs) and mental health professionals (care coordinators, CCs) providing community case management. Methods: A nested qualitative study design was employed as part of a randomised controlled trial of ERP. Semi-structured interviews were conducted with a purposive sub-sample of 21 CCs and 21 SUs, and an iterative approach used to develop a framework of conceptual categories that was applied systematically to the data. Results: The process of implementing and receiving ERP was valued by both SUs and CCs for three similar sets of reasons: improved understanding of BD (where a knowledge deficit of BD was perceived), enhanced working relationships, and improved ways of managing the condition. There were some differences in the implications these had for both CCs and SUs who also held some reservations. Conclusion: CCs and SUs perceive similar value in early warning signs interventions to prevent relapse, and these have particular benefits to them. If this perceived value is maintained, CCs and SUs in routine practice may use ERP long-term

Raue,P.J., et al. (2009). Patients' depression treatment preferences and initiation, adherence, and outcome: a randomized primary care study. *Psychiatric Services*, 60(3), 337-343.

<http://dx.doi.org/10.1176/appi.ps.60.3.337>

<http://pmid.us/19252046>

Objective: The authors examined the association of treatment preferences with treatment initiation, adherence, and clinical outcome among nonsenior adult and senior primary care patients with depression. Methods: Sixty primary care participants meeting DSM-IV criteria for major depression were randomly assigned to receive treatment congruent or incongruent with their primary stated preference. Participants received either 20 weeks of escitalopram, with monitoring by a care manager, or 12 weekly sessions of interpersonal psychotherapy followed by two monthly booster sessions. Adherence to treatment and depression severity were reassessed at weeks 4, 8, 12, and 24. Results: Participants expressed stronger preferences for psychotherapy than for antidepressant medication. Preference strength was a more sensitive measure of outcome than was congruence versus incongruence of preference with the assigned treatment. Across age groups, preference strength was significantly associated with treatment initiation and 12-week adherence rate but not with depression severity or remission. Conclusions: A continuous measure of preference strength may be a more useful measure in clinical practice than preferences per se. Future research should focus on whether and how greater facilitation of the treatment decision-making process between patient and clinician influences clinical outcome

Roca,M., et al . (2009). Prevalence and comorbidity of common mental disorders in primary care. *Journal of Affective Disorders* Online 9/04/2009

<http://dx.doi.org/10.1016/j.jad.2009.03.014>

<http://pmid.us/19361865>

Objective: To estimate the prevalence and comorbidity of the most common mental disorders in primary care practice in Spain, using the Primary Care Evaluation of Mental Disorders (PRIME-MD) questionnaire. Design: A systematic sample of 7936 adult primary care patients was recruited by 1925 general practitioners in a large cross-sectional national epidemiological study. The PRIME-MD was used to diagnose psychiatric disorders. Setting: 1356 primary care units proportionally distributed throughout the country. RESULTS: 53.6% of the sample presented one or more psychiatric disorder. The most prevalent were affective (35.8%), anxiety (25.6%), and somatoform (28.8%) disorders. 30.3% of the patients had more than one current mental disorder. 11.5% presented comorbidity between affective, anxiety, and somatoform disorders. Conclusions: The study provides further evidence of the high prevalence and high comorbidity of mental disorders in primary care. Given the large overlap between affective, anxiety and somatoform disorders, future diagnostic classifications should reconsider the current separation between these entities

Wierdsma,A., Mulder,C., de,V.S., & Sytema,S. (2009). Reconstructing continuity of care in mental health services: a multilevel conceptual framework. *Journal of Health Services Research and Policy*, 14(1), 52-57.

<http://dx.doi.org/10.1258/jhsrp.2008.008039>

<http://pmid.us/19103917>

Continuity of mental health care is a key issue in the organization and evaluation of services for patients with disabling chronic conditions. Over many years, health services researchers have been exploring the conceptual boundaries between continuity of care and other service characteristics. On the basis of papers published over the past decade, we argue that while conceptual consensus is growing, there is room to improve continuity measures, and the development of practical interventions is still at an early stage. There is growing consensus that continuity of care is a multidimensional concept. We identified four core elements: continuous care; care of an individual patient; cross-boundary care; and care recorded objectively. These elements help clarify conceptual boundaries, and incorporate measurement guidelines. With reference to these core elements, we define types of continuity of care, including informational continuity, management continuity, relational continuity and contact continuity. In order to improve continuity of care, better understanding is needed of the complex inter-relationship of core elements and types of continuity. A multilevel perspective on continuity of care can guide research to develop and evaluate new interventions. Achieving continuity of care is hindered by the lack of standard measures and administrative data appropriate to assessing continuity. Account should be taken not only of the nature of the patient population, but also of local conditions. To address these topics and identify best practices, research should be multidisciplinary and take a comparative, naturalistic form

ORGANISATIONS

Edmonstone,J. (2008) Clinical leadership: the elephant in the room. *International Journal of Health Planning and Management* Online 4/9/2008

<http://dx.doi.org/10.1002/hpm.959>

<http://pmid.us/18770874>

The article explores the concept of clinical leadership in the National Health Service in the UK by seeking to establish a workable definition and by contrasting it with managerial leadership, focussing on the 'disconnected hierarchy' in professional organizations. It proposes that the problems faced by clinical leadership relate to the current nature of general management in the NHS and concludes by suggesting that clinical leadership is the 'elephant in the room'-often ignored or unaddressed.

Hughes,D., & Vincent-Jones,P. (2008). Schisms in the church: National Health Service systems and institutional divergence in England and Wales. *Journal of Health and Social Behavior*, 49(4), 400-416.

<http://pmid.us/19181046>

Since devolution, the four countries of the United Kingdom have pursued strikingly different National Health Service (NHS) reforms. While England created a supply-side market more radical than the previous internal market system, Wales moved to a softer version of the purchaser/provider split emphasizing localism. This article deploys institutional theory to analyze the forces shaping change, and describes the hybrid forms of economic organization emerging, including the economic regulation model implemented in England. The schism that has resulted in separate NHS subsystems warrants a different analysis from the more familiar phenomenon of infield divergence. We argue that schism was triggered by political-regulatory influences rather than economic or other social institutional forces, and predict that other decentralized public health care systems may follow a similar path. While political-regulatory, normative, and cognitive institutional influences push in the same direction in Wales, the misalignment of political-regulatory and normative elements in England looks set to result in a period of organizational turbulence

Schmidt, H.. (2009). Personal responsibility in the NHS Constitution and the social determinants of health approach: competitive or complementary? *Health Economics, Policy and Law*, Online 9/03/2009

<http://dx.doi.org/10.1017/S1744133109004976>

<http://pmid.us/19267958>

The final report of the World Health Organization's (WHO) Commission on Social Determinants of Health (CSDH), *Closing the gap in a generation: Health equity through action on the social determinants of health*, was published in August 2008 (CSDH, 2008; Marmot et al., 2008). Welcoming the document on behalf of WHO, Director-General Margaret Chan noted: "the Commission's main finding is straightforward: the conditions in which people are born, live, and work are the single most important determinant of good health, or ill health; of a long and productive life, or a short and miserable one" (Chan, 2008). The report presents an excellent overview and analysis of the range of structural factors that influence individual and population health, and makes a number of practical recommendations that seek to ensure that avoidable health inequalities are levelled out, so that everyone has an equal opportunity of leading a healthy life. Roughly around the time of publication of the CSDH report, and in the 60th anniversary year of the NHS, the UK Department of Health (DH) held a consultation on a draft NHS Constitution. The document aimed to set out the NHS' fundamental values and principles and included a range of individual rights of NHS users, detailing also their responsibilities. A final version of the constitution was published in January 2009 (DH, 2009). Given the CSDH's emphasis on the primary role of the social determinants of health (CSDH, 2007, 2008), what should we make of the DH's initiative to introduce, for the first time in NHS history, explicit health-related responsibilities for individuals? Why talk about individual responsibility if yet further evidence has been produced that demonstrates the importance of environmental factors? For those sympathetic to the social determinants of health (SDH) approach, there seem to be three principal types of

response: (i) to reject the DH's move; (ii) to agree that it makes some sense, but to argue that it should nonetheless be abandoned for other reasons; or (iii) to accept it as an approach that, in principle, is capable of complementing the aims of the SDH approach

PATIENT AND PUBLIC INVOLVEMENT

Learmonth,M., Martin,G.P., & Warwick,P. (2009). Ordinary and effective: the Catch-22 in managing the public voice in health care? *Health Expectations*, 12(1), 106-115.

<http://dx.doi.org/10.1111/j.1369-7625.2008.00529.x>

<http://pmid.us/19250156>

Introduction: Joseph Heller's Catch-22 is regularly invoked to critique the irrationality inherent in supposedly rational bureaucracy. We explore a Catch-22 for policy concerning public involvement in English health care: you have to be ordinary to represent the community effectively, but, if you are ordinary, you cannot effectively represent your community. The nature of public participation groups: Starting with community health councils, we trace government policy about involving local people in health care, up to the current arrangements for local involvement networks and show how the above Catch-22 works. We do this in two principal ways. First, by an analysis of some of the unrecognized paradoxes in current government policies designed to populate health-care participation groups and second, by providing a series of narrative vignettes, drawn from our own experiences of working in such groups, which illustrate the nature of the dilemmas members face. Conclusions: Our proposal to get out of the worst of the Catch-22 for effective public involvement groups is (paradoxically) to suggest focusing less on effectiveness, or more precisely, focusing less on those conventional, managerially defined notions of effectiveness that are now pretty much taken for granted within public services. This is because, if bodies like LINKs are to do more than provide unthreatening, homogenous and tokenistic public perspectives, they need to be given space and time to pursue their own agendas

Lee,S.K., Thompson,S.C., & Morin-Woods,D. (2009). One service, many voices: enhancing consumer participation in a primary health service for multicultural women. *Quality in Primary Care*, 17(1), 63-69.

<http://pmid.us/19281676>

Background: Consumer participation in primary health care is important in providing quality consumer-focused care, but challenging when working with disadvantaged groups of diverse cultural and linguistic backgrounds. Women's Health Services (WHS) works with women from over 60 different nationalities, including many newly arrived migrants and refugees. New arrivals access a wide range of WHS programmes including medical

services, counselling, information, community talks and workshops, referral, and outreach, but few ethnic women attended the alcohol and other drug (AOD) services offered by the organisation. AIM: To establish an active consumer reference group to assist understanding and reducing the barriers to AOD services for a heterogeneous disadvantaged group that includes individuals from different cultural, language and educational backgrounds. Results: Leaning heavily on experiences from the mental health field, WHS overcame many practical and philosophical considerations which included: agreeing upon the purpose of the group and how it would operate within the structure of the organisation; the level of English language required by participants for the group to function; issues of resourcing the group; and ensuring an appropriate, workable demographic mix in terms of age, language, and migration experiences. Conclusion: The process and the outcome of establishing a consumer reference group (CRG) in a primary healthcare setting has been valuable for consumers' and health service providers within the organization

Smith,E., et al (2009) Getting ready for user involvement in a systematic review. *Health Expectations* Published online 20/02/2009

<http://dx.doi.org/10.1111/j.1369-7625.2009.00535.x>

<http://pmid.us/19236632>

Objective This paper aims to support the critical development of user involvement in systematic reviews by explaining some of the theoretical, ethical and practical issues entailed in 'getting ready' for user involvement. **Background** Relatively few health or social care systematic reviews have actively involved service users. Evidence from other research contexts shows that user involvement can have benefits in terms of improved quality and outcomes, hence there is a need to test out different approaches in order to realize the benefits of user involvement and gain a greater understanding of any negative outcomes. **Design** Setting up a service-user reference group for a review of user involvement in nursing, midwifery and health visiting research involved conceptualizing user involvement, developing a representation framework, identifying and targeting service users and creating a sense of mutuality and reciprocity. **Setting and participants** Recruitment was undertaken across England by two researchers. Members from 24 national consumer organizations were selected to participate in the review. **Main variables studied** Learning was gained about finding ways of navigating consumer networks and organizations, how best to communicate our goals and intentions and how to manage selection and 'rejection' in circumstances where we had stimulated enthusiasm. **Results and conclusions** Involving service users helped us to access information, locate the findings in issues that are important to service users and to disseminate findings. User involvement is about relationships in social contexts: decisions made at the early conceptual level of research design affect service users and researchers in complex and personal ways

PRIMARY/SECONDARY CARE INTERFACE

Berendensen A, & et al (2009). Transition of care: experiences and preferences of patients across the primary / secondary interface - a qualitative study. *BMC Health Services Research*, 9:(62).

<http://dx.doi.org/10.1186/1472-6963-9-62>

<http://www.biomedcentral.com/1472-6963/9/62/abstract>

Background Coordination between care providers of different disciplines is essential to improve the quality of care, in particular for patients with chronic diseases. The way in which general practitioners (GP's) and medical specialists interact has important implications for any healthcare system in which the GP plays the role of gatekeeper to specialist care. Patient experiences and preferences have proven to be increasingly important in discussing healthcare policy. The Dutch government initiated the development of a special website with information for patients on performance indicators of hospitals as well as information on illness or treatment. In the present study we focus on the transition of care at the primary - secondary interface with reference to the impact of patients' ability to make choices about their secondary care providers. The purpose of this study is to (a) explore experiences and preferences of patients regarding the transition between primary and secondary care, (b) study informational resources on illness/treatment desired by patients and (c) determine how information supplied could make it easier for the patient to choose between different options for care (hospital or specialist). **Methods** We conducted a qualitative study using semi-structured focus group interviews among 71 patients referred for various indications in the north and west of The Netherlands. **Results** Patients find it important that they do not have to wait, that they are taken seriously, and receive adequate and individually relevant information. A lack of continuity from secondary to primary care was experienced. The patient's desire for free choice of type of care did not arise in any of the focus groups. **Conclusion** Hospital discharge information needs to be improved. The interval between discharge from specialist care and the report of the specialist to the GP might be a suitable performance indicator in healthcare. Patients want to receive information, tailored to their own situation. The need for information, however, is quite variable. Patients do not feel strongly about self-chosen healthcare, contrary to what administrators presently believe.

Jiwa,M., et al (2009). What is the importance of the referral letter in the patient journey? A pilot survey in Western Australia. *Quality in Primary Care*, 17(1), 31-36.

<http://pmid.us/19281672>

Background: Access to specialists is mediated by general practitioners in many countries. In these settings, specialists rely on information in referral letters when deciding which cases to schedule for their clinics. Method: Two-hundred and seven consecutive referral letters to gastroenterologists were scored for the amount of information relayed to the specialist, using a published schedule. The 'quality' scores for these referral letters were compared for four groups of patients: patients diagnosed with histological lesion, those with no histological lesion, those who failed to attend clinic, or those who had a diagnosis unknown. Forty-two referral letters were generated with a range of quality scores. Four gastroenterologists were asked to identify which letters described patients 'likely' to have a significant or benign colorectal condition, and whether they could triage the cases for their clinic given only the information in the letters. Results: It was not possible to differentiate which letters related to patients in each of the four categories ($P = 0.6$). Patients who failed to attend were more symptomatic than those with a histological lesion (35.4 versus 28.2, mean difference 7.14, 95% confidence interval (CI) 14.1 to 0.15, $P = 0.045$). Patients referred 'urgently' were not, on the basis of the referral letters, the most symptomatic group (29.7 versus 27, mean difference 2.7, 95% CI -3.4 to 8.8, $P = 0.38$). The specialists failed to agree on the proportion of cases that could be triaged for their clinics. The cases that could be triaged contained more information (mean 66.38 versus 49.86, mean difference 16, 95% CI 1.3-31.7, $P < 0.001$). Conclusion: There was no evidence for an association between the amount of information relayed and the diagnosis of a histological lesion. However, more information was helpful when deciding which patients to schedule first. By corollary, patients referred with lesser documentation of their clinical presentation may be denied 'urgent' access to the gastroenterology clinic

Sheaff,R., et al (2009). Impacts of case management for frail elderly people: a qualitative study. *Journal of Health Services Research and Policy*, 14(2), 88-95.

<http://dx.doi.org/10.1258/jhsrp.2008.007142>

<http://pmid.us/19299262>

Objective: To assess the impacts of different forms of case management for people aged over 65 years at risk of unplanned hospital admission, in particular the impacts upon patients, carers and health service organization in English primary care; and, in these respects, compare the Evercare model with alternatives. Methods: Multiple qualitative case studies comparing case management in nine English Primary Care Trusts which piloted the Evercare model of case management and four sites which implemented alternative forms of case management between 2003 and 2005. Data were obtained from 231 interviews with patients, carers and other key informants, and from content analysis of documents and observation of meetings. Results: All the projects established functioning case management services, but none led to major service reorganization or savings elsewhere in the health care system. Many informants reported examples of admissions which case management had prevented, but overall hospital admissions did not significantly change, possibly due to increased case-finding. Patients and carers

valued case management for improving access to health care, increasing psychosocial support and improving communication with health professionals. Conclusion: Case management was highly valued by patients and their carers, but there were few major differences in outcomes between Evercare and other models

Valderas,J.M., et al (2009). Ambulatory care provided by office-based specialists in the United States. *Annals of Family Medicine*, 7 (2), 104-111.

<http://dx.doi.org/10.1370/afm.949>

<http://pmid.us/19273864>

Purpose Increasing use of specialist services in the United States is leading to a perception of a specialist shortage. Little is known, however, about the nature of care provided by this secondary level of services. The aim of this study was to examine the content of care provided by specialists in community settings, including visits for which the patient had been referred by another physician. Methods Nationally representative visit data were obtained from the National Ambulatory Medical Care Survey (NAMCS) for the years 2002 through 2004. To describe the nature of care, we developed a taxonomy of office-based visit types and constructed logistic regression models allowing for adjusted comparisons of specialty types. Results Overall, 46.3% of visits were for routine follow-up and preventive care of patients already known to the specialist. Referrals accounted for only 30.4% of all visits. Specialists were more likely to report sharing care with other physicians for referred, compared with not referred, patients (odds ratio [OR] = 2.99; 95% confidence interval [CI], 2.52-3.55). Overall, 73.6% of all visits resulted in a return appointment with the same physician, in more than one-half of all cases as a result of a routine or preventive care visit. Conclusions Ambulatory office-based activity of specialists includes a large share of routine and preventive care for patients already known, not referred, to the physician. It is likely that many of these services could be managed in primary care settings, lessening demand for specialists and improving coordination of care

QUALITY

Atlas,S.J., et al (2009). Patient-physician connectedness and quality of primary care. *Annals of Internal Medicine* 150(5), 325-335.

<http://pmid.us/19258560>

Background: Valid measurement of physician performance requires accurate identification of patients for whom a physician is responsible. Among all patients seen by a physician, some will be more strongly connected to their physician than others, but the effect of connectedness on measures of physician performance is not known. Objective: To determine whether patient-physician connectedness affects measures of clinical performance. Design: Population-based cohort study. Setting: Academic network of 4

community health centers and 9 hospital-affiliated primary care practices. Patients: 155 590 adults with 1 or more visits to a study practice from 2003 to 2005. Measurements: A validated algorithm was used to connect patients to either 1 of 181 physicians or 1 of 13 practices in which they received most of their care. Performance measures included breast, cervical, and colorectal cancer screening in eligible patients; hemoglobin A(1c) measurement and control in patients with diabetes; and low-density lipoprotein cholesterol measurement and control in patients with diabetes and coronary artery disease. Results: Overall, 92 315 patients (59.3%) were connected to a specific physician, whereas 53 669 patients (34.5%) were connected only to a specific practice and 9606 patients (6.2%) could not be connected to a physician or practice. The proportion of patients in a practice who could be connected to a physician varied markedly (45.6% to 71.2% of patients per practice; $P < 0.001$). Physician-connected patients were significantly more likely than practice-connected patients to receive guideline-consistent care (for example, adjusted mammography rates were 78.1% vs. 65.9% [$P < 0.001$] and adjusted hemoglobin A(1c) rates were 90.3% vs. 74.9% [$P < 0.001$]). Receipt of preventive care varied more by whether patients were more or less connected to a physician than by race or ethnicity. Limitation: Patient-physician connectedness was assessed in 1 primary care network. Conclusion: Patients seen in primary care practices seem to be variably connected with a specific physician, and less connected patients are less likely to receive guideline-consistent care.

Biderman,A., et al (2009). Treatment satisfaction of diabetic patients: what are the contributing factors? *Family Practice* Advanced Access published online 2/03/2009

<http://dx.doi.org/10.1093/fampra/cmp007>

<http://pmid.us/19254969>

Background. Treatment satisfaction is an important factor of quality of care, especially in treating chronic diseases such as diabetes mellitus. Identifying factors that independently influence treatment satisfaction may help in improving clinical outcomes. Objective. To find the relationship between treatment satisfaction of diabetic patients and socio-demographic, clinical, adherence, treatment and health perception factors. Methods. Patients were interviewed by telephone about their socio-demographic parameters, health status, clinical data and treatment factors. The Diabetes Treatment Satisfaction Questionnaire (DTSQ) was used to measure satisfaction and adherence. This is a cross-sectional study, as part of a larger study of chronic patients in Israel. Subjects were randomly selected diabetes patients. The main outcome measures were DTSQ levels. A multivariate linear regression model was constructed to identify factors independently associated with patients' satisfaction. Results. In all, 630 patients were included in the study. Multivariate analysis indicated that demographic parameters (e.g. female gender, $P = 0.036$), treatment factors (e.g. type of medication, $P < 0.001$), adherence factors (e.g. difficulty attending follow-up or taking medications, $P < 0.001$) and clinical factors (e.g. diabetes complications, $P < 0.01$) were independently associated with lower treatment satisfaction. Conclusions. Treatment satisfaction is lower among diabetic patients who have a lower educational level, who are insulin treated or have a diabetic complication

and is related to difficulties in taking medications and coming to follow-up visits. Addressing the specific needs of these patients might be effective in improving their satisfaction, thus having a positive influence on other clinical outcomes

DeVoe, J.E., Wallace, L.S., & Fryer, G.E., Jr. (2009). Measuring patients' perceptions of communication with healthcare providers: do differences in demographic and socioeconomic characteristics matter? *Health Expectations*, 12(1), 70-80

<http://dx.doi.org/10.1111/j.1369-7625.2008.00516.x>

<http://pmid.us/19250153>

Background: National governments across the globe have set goals to improve healthcare delivery. Understanding patient-provider communication is essential for the development of policies that measure how well a healthcare system delivers care. Objectives: This study was designed to determine which, if any, demographic factors were independently associated with how US patients perceive various aspects of communication with their healthcare providers. Design and methods: The study was a secondary, cross-sectional analysis of nationally representative data from the 2002 Medical Expenditure Panel Survey (MEPS). Among US adults with a healthcare visit in the past year (n = approximately 16,700), we assessed the association between several covariate demographic and socioeconomic factors and four dependent measures of patient perceptions of communication with their healthcare providers. Results: Across all four measures of communication, older patients were more likely to report positively. Having health insurance and a usual source of care were consistent predictors of positive perceptions of communication. Hispanic patients also reported better perceptions of communication across all four measures. The most economically disadvantaged patients were less likely to report that providers always explained things so that they understood. Male patients were more likely to report that providers always spent enough time with them. Conclusions: This study suggests that patient perceptions of communication in healthcare settings vary widely by demographics and other individual patient characteristics. In this paper, we discuss the relevance of these communication disparities to design policies to improve healthcare systems, both at the individual practice level and the national level

Edwards, M., Davies, M., & Edwards, A. (2009). What are the external influences on information exchange and shared decision-making in healthcare consultations: A meta-synthesis of the literature. *Patient Education and Counseling* 75(1), 37-52.

<http://dx.doi.org/10.1016/j.pec.2008.09.025>

<http://pmid.us/19036550>

Objective: To review the literature to identify external influences on information exchange and shared decision-making in healthcare consultations and conceptualise how information is used both outside and within a consultation. Methods: A 'meta-study' approach (meta-data-analysis, meta-theory, meta-method, and meta-synthesis) was used

to locate, review, synthesise and summarise the findings, methodology, theoretical orientation and interpretation of qualitative research papers. Results: In a model of external influences on information exchange within healthcare consultations, practitioner influences were: receptiveness to informed patients and patient choice, lack of knowledge of cultural difference, patient centredness vs. stereotyping. Patient influences were: motivation to seek and engage with information; the appraisal of information before a consultation, expression of cultural identity, and ways of managing the risk of poor information. Shared influences were: differing illness notions, role expectations and language. Empowerment, disempowerment and non-empowerment were outcomes of information exchange and health literacy was a mediator of external influences and empowerment. Conclusion: This meta-study provides a conceptualisation of external influences on information exchange in shared decision-making where health literacy mediates patient related influences and is also an influence on empowerment. Practice implications: Our model can inform the development of interventions aimed at improving information exchange and shared decision-making, potentially contributing to more equitable healthcare encounters

Grytten,J., Carlsen,F., & Skau,I. (2009). Services production and patient satisfaction in primary care. *Health Policy*, 89(3), 312-321.

<http://dx.doi.org/10.1016/j.healthpol.2008.06.006>

<http://pmid.us/18656276>

Context The institutional setting for the study was the primary physician service in Norway, where there is a regular general practitioner scheme. Each inhabitant has a statutory right to be registered with a regular general practitioner. There are large differences between physicians in service production.**Objective** We studied whether difference in services production between physicians has an effect on how satisfied patients are with the services that are provided.**Methodology** Data about patient satisfaction were obtained from a survey of a representative sample of the population. We obtained data about how satisfied the respondents were with: waiting time to get an appointment, amount of time the physician spent with them, and to what extent they perceived that the physician took their medical problems seriously. The survey data were merged with data on service production for the primary physician that the respondent was registered with. Service production was measured as the number of consultations per person on the list.**Results** There was a positive and relatively strong association between the level of service production of the general practitioners and patient satisfaction with waiting time for a consultation. There was no association between the level of service production and the two other measures of patient satisfaction.**Conclusion** The results provide evidence about one of several factors that should be taken into account when deciding on future health manpower policies with respect to primary physician services in Norway

Haskard, K.B., DiMatteo, M.R., & Heritage, J. (2009). Affective and instrumental communication in primary care interactions: predicting the satisfaction of nursing staff and patients. *Health Communication*, 24(1), 21-32.

<http://dx.doi.org/10.1080/10410230802606968>

<http://pmid.us/19204855>

Verbal and nonverbal communication between nursing staff and patients has received scant research attention. This study examined patients' and nursing staff members' global affective and instrumental communication, mutual influence, and relationship to postvisit satisfaction. This study employed ratings of videotaped primary care visits of 81 nursing staff members with 235 patients, and assessed communication in 2 channels: nonverbal visual and speech including vocal tone. Communication channel differences and prediction of patient satisfaction were examined. The visual and vocal communication of nursing staff members and patients robustly predicted each other's satisfaction and reflected their own satisfaction with the dyadic visit. Affect was communicated more clearly through the speech with vocal tone channel, whereas instrumental communication was stronger in visual nonverbal behavior. Patients' and nursing staff members' behaviors of pleasantness and involvement frequently co-occurred

Lown, B.A., Hanson, J.L., & Clark, W.D. (2009). Mutual influence in shared decision making: a collaborative study of patients and physicians. *Health Expectations* Published online 20/02/2009

<http://dx.doi.org/10.1111/j.1369-7625.2008.00525.x>

<http://pmid.us/19236633>

Objective To explore how patients and physicians describe attitudes and behaviours that facilitate shared decision making. **Background** Studies have described physician behaviours in shared decision making, explored decision aids for informing patients and queried whether patients and physicians want to share decisions. Little attention has been paid to patients' behaviours that facilitate shared decision making or to the influence of patients and physicians on each other during this process. **Methods** Qualitative analysis of data from four research work groups, each composed of patients with chronic conditions and primary care physicians. **Results** Eighty-five patients and physicians identified six categories of paired physician/patient themes, including act in a relational way; explore/express patient's feelings and preferences; discuss information and options; seek information, support and advice; share control and negotiate a decision; and patients act on their own behalf and physicians act on behalf of the patient. Similar attitudes and behaviours were described for both patients and physicians. Participants described a dynamic process in which patients and physicians influence each other throughout shared decision making. **Conclusions** This study is unique in that clinicians and patients collaboratively defined and described attitudes and behaviours that facilitate shared decision making and expand previous descriptions, particularly of patient attitudes and behaviours that facilitate shared decision making. Study participants described relational,

contextual and affective behaviours and attitudes for both patients and physicians, and explicitly discussed sharing control and negotiation. The complementary, interactive behaviours described in the themes for both patients and physicians illustrate mutual influence of patients and physicians on each other

Pearce,C et al (2009). Contributions from the lifeworld: quality, caring and the general practice nurse. *Quality in Primary Care*, 17(1), 5-13.

<http://pmid.us/19281669>

Introduction: Enhancing quality and safety in primary health systems is of central importance to funders, practitioners, policy makers and consumers. In this paper we explore the roles of general practice nurses in relation to quality and safety. Method: Cross-sectional multimethod study of 25 Australian general practices. Using rapid appraisal we collected data for each practice from interviews with practice nurses, general practitioners and practice managers; photographs of nurse-identified 'key workspaces'; structured observation of nurses for two one-hour sessions; and floor plans. Results: Quality was articulated in two domains, reflecting both external and intrinsic determinants. External determinants included a large number of essentially structural, procedural or regulatory processes, the most marked of these being practice accreditation and occupational health and safety; these corresponded to the Habermasian idea of system. Intrinsic determinants related mostly to nurse perception of their own quality behaviour, and consisted of ways and means to improve or optimise patient care; these correspond to Habermas' notion of the lifeworld. Discussion: Nurses describe a productive tension between the regulatory roles that they play in general practices, and patient-focused care, contrary to Habermas' suggestion that system subsumes lifeworld. Current funding systems often fail to recognise the importance of the particular elements of nurse contributions to quality and safety in primary care

Ridd,M., et al (2009). The patient-doctor relationship: a synthesis of the qualitative literature on patients' perspectives. *British Journal of General Practice* 59(561), e116-e133.

<http://dx.doi.org/10.3399/bjgp09X420248>

<http://pmid.us/19341547>

Background: The patient-doctor relationship is an important but poorly defined topic. In order to comprehensively assess its significance for patient care, a clearer understanding of the concept is required. Aim: To derive a conceptual framework of the factors that define patient-doctor relationships from the perspective of patients. Design of study: Systematic review and thematic synthesis of qualitative studies. Method: Medline, EMBASE, PsychINFO and Web of Science databases were searched. Studies were screened for relevance and appraised for quality. The findings were synthesised using a thematic approach. RESULTS: From 1985 abstracts, 11 studies from four countries were included in the final synthesis. They examined the patient-doctor relationship generally (n = 3), or in terms of loyalty (n = 3), personal care (n = 2), trust (n = 2), and continuity (n =

1). Longitudinal care (seeing the same doctor) and consultation experiences (patients' encounters with the doctor) were found to be the main processes by which patient-doctor relationships are promoted. The resulting depth of patient-doctor relationship comprises four main elements: knowledge, trust, loyalty, and regard. These elements have doctor and patient aspects to them, which may be reciprocally related. Conclusion: A framework is proposed that distinguishes between dynamic factors that develop or maintain the relationship, and characteristics that constitute an ongoing depth of relationship. Having identified the different elements involved, future research should examine for associations between longitudinal care, consultation experiences, and depth of patient-doctor relationship, and, in turn, their significance for patient care

Salisbury, C. et al (2009). How should continuity of care in primary health care be assessed? *British Journal of General Practice* 59(561), e134-e141.

<http://dx.doi.org/10.3399/bjgp09X420257>

<http://pmid.us/19341548>

Recent changes in the organisation of primary health care have increased the range of professionals that patients may encounter, leading to renewed interest in the importance of continuity of care. To assess whether organisational changes have had an impact on continuity, it is necessary to define and measure the term. Researchers seeking to assess continuity face many conceptual and practical difficulties. This article argues that it is important to distinguish between three distinct but related concepts: longitudinal continuity from a minimum number of health professionals, caring relationships between patients and professionals, and well-coordinated care between professionals. An evaluation of Advanced Access as a case study is used to illustrate how researchers need to make several value judgements in operationalising longitudinal continuity. These include whether continuity should be measured from the perspective of patient, doctor, or healthcare system, the types of professionals and consultations that should be considered, the time period to be assessed, the measure to be used, and also practical considerations about data collection. It is argued that decisions about these issues should be based on an underlying hypothesis about why continuity may be important in the particular context. Distinguishing between longitudinal continuity, patient-professional relationships, and coordinated care makes it possible to examine interactions between these different concepts, and to examine relationships with outcomes such as patient satisfaction and quality of care. It will also give greater clarity to debates about whether new models of primary care reduce continuity

Solberg, L.I., et al (2009). How can primary care cross the quality chasm? *Annals of Family Medicine* 7(2), 164-169.

<http://dx.doi.org/10.1370/afm.951>

<http://pmid.us/19273872>

The chasm between knowledge and practice decried by the Institute of Medicine (IOM) is the result of other chasms that have not been addressed. They include the chasm between what we know and what we need to know to improve care; the chasm between those who provide primary care and those who do not fund, study, support, or publish practical primary care studies; and the chasm between research and quality improvement (QI). These chasms are a result of problematic concepts, attitudes, traditions, time frames, and financing approaches among the various participants. If we are to facilitate the production and use of the knowledge needed for primary care to cross IOM's chasm, major changes are needed. These changes include the following: (1) admission by all primary care professions that we have quality problems that require our unified attention and action; (2) conversion of the paradigm from "translate research into practice" to "optimizing health and health care through research and QI"; (3) development and facilitation of more partnerships among clinicians, researchers, and care delivery leaders for engaged scholarship in both research and QI; (4) modification of the agendas and methods of funders and researchers so they emphasize the problems of patients and patient care and support practical time frames and research designs; and (5) facilitation by funders and journals of the dissemination and implementation of lessons from QI and practical research

Stolper, E., et al (2009). The diagnostic role of gut feelings in general practice A focus group study of the concept and its determinants. *BMC Family Practice*, 10(1), 17.

<http://dx.doi.org/10.1186/1471-2296-10-17>

<http://www.biomedcentral.com/1471-2296/10/17/abstract>

<http://pmid.us/19226455>

Background: General practitioners sometimes base clinical decisions on gut feelings alone, even though there is little evidence of their diagnostic and prognostic value in daily practice. Research into these aspects and the use of the concept in medical education require a practical and valid description of gut feelings. The goal of our study was therefore to describe the concept of gut feelings in general practice and to identify their main determinants. Methods: Qualitative research including 4 focus group discussions. A heterogeneous sample of 28 GPs. Text analysis of the focus group discussions, using a grounded theory approach. Results: Gut feelings are familiar to most GPs in the Netherlands and play a substantial role in their everyday routine. The participants distinguished two types of gut feelings, a sense of reassurance and a sense of alarm. In the former case, a GP is sure about prognosis and therapy, although they may not always have a clear diagnosis in mind. A sense of alarm means that a GP has the feeling that something is wrong even though objective arguments are lacking. GPs in the focus groups experienced gut feelings as a compass in situations of uncertainty and the majority of GPs trusted this guide. We identified the main determinants of gut feelings:

fitting, alerting and interfering factors, sensation, contextual knowledge, medical education, experience and personality. Conclusion: The role of gut feelings in general practice has become much clearer, but we need more research into the contributions of individual determinants and into the test properties of gut feelings to make the concept suitable for medical education

Tung, Y.C., & Chang, G.M. (2009). Patient satisfaction with and recommendation of a primary care provider: associations of perceived quality and patient education. *International Journal of Quality in Health Care* Online 2/03/2009

<http://dx.doi.org/10.1093/intqhc/mzp006>

<http://pmid.us/19258342>

Objective: To identify whether attributes of perceived clinic quality and patient education are associated with patient satisfaction and recommendation of a primary care provider. Design: Data used in this study were obtained through a national telephone survey by random sampling. Setting: Clinics throughout Taiwan. Participants: A total of 1910 patients. Main outcome measures: Overall patient satisfaction and recommendation were measured by single item questions. Attributes of clinic quality were measured using 11 items: doctor's technical skill (four items), doctor's interpersonal skill (three items), staff care and access (four items). Patient education was measured on the basis of education provided on disease prevention and control during the visit. Results: With regard to clinic quality, doctor's technical skill was most related to overall satisfaction and recommendation, followed by doctor's interpersonal skill. Staff care and access were associated with overall satisfaction but were not associated with recommendation. Patient education was related to both overall satisfaction and recommendation. Conclusion: Doctor's technical skill is the most critical attribute of primary care quality for both overall satisfaction and recommendation, followed by doctor's interpersonal skill. Staff care and access are associated with improved overall satisfaction but not related to increasing the likelihood of recommending a clinic to relatives and friends. Doctor's technical and interpersonal skills rather than staff care and access can be the essence of quality competition in the primary care market. Providing patient education during the visit on how to prevent or control diseases may also relate to improved patient satisfaction and recommendation

Wynne-Jones, G., et al (2008). Rates of sickness certification in European primary care: A systematic review. *The European Journal of General Practice*, 14(3), 99-108.

<http://dx.doi.org/10.1080/13814780802687521>

<http://pmid.us/19153887>

General practitioners (GPs) are responsible for assessing a patient's capacity for work and issuing a sickness certificate, enabling a patient to receive statutory sick pay and take time away from the workplace. The management of sickness absence across Europe varies considerably, and there is a need for comparable rates of certification to facilitate

appropriate health and economic planning. *Objective:* To systematically review the literature reporting rates of sickness certification in general practice settings. *Methods:* Electronic databases were searched from their inception to November 2007. Inclusion criteria were reporting a measure of sickness certification, conducted in European primary care. *Results:* 298 citations were identified from the literature search, of which 11 met the inclusion criteria. These studies demonstrated that the rates of sickness certification are not routinely recorded. The certified rates were subject to wide variation, ranging from 18 per 100 person years in Norway to 239 per 100 person years in Malta. *Conclusion:* There is large variability in sickness certification policy and hence sickness certification rates across Europe. A system that enables comparisons across countries would be beneficial in ensuring health and economic planning. To enable a baseline rate of certification to be established and compared across countries, standardized reporting of sickness certification is needed

RESEARCH AND DEVELOPMENT

Draper,H., et al (2009) Offering payments, reimbursement and incentives to patients and family doctors to encourage participation in research. *Family Practice Advanced Access* published online 3/03/2009

<http://dx.doi.org/10.1093/fampra/cmp011>

<http://pmid.us/19261621>

Sometimes researchers fail to meet their recruitment targets, and sometimes it is predicted that recruitment may prove difficult but it is not obvious what ethical latitude researchers have to boost participation by, for instance, paying participants to take part or by paying family doctors to recruit patients to participate. In this paper, we distinguish between payment, reimbursement and inducement. We look first at the ethics of paying research participants. We conclude that payment raises all kinds of ethical difficulties, but that reimbursement--whilst not completely unproblematic--is an ethical requirement. We then look at whether some inducement to participate is acceptable and conclude that it is. We continue by asking whether the same arguments can be applied to encouraging family doctors to recruit patients. We conclude that it is right for family doctors to be reimbursed for the costs of recruiting research participants and also argue that there are fewer problems with paying family doctors to recruit patients than there are with paying research participants. Given, however, that there is a fine line between reimbursement and payment, given the potential for conflicts of interests to arise, and given that even suspicion of such a conflict might undermine trust in doctors, systems of both payment and reimbursement need to be transparent

Eccles,M., et al (2009). An implementation research agenda. *Implementation Science*, 4(1), 18. Online 7/04/2009

<http://dx.doi.org/10.1186/1748-5908-4-18>

<http://www.implementationscience.com/content/4/1/18>

<http://pmid.us/19351400>

In October 2006, the Chief Medical Officer (CMO) of England asked Professor Sir John Tooke to chair a High Level Group on Clinical Effectiveness in response to the chapter 'Waste not, want not' in the CMOs 2005 annual report 'On the State of the Public Health'. The high level group made recommendations to the CMO to address possible ways forward to improve clinical effectiveness in the UK National Health Service (NHS) and promote clinical engagement to deliver this. The report contained a short section on research needs that emerged from the process of writing the report, but in order to more fully identify the relevant research agenda Professor Sir John Tooke asked Professor Martin Eccles to convene an expert group -- the Clinical Effectiveness Research Agenda Group (CERAG) -- to define the research agenda. The CERAG's terms of reference were 'to further elaborate the research agenda in relation to pursuing clinically effective practice within the (UK) National Health Service'. This editorial presents the summary of the CERAG report and recommendations

Goodyear-Smith,F., York,D., Petousis-Harris,H., Turner,N., Copp,J., Kerse,N., & Grant,C. (2009). Recruitment of practices in primary care research: the long and the short of it. *Family Practice Online* 27/02/2009

<http://dx.doi.org/10.1093/fampra/cmp015>

<http://pmid.us/19251761>

Objective: To determine factors that facilitated or hindered recruitment of general practices into a large New Zealand primary care project that aimed to determine general practice characteristics of immunization coverage. Methods: The project had a multi-level recruitment strategy requiring recruitment of randomly selected practices before randomly selecting GPs, practice nurses and caregivers of children enrolled at those practices. Detailed quantitative and qualitative recruitment data were recorded on an access database. Post-recruitment, recruiters underwent semi-structured interviews. Analysis was mixed method, with triangulation of descriptive statistics of the number of calls and time course to recruitment and general inductive thematic analysis of qualitative data. Results: Identifying key decision makers and how individual practice processes work can save significant recruitment time. Factors identified as assisting practice recruitment included using a personal approach from doctor to doctor, getting buy-in from all practice staff, streamlining the research process to minimize disruption to the practice and flexibility to accommodate practices. Conclusions: The task of recruiting should not be underestimated. Adequate time and resource need to be allocated from the onset. Long periods where practices have no added burdens such as audits, mass

vaccination programmes or influenza season are unlikely, therefore there are always considerable challenges in recruiting practices for research. Remaining flexible to individual practice styles and influences and acknowledging the commitment of participants is important

Graffy, J., et al (2009) UK research staff perspectives on improving recruitment and retention to primary care research; nominal group exercise. *Family Practice* 26(1), 48-55.

<http://dx.doi.org/10.1093/fampra/cmn085>

<http://pmid.us/19011173>

Background: Primary care studies often encounter recruitment difficulties, but there is little evidence to inform solutions. As part of a National Institute for Health Research School for Primary Care Research and UK Clinical Research Network programme, we elicited research staff perspectives on factors facilitating or obstructing recruitment. Objective: To identify factors that experienced research staff consider important in successful recruitment and retention and their confidence in achieving them. Methods: An iterative series of three workshops was held. The third used a modified nominal group technique to categorize whether factors related to the 'context' in which the research took place, the 'content' of the study or the recruitment 'process' and to prioritize them by their importance to success. Results: Eighteen research staff participated in the prioritization workshop. They prioritized positive attitudes of primary care staff towards research and trust of researchers by potential participants as major contextual factors affecting recruitment. Studies needed to be considered safe and relevant by staff and fit with practice systems. They proposed that researchers strengthen relationships with staff and participants and minimize workload for primary care teams. Although confident in many recruitment processes, respondents remained uncertain how to achieve cultural change so that research became part of normal practice activity and how best to motivate patients to participate. Conclusions: Research workers taking part identified factors which might be important in recruitment, several of which they expressed little confidence in addressing. Understanding how to improve recruitment is crucial if current efforts to strengthen primary care research are to bear fruit

Hildebrandt,M., Vervoelgyi,E., & Bender,R. (2009). Calculation of NNTs in RCTs with time-to-event outcomes: A literature review. *BMC Medical Research Methodology*, 9(1), 21.

<http://dx.doi.org/10.1186/1471-2288-9-21>

<http://www.biomedcentral.com/1471-2288/9/21/abstract>

<http://pmid.us/19302699>

Background: The number needed to treat (NNT) is a well-known effect measure for reporting the results of clinical trials. In the case of time-to-event outcomes, the calculation of NNTs is more difficult than in the case of binary data. The frequency of

using NNTs to report results of randomised controlled trials (RCT) investigating time-to-event outcomes and the adequacy of the applied calculation methods are unknown. Methods: We searched in PubMed for RCTs with parallel group design and individual randomisation, published in four frequently cited journals between 2003 and 2005. We evaluated the type of outcome, the frequency of reporting NNTs with corresponding confidence intervals, and assessed the adequacy of the methods used to calculate NNTs in the case of time-to-event outcomes. Results: The search resulted in 734 eligible RCTs. Of these, 373 RCTs investigated time-to-event outcomes and 361 analyzed binary data. In total, 62 articles reported NNTs (34 articles with time-to-event outcomes, 28 articles with binary outcomes). Of the 34 articles reporting NNTs derived from time-to-event outcomes, only 17 applied an appropriate calculation method. Of the 62 articles reporting NNTs, only 21 articles presented corresponding confidence intervals. Conclusions: The NNT is used as effect measure to present the results from RCTs with binary and time-to-event outcomes in the current medical literature. In the case of time-to-event data incorrect methods were frequently applied. Confidence intervals for NNTs were given in one third of the NNT reporting articles only. In summary, there is much room for improvement in the application of NNTs to present results of RCTs, especially where the outcome is time to an event

Kothari A, McClean L, & Edwards N (2009). Increasing capacity for knowledge translation: understanding how some researchers engage policy makers. *Evidence & Policy*, 5(1), 33-51.

<http://dx.doi.org/10.1332/174426409X395402>

The potential for research to influence policy, and for researchers to influence policy actors, is significant. The purpose of this qualitative study was to explore the experiences of health services researchers engaging in (or not able to engage in) policy-relevant research. Semistructured telephone interviews were completed with 23 experienced researchers. The results paint a complex and dynamic picture of the policy environment and the relationship between government officials and academic researchers. Elements of this complexity included diverse understandings of the nature of policy and how research relates to policy; dealing with multiple stakeholders in the policy-making process; and identifying strategies to manage the different cultures of government and academia.

Mitchell,P., et al (2009). Partnerships for knowledge exchange in health services research, policy and practice. *Journal of Health Services Research and Policy*, 14(2), 104-111.

<http://dx.doi.org/10.1258/jhsrp.2008.008091>

<http://pmid.us/19299264>

Within the health services research community there is a growing strength of feeling that ongoing partnerships between researchers and decision-makers are critically important to effective transfer and exchange of knowledge generated from health services research. A

body of literature is emerging around this idea that favours a particular model of partnership based on decision-maker involvement in research. This model is also gaining favour among health research funding bodies internationally. We argue that it is premature for the health services community to privilege any particular model of partnership between researchers and decision-makers. Rather a diversity of models should be conceptualized, explored in theory and practice, and evaluated. We identify seven dimensions that could be used to describe and differentiate models of partnerships for knowledge exchange and illustrate how these dimensions could be applied to analysing partnerships, using three case studies from recent and ongoing health services research partnerships in Australia

Noble,S., et al (2009). Feasibility and cost of obtaining informed consent for essential review of medical records in large-scale health services research. *Journal of Health Services Research and Policy*, 14(2), 77-81.

<http://dx.doi.org/10.1258/jhsrp.2008.008085>

<http://pmid.us/19299260>

Objective: To evaluate the effectiveness and cost of obtaining consent for review of medical records within the passively observed non-intervention arm of a cluster randomized controlled trial, 'Comparison Arm for ProtecT'. Methods: Two hundred and thirty men, who had been notified to the trial by cancer registries as having prostate cancer, were sent a consent form from their general practitioner or secondary care clinician. The consent rate of participants to the review of their medical records and the estimated costs of the process were evaluated. Results: One hundred and seventy-nine men (84%: 95% CI = 78%, 89%) consented to have their medical notes reviewed at an estimated cost of pound123 (euro172, \$248) per person. Conclusions: A high consent rate for review of medical notes is achievable but at a cost. There needs to be renewed debate about the automatic need for consent to review medical records where the chance of personal harm is negligible and the purpose of the review is to provide robust evidence to save lives, prevent needless suffering, and improve the effectiveness and efficiency of health care delivery

Norfolk,T., & Siriwardena,A.N. (2009). A unifying theory of clinical practice: Relationship, Diagnostics, Management and professionalism (RDM-p). *Quality in Primary Care*, 17(1), 37-47.

<http://pmid.us/19281673>

This discussion paper puts forward a unifying theory of clinical practice using three core performance areas of relationship, diagnostics and management, underpinned by professionalism. The model is described, explained and applied to current frameworks for selection, curriculum and assessment. The model is currently being used as a diagnostic tool for defining, exploring and explaining clinically related behaviour in general practice and across a range of hospital specialties, in particular with doctors whose performance has been a cause for concern. There is potential to further apply, develop and research the

model in other clinical areas, in non-clinical groups working in health care or other client-based environments

Sarre,G., & Cooke,J. (2008). Developing indicators for measuring Research Capacity Development in primary care organizations: a consensus approach using a nominal group technique. *Health and Social Care in the Community*. Online 14/11/2008

<http://dx.doi.org/10.1111/j.1365-2524.2008.00821.x>

<http://pmid.us/19040697>

Research Capacity Development (RCD) in the National Health Service supports the production of evidence for decision-making in policy and practice. This study aimed to establish a level of consensus on a range of indicators to measure research capacity in primary care organizations. Indicators were developed in a two-stage process using workshops and modified nominal group technique. In 2005, workshops were used to generate possible indicators from a wide range of research active and research-interested people. A theoretical framework of six principles of RCD was used to explore and identify indicators. Data were thematically coded, and a 129-item, 9-point Likert scale questionnaire was developed. A purposive sample of nine experts in developing research capacity in primary care agreed to take part in a nominal group in April 2006. The questionnaire was circulated prior to the meeting, and analysis of the responses formed the basis for structured discussion. Participants were then asked to rescore the questionnaire. Only seven participants were able to take part in the discussion and rescore stages. Data were analysed in two ways: level of relevance attributed to each indicator as a measure of organizational RCD, represented by median responses (medians of 7-9 defined strong support, 4-6 indicated moderate support and 1-3 indicated weak support), and level of consensus reached by the group. Consensus was reached if 85% of the group rated an indicator within the same band. Eighty-nine (68%) indicators were ranked as strongly relevant, and for seventy-three of these indicators, a consensus was reached. The study was successful in generating a set of agreed indicators considered relevant for measuring RCD in primary care organizations. These will form the basis of a pilot tool kit to assist primary care organizations to develop research capacity. Further work will explore the applicability of the indicators in practice

Spaar, A., et al (2009). Recruitment barriers in a randomized controlled trial from the physicians' perspective û A postal survey. *BMC Medical Research Methodology*, 9(1), 14.

<http://dx.doi.org/10.1186/1471-2288-9-14>

<http://www.biomedcentral.com/1471-2288/9/14>

<http://pmid.us/19254374>

Background: The feasibility of randomized trials often depends on successful patient recruitment. Although numerous recruitment barriers have been identified it is unclear which of them complicate recruitment most. Also, most surveys have focused on the patients' perspective of recruitment barriers whereas the perspective of recruiting physicians has received less attention. Therefore, our aim was to conduct a postal survey among recruiting physicians of a multi-center trial to weigh barriers according to their impact on recruitment. Methods: We identified any potential recruitment barriers from the literature and from our own experience with a multi-center trial of respiratory rehabilitation in patients with chronic obstructive pulmonary disease. We developed and pilot-tested a self-administered questionnaire where recruiting physicians were asked to express their agreement with statements about recruitment barriers on a Likert-type scale from 1 (full agreement with statement = very substantial recruitment barrier) to 7 (no agreement with statement = no recruitment barrier). Results: 38 of 55 recruiting physicians returned questionnaires (69% response rate), of which 35 could be analyzed (64% useable response rate). Recruiting physicians reported that "time constraints" (median agreement of 3, interquartile range 2-5) had the most negative impact on recruitment followed by "difficulties including identifying eligible patients" (median agreement of 5, IQR 3-6). Other barriers such as "trial design barriers", "lack of access to treatment", "individual barriers of recruiting physicians" or "insufficient training of recruiting physicians" were perceived to have little or no impact on patient recruitment. Conclusion: Physicians perceived time constraints as the most relevant recruitment barrier in a randomized trial. To overcome recruitment barriers interventions, that are affordable for both industry- and investigator-driven trials, need to be developed and tested in randomized trials.

Williams I, & et al (2009). Clinical microsystems and the NHS: A sustainable method for improvement? *Journal of Health Organization and Management*, 23(1), 119-132.

<http://dx.doi.org/10.1108/14777260910942597>

Purpose - The purpose of this paper is to evaluate the claims made for the clinical microsystems approach of healthcare improvement within an English NHS context. Design/methodology/approach - The research adopted a Realistic Evaluation approach to examine a series of pilot clinical microsystems sites to determine what worked for whom, when and within what circumstances. Interviews and group discussions were used to collect qualitative data, whilst quantitative outcome data was also collected within each of the sites. Data was triangulated to produce case studies for each of the sites. Findings - The research concurred with many of the claims for clinical microsystems, particularly that democratic, consensual approaches to change and improvement can be better received than externally derived initiatives with imposed targets. The clinical microsystem approach emphasises identifying and nurturing strengths - of both teams and individuals - and this reinforced these positive aspects. The case study sites demonstrated higher staff morale, empowerment, commitment and clarity of purpose. To a lesser extent the research also indicated an enhanced predisposition towards improvement and innovation and a seemingly embedded sense of improvement as an ongoing (if essentially

episodic) process. Research limitations/implications - The evaluation was limited in terms of the numbers of case study sites that it was able to incorporate. This sample represented sites of different sizes, coverage of primary, secondary and tertiary care and those reporting more and less positive experiences of the clinical microsystems approach - but any findings may be limited in their generaliseability and further studies may be needed to test out the relevance of these findings in wider settings. Practical implications - Future microsystem programmes will need to address components of patient involvement and process/outcome monitoring if the broader legitimacy of the approach is to be cemented and enhanced. In particular, the importance of strong data collection in achieving "high performing" status is emphasised. Originality/value - There is currently no other empirical studies within the academic literature which investigate the value of the clinical microsystems approach to an English NHS context.

SELF CARE

Berzins, K et al . (2009). UK self-care support initiatives for older patients with long-term conditions: a review. *Chronic Illness*, 5(1), 56-72.

<http://dx.doi.org/10.1177/1742395309102886>

<http://pmid.us/19276226>

Objectives: Supporting self-care for people with long-term conditions is an aim of UK health policy. As many with long-term conditions are older it is of interest to explore which self-care support interventions have positive impacts for this group. This review explores what types of intervention have been reported in the UK and their impact upon older people. Methods: Studies were identified using existing reviews, electronic databases and through hand searching journals. After inclusion and exclusion criteria were applied data were extracted from 18 studies. These were summarized in a narrative synthesis supported by summary tables. Results: All studies described interventions to support self-care, many targeted at people with arthritis. All used patient education, usually delivered to groups by a range of professionals. The majority of studies reported some significant positive outcomes, most frequently changes in physical functioning, illness knowledge and increased self-efficacy. The average age of participants was 60. Discussion: This review shows that self-care interventions have had positive effects for older participants but it remains unknown how best to support self-care in participants over 75, a group of people with long-term conditions who may have different needs

Blenkinsopp,A., et al (2006). Joining Up Self-Care: evaluation of a PCT-wide programme of support for self-care. *Primary Health Care Research & Development*, (-1), 1-15.

<http://dx.doi.org/10.1017/S1463423608000984>

Background and Aim Although there is existing activity within the NHS and local communities to support self-care there has been no previous attempt at integration across a Primary Care Trust (PCT). The Joining Up Self-Care (JUSC) study aimed to implement and evaluate such a programme. **Methods** Three self-care support modules for members of the public, together with a training course for primary care teams, were developed with, and implemented in, one PCT. The modules related to disease prevention (community-based coronary heart disease (CHD) prevention), care of people with long-term conditions (a disease-specific self-care skills training course for asthma) and the management of minor ailments aimed at mothers of children aged 3 months to 12 years (the 'Pharmacy First' service plus information booklets and campaigns). Postal questionnaires were completed by participants in CHD prevention (178), management of asthma (76) and minor ailments management (92), and by controls. A general population survey ($n = 540$) provided a comparison group for the CHD module and assessed general awareness of local self-care support. Four focus groups were held with mothers of young children. An audit of general practitioner (GP) records was conducted for consultations for minor ailments. Structured telephone interviews were conducted with 51 local health professionals and nine members of staff from the PCT. **Results** Participants in the CHD module reported significantly more risk-reducing behaviours. Participants in a disease-specific Expert Patient Programme (EPP) for people with asthma rated the course positively, were subsequently more confident about discussing asthma with their doctor and had fewer concerns about their asthma medicines. Most users of the 'Pharmacy First' minor ailments scheme reported positive feedback and an intent to use the service again in the future. There were no significant differences in numbers of GP consultations for minor ailments between intervention and control groups. Health professionals were generally positive about encouraging self-care. Many felt they were already doing this but had insufficient time to implement it. A Local Enhanced Service (LES) was successful in engaging local general practices with self-care. Some organizational development relating to self-care occurred within the PCT but integration across different directorates was not achieved. **Conclusions** The JUSC programme was associated with changes in self-reported CHD risk reduction behaviours, in confidence to manage asthma and fewer concerns about medication, and with more positive attitudes towards consulting a pharmacist for minor ailments. Key principles for future PCT self-care strategies were identified. Further work is needed to embed support for self-care across the PCT as an organization.

Collins,M.M., et al (2009). Self-care coping strategies in people with diabetes: a qualitative exploratory study. *BMC Endocrine Disorders* , 9(1), 6.

<http://dx.doi.org/10.1186/1472-6823-9-6>

<http://www.biomedcentral.com/1472-6823/9/6>

<http://pmid.us/19232113>

Background: The management of diabetes self-care is largely the responsibility of the patient. With more emphasis on the prevention of complications, adherence to diabetes self-care regimens can be difficult. There is a limited understanding of how patients with diabetes cope with the burden of self-care. This study will explore patient perceptions of diabetes self-care, with particular reference to the burden of self-care and coping strategies among patients. Methods: A maximum variation sample of 17 patients was selected from GP practices and diabetes clinics in Ireland to include patients with types 1 and 2 diabetes, various self-care regimens, and a range of diabetes complications. Data were collected by in-depth interviews; which were tape-recorded and transcribed. The transcripts were analysed using open and axial coding procedures to identify main categories, and were reviewed by an independent corroborator. Discussion of the results is made in the theoretical context of the health belief, social learning, and locus of control (LOC) frameworks. Results: Patients' perceptions of their self-care varied on a spectrum, displaying differences in self-care responsibilities such as competence with dietary planning, testing blood sugar and regular exercise. Three "ideal" patient types could be distinguished, which were labeled: "reactive manager," a patient who independently monitors blood glucose and adjusts his/her self-care regime to maintain metabolic control; "passive follower," a patient who follows his/her prescribed self-care regime, but does not react autonomously to changes in metabolic control; and "nonconformist," a patient who does not follow most of his/her prescribed self-care regimen. Conclusions: Patients have different diabetes self-care coping strategies which are influenced by their self-care health value and consequently may affect their diet and exercise choices, frequency of blood glucose monitoring, and compliance with prescribed medication regimens. Particular attention should be paid to the patient's self-care coping strategy, and self-care protocols should be tailored to complement the different "ideal" patient types

Dewalt,D.A., et al (2009). Goal setting in diabetes self-management: Taking the baby steps to success. *Patient.Education and Counseling Online* 7/04/2009

<http://dx.doi.org/10.1016/j.pec.2009.03.012>

<http://pmid.us/19359123>

Objective: To evaluate the usefulness of a diabetes self-management guide and a brief counseling intervention in helping patients set and achieve their behavioral goals. Methods: We conducted a quasi-experimental study using a one group pretest posttest design to assess the effectiveness of a goal setting intervention along with a self-management guide. English- and Spanish-speaking patients with diabetes had one in-person session and two telephone follow-up calls with a non-clinical provider over a 12-16-week period. At each call and at the end of the study, we assessed success in achieving behavioral goals and problem solving toward those goals. Satisfaction with the self-management guide was assessed at the end of the study. Results: We enrolled 250

patients across three sites and 229 patients completed the study. Most patients chose to set goals in diet and exercise domains. 93% of patients achieved at least one behavioral goal during the study and 73% achieved at least two behavioral goals. Many patients exhibited problem solving behavior to achieve their goals. We found no significant differences in reported achievement of behavior goals by literacy or language. Patients were very satisfied with the guide. Conclusions: A brief goal setting intervention along with a diabetes self-management guide helped patients set and achieve healthy behavioral goals. Practice implications: Non-clinical providers can successfully help a diverse range of patients with diabetes set and achieve behavioral goals

Munir,F., et al (2009). Self-management of health-behaviors among older and younger workers with chronic illness. *Patient.Education and Counseling* Online 6/04/2009

<http://dx.doi.org/10.1016/j.pec.2009.02.014>

<http://pmid.us/19356885>

Objective: To examine the self-management of health behaviors carried out by older (aged 50-69 years) and younger workers (aged 20-49 years) with a chronic illness. Methods: Questionnaire data was collected from 759 employees with a diagnosed chronic illness. Four categories of self-managing health behaviors were examined: using prescribed medication, monitoring and responding to symptoms, managing an appropriate diet and exercising. Results: The majority of participants (56-97%) reported being advised to carry out health behaviors at home and at work. Controlling for confounding factors, medication use was associated with younger and older workers. Managing an appropriate diet was associated with younger workers with asthma, musculoskeletal pain or diabetes. Exercising was associated with younger workers with asthma and with older workers with heart disease, arthritis and rheumatism or diabetes. Conclusions: The findings indicate that there are differences in diet and exercise activities among younger and older workers. Practice implications: To increase self-management in health behaviors at work, improved communication and understanding between the different health professions and the patient/employee is required so that different tailored approaches can be effectively targeted both by age and within the context of the working environment, to those managing asthma, heart disease, diabetes and arthritis and rheumatism

Pols,R.G., et al (2009). Chronic condition self-management support: proposed competencies for medical students. *Chronic Illness*, 5(1), 7-14.

<http://dx.doi.org/10.1177/1742395308098888>

<http://pmid.us/19276220>

Objective: Governments and the medical profession are concerned that there continues to be less than optimal health outcomes despite escalating expenditure on health services from the effect of the ageing population with chronic illnesses. In this context, doctors will need to have knowledge and skills in effective chronic condition management

(CCM) and chronic condition self-management (CCSM). Method: A national workshop of representatives of eight medical schools from the CCSM special interest group (SIG) of the Australian and New Zealand Association on Medical Education met in September 2004, to consider curriculum content in CCM and CCSM. Results: The workshop recommended that the Committee of Deans of Australian Medical Schools and the Commonwealth Department of Health and Ageing consider the identification and possible development of a specific curriculum for CCM and CCSM within the curricula of Australian Medical Schools. Discussion: Consideration needs to be given to the changing nature of medical practice and that as part of this; doctors of the future will need skills in team participation, continuity of care, self-management support and patient-centered collaborative care planning. Doctors will also need skills to assist patients to better adhere to medical management, lifestyle behaviour change and risk factor reduction, if optimal health outcomes are to be achieved and costs are to be contained

Ryan,A., et al (2009). Factors associated with self-care activities among adults in the United Kingdom: a systematic review. *BMC Public Health*, 9(1), 96.

<http://dx.doi.org/10.1186/1471-2458-9-96>

<http://www.biomedcentral.com/1471-2458/9/96>

<http://pmid.us/19344526>

Background: The Government has promoted self-care. Our aim was to review evidence about who uses self-tests and other self-care activities (over-the-counter medicine, private sector, complementary and alternative medicine (CAM), home blood pressure monitors). Methods: During April 2007, relevant bibliographic databases (Medline, Embase, Cumulative Index to Nursing and Allied Health Literature, Applied Social Sciences Index and Abstracts, PsycINFO, British Nursing Index, Allied and Complementary Medicine Database, Sociological Abstracts, International Bibliography of the Social Sciences, Arthritis and Complementary Medicine Database, Complementary and Alternative Medicine and Pain Database) were searched, and potentially relevant studies were reviewed against eligibility criteria. Studies were included if they were published during the last 15 years and identified factors, reasons or characteristics associated with a relevant activity among UK adults. Two independent reviewers used proformas to assess the quality of eligible studies. Results: 206 potentially relevant papers were identified, 157 were excluded, and 49 papers related to 46 studies were included: 37 studies were, or used data from questionnaire surveys, 36 had quality scores of five or more out of 10, and 27 were about CAM. Available evidence suggests that users of CAM and over-the-counter medicine are female, middle-aged, affluent and / or educated with some measure of poor health, and that people who use the private sector are affluent and / or educated. Conclusions: People who engage in these activities are likely to be affluent. Targeted promotion may, therefore, be needed to ensure that use is equitable. People who use some activities also appear to have poorer measures of health than non-users or people attending conventional services. It is, therefore, also important to ensure that self-care is

not used as a second choice for people who have not had their needs met by conventional services

SERVICE ORGANIZATION AND DELIVERY

McDonald,R., Harrison,S., & Checkland,K. (2008). Identity, contract and enterprise in a primary care setting: an English general practice case study. *Organization*, 15(3), 355-370.

<http://dx.doi.org/10.1177/1350508408088534>

This paper examines the responses of primary health care clinicians (doctors and nurses) to an invitation to enterprise contained in a new contract which offers financial rewards for meeting targets. We suggest that far from being swept along by a hegemonic enterprise discourse or having 'no choice but to comply' (Cohen and Musson, 2000: 45), the engagement of our study participants in enterprising behaviours can be understood in terms of a more active process, albeit one characterized by new bureaucratic forms. Rather than riding roughshod over cherished traditional identities, part of the attraction of enterprise in our case study can be understood in terms of its role in assisting enterprising clinicians in managing the tensions inherent in these identities

McDonald,R., et al (2009). Rethinking collegiality: Restratification in English general medical practice 2004-2008. *Social Science and Medicine* 68(7), 1199-1205

<http://dx.doi.org/10.1016/j.socscimed.2009.01.042>

<http://pmid.us/19232453>

For Freidson [(1985). The reorganisation of the medical profession. *Medical Care Review*, 42(1), 11-35], collegiality, or ostensible equal status amongst members of the medical profession, serves a dual purpose. It socialises members into an attitude of loyalty to colleagues and presents an image to those outside the profession that all its members are competent and trustworthy. However, Freidson saw the use of formal standards developed by one (knowledge) elite within medicine and enforced by another (administrative) elite as threatening collegiality and professional unity. Drawing on two studies in English primary medical care this paper reports the emergence of new strata or elites, with groups of doctors involved in surveillance of others and action to improve compliance in deficient individuals and organizations. Early indications are that these developments have not led to the consequences which Freidson predicted. The increasing acceptance of the legitimacy of professional scrutiny and accountability that we identify suggests that new norms are emerging in English primary medical care, the possibility of which Freidson's analysis fails to take account

Morgan,C.L., & Beerstecher,H.J. (2009). Practice size and service provision in primary care: an observational study. *British Journal of General Practice*, 59(560), e71-e77.

<http://dx.doi.org/10.3399/bjgp09X419538>

<http://pmid.us/19275826>

Background: In 2004, primary care payments for basic services and enhanced services were separated. This change has greatly facilitated the evaluation of the breadth and volume of services. Aim: To determine whether larger practices produce a higher volume and greater diversity of enhanced services. Design of study: Cross-sectional observational study using practice data obtained under the Freedom of Information Act 2000. Setting: A total of 384 practices in 14 English primary care trusts. Method: Practice data for all practices were collated for enhanced services, practice size, and deprivation. Diversity and volume of enhanced services were used as dependent variables in a series of multiple regression models to ascertain the effect of practice size, and any relationship with deprivation. Results: Larger practices provided a greater diversity of services ($P = 0.002$), although this effect was not present in practices with more than 6330 patients. Practice size seems to influence the volume of enhanced services in general medical services, but this effect disappeared when deprivation was taken into account. Deprivation had a negative influence on the volume of enhanced services provided ($P = 0.019$). The effect of deprivation on volume persisted in practices with more than 6330 patients. Conclusion: Current average-sized practices provide similar volume and diversity of enhanced services as those in the largest quartile; therefore, there seems to be little merit in creating 'supersurgeries' if the aim is to transfer work from secondary to primary care. There does not seem to be an upper threshold above which practice size creates spare capacity and expertise to deliver a significantly greater volume or more diversity of extra services

Pullon,S., McKinlay,E., & Dew,K. (2009). Primary health care in New Zealand: the impact of organisational factors on teamwork. *British Journal of General Practice*, 59 (560), 191-197.

<http://dx.doi.org/10.3399/bjgp09X395003>

<http://pmid.us/19275835>

Background: Although teamwork is known to optimise good health care, organisational arrangements and funding models can foster, discourage, or preclude functional teamworking. Despite a new, enhanced population-based funding system for primary care in New Zealand, bringing new opportunities for more collaborative practice, fully implemented healthcare teamwork remains elusive. Aim: To explore perceptions of interprofessional relationships, teamwork, and collaborative patient care in New Zealand primary care practice. Design of study: Qualitative. Setting: Eighteen nurses and doctors working in primary care, Wellington, New Zealand. Method: Data were collected using in-depth interviews with individual nurses and doctors working in primary care settings.

Perceptions of, and attitudes about, interprofessional relationships, teamwork, and collaborative patient care were explored, using an interactive process of content analysis and principles of naturalistic enquiry. Results: Nurses and doctors working in New Zealand primary care perceive funding models that include fee-for-service, task-based components as strongly discouraging collaborative patient care. In contrast, teamwork was seen to be promoted when health services, not individual practitioners, were bulk-funded for capitated healthcare provision. In well-organised practices, where priority was placed on uninterrupted time for meetings, open communication, and interprofessional respect, good teamwork was more often observed. Salaried practices, where doctors and nurses alike were employees, were considered by some interviewees to be particularly supportive of good teamwork. Few interviewees had received, or knew of, any training to work in teams. Conclusion: Health system, funding, and organisational factors still act as significant barriers to the successful implementation of, and training for, effective teamwork in New Zealand primary care settings, despite new opportunities for more collaborative ways of working

SOCIAL CAPITAL

d'Hombres,B., et al (2009). Does social capital determine health? Evidence from eight transition countries. *Health Economics* Online 19/03/2009

<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.

Derose,K.P., & Varda,D.M. (2009). Social Capital and Health Care Access: A Systematic Review. *Medical Care Research and Review* Online 27/01/2009

<http://dx.doi.org/10.1177/1077558708330428>

<http://pmid.us/19174538>

There is a growing interest in community level characteristics such as social capital and its relationship to health care access. To assess the rigor with which this construct has been empirically applied in research on health care access, a systematic review was conducted. A total of 2,396 abstracts were reviewed, and 21 met the criteria of examining some measure of social capital and its effects on health care access. The review found a lack of congruence in how social capital was measured and interpreted and a general inconsistency in findings, which made it difficult to draw firm conclusions about the effects of social capital on health care access. Insights from the social network literature can help improve the conceptual and measurement problems. Future work should distinguish among bonding, bridging, and linking social capital and their sources and benefits, and examine whether three dimensions of social capital actually exist: cognitive, behavioral, and structural

Snelgrove,J.W., Pikhart,H., & Stafford,M. (2009). A multilevel analysis of social capital and self-rated health: Evidence from the British Household Panel Survey. *Social Science and Medicine* Online 02/05/2009

<http://dx.doi.org/10.1016/j.socscimed.2009.03.011>

<http://pmid.us/19345465>

Social capital is often described as a collective benefit engendered by generalised trust, civic participation, and mutual reciprocity. This feature of communities has been shown to associate with an assortment of health outcomes at several levels of analysis. The current study assesses the evidence for an association between area-level social capital and individual-level subjective health. Respondents participating in waves 8 (1998) and 9 (1999) of the British Household Panel Survey were identified and followed-up 5 years later in wave 13 (2003). Area social capital was measured by two aggregated survey items: social trust and civic participation. Multilevel logistic regression models were fitted to examine the association between area social capital indicators and individual poor self-rated health. Evidence for a protective association with current self-rated health was found for area social trust after controlling for individual characteristics, baseline self-rated health and individual social trust. There was no evidence for an association between area civic participation and self-rated health after adjustment. The findings of this study expand the literature on social capital and health through the use of longitudinal data and multilevel modelling techniques

Ziersch,A.M., et al (2009). Social capital and health in rural and urban communities in South Australia. *Australia and New Zealand Journal of Public Health*, 33(1), 7-16.

<http://dx.doi.org/10.1111/j.1753-6405.2009.00332.x>

Objective: This paper seeks to compare the relationships between social capital and health for rural and urban residents of South Australia. Methods: Using data from a South Australian telephone survey of 2,013 respondents (1,402 urban and 611 rural), separate path analyses for the rural and urban samples were used to compare the relationships between six social capital measures, six demographic variables, and mental and physical health (measured by the SF-12). Results: Higher levels of networks, civic participation and cohesion were reported in rural areas. Education and income were consistently linked with social capital variables for both rural and urban participants, with those on higher incomes and with higher educational achievement having higher levels of social capital. However, there were also differences between the rural and urban groups in some of the other predictors of social capital variables. Mental health was better among rural participants, but there was no significant difference for physical health. Social capital was associated with good mental health for both urban and rural participants, but with physical health only for urban participants. Higher levels of social capital were significantly associated with better mental health for both urban and rural participants, but with better physical health only for urban participants. Conclusions and implications: The study found that social capital and its relationship to health differed for participants in rural and urban areas, and that there were also differences between the areas in associations with socioeconomic variables. Policies aiming to strengthen social capital in order to promote health need to be designed for specific settings and particular communities within these

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Chenot, J.F., Kochen, M.M., & Himmel, W. (2009). Student evaluation of a primary care clerkship: Quality assurance and identification of potential for improvement. *BMC Medical Education* 9(1), 17.

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<http://www.biomedcentral.com/1472-6920/9/17>

<http://pmid.us/19368712>

Background: In Germany, like many other countries, general practice clerkships have only recently become mandatory during medical education. The biggest challenges for the organisation of such clerkships are achieving a minimum level of standardisation,

and developing and maintaining a system of quality assurance. The aim of this study is to assess the instructional quality in teaching practices using a benchmark system. Methods: Before commencing, students anonymously assessed the importance of core aspects of the mandatory primary care clerkship. After the clerkship, they evaluated learning opportunities and teaching performance. Based on this data, a benchmark system was developed to identify areas of strength and weakness for all practices as well as individual teaching practices. Results: A total of 695 students evaluated 97 family practices belonging to a teaching network. Prior to the clerkship, most students considered recognition of frequent diseases (85 %) and communication skills (65 %) the most important learning goals. After the clerkship, nearly 90 % of students confirmed that the general practitioner (GP) was good or excellent at teaching these two goals but only two-thirds thought the GP's teaching performance good or excellent in preventive medicine and screening. In an exemplary analysis, we identified the 2 best and the 2 worst practices that consistently received scores far above or below average, respectively. Conclusion: We were able to identify areas of weakness in teaching and identified specific GPs who did not meet the students' needs and expectations. This evaluation seems to be a useful quality assurance tool to identify the potential for improvement and faculty development

Gemmell, I., et al (2009). Assessing workload in general practice in England before and after the introduction of the pay-for-performance contract. *Journal of Advanced Nursing* 65(3), 509-515.

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<http://pmid.us/19222648>

Aim: This paper is a report of a study conducted to describe changes in practice team size and composition, and the workload of doctors and nursing staff, before (2003) and after (2005) the introduction of the pay-for-performance contract for general practice. Background: In 2004, a new pay-for-performance contract for general practice was introduced in England. This improved the quality but may also have altered practice workload, including the workload of nursing staff. Method: Practice profile questionnaires and staff workload diaries were completed in 42 practices in England in 2003 and 2005. Managers provided information on team size and composition in 2003 and 2005. One week workload diaries were completed by doctors and nursing staff in both years. Diaries recorded: hours of work, number and complexity of patient visits, and types of problems (acute, chronic, preventative). Findings: The number of practice staff increased with greater increases observed for nursing staff than doctors. There was no change in the average number of hours worked per week by nursing staff or doctors but nurse visit rates increased while doctors' rates decreased. The proportion of presenting problems described as chronic or preventative increased for doctors ($\chi^2 = 8.54$, d.f. = 1, $P < 0.004$) but was unchanged for nursing staff. Nursing staff dealt with more complex visits in 2005 compared to 2003 ($\chi^2 = 30.70$, d.f. = 3, $P < 0.001$) but there was no change for doctors. Conclusion: General practices may have responded to the 2004

contract by increasing staffing levels, with nursing staff absorbing a higher proportion of the clinical workload and doctors focusing more attention on chronic and preventive care. Expanding nursing staff roles may increase the quality of primary care but may lead also to intensification of nurses' work

Kalra VS, Abel P, & Esmail A (2009). Developing leadership interventions for Black and minority ethnic staff: A case study of the National Health Service (NHS) in the UK. *Journal of Health Organization and Management*, 23(1), 103-118.

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Purpose – The National Health Service (NHS) is the largest employer in the UK but, despite decades of equal opportunities legislation, its senior management workforce does not reflect the diversity of either the wider NHS workforce or the UK population. The aim of the paper is to consider the range of management interventions available to organisations like the NHS to deliver change in the area of promotion of Black and minority ethnic staff. Design/methodology/approach – Intervention programmes in a range of public and private organisations are reviewed and the nature of barriers to promotion and the range of interventions to overcome these are explored. The paper uses the paradigm of institutional racism to examine the ways in which the NHS discriminates against certain sections of its workforce. The methods used include a literature review combined with key stakeholder interviews. A comparative dimension which involved a review of research on leadership initiatives in the USA was also undertaken. Findings – The literature review found that there were a range of initiatives which could be implemented by public organisations such as the NHS to increase the presence of Black and Minority Ethnic (BME) staff in senior management positions. Most of these interventions were largely focused on the individual. Much more progress on institutional or organisational change needed to be made before the NHS could be perceived as a model employer in this area. The literature review also indicated that there is little published research on such initiatives within other European Union countries. Originality/value – The paper is targeted at both policy makers and human resource officers responsible for equality and diversity issues within large organisations, who have a remit to improve the career pathways of staff. The analysis provided offers a set of critical tools and interventions that have not hitherto been well examined in the UK context.

McDonald,R., Campbell,S., & Lester,H. Practice nurses and the effects of the new general practitioner contract in the English National Health Service: The extension of a professional project? *Social Science & Medicine*, Online 28/02/2009

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<http://pmid.us/19254819>

This paper reports the impact on nurses working in primary health care settings of changes to the general practitioner (GP) contract in England implemented in 2004. Previous changes to the GP contract in 1990, which gave financial rewards for health

promotion activities, were seen as enabling nurses to take on work that GPs did not want and providing an impetus for the development of a professional project (Broadbent, J. (1998). Practice nurses and the effects of the new general practitioner contract in the British NHS: the advent of a professional project? *Social Science & Medicine*, 47(4), 497-506). Our study, which involved interviews with nurses from 20 practices, finds that nurses are taking on work which has previously been the exclusive preserve of medical professionals. An increasing emphasis in nurses' accounts on technical skills and knowledge may help decouple nursing from a narrative of caring, which has been seen as detracting from professional advancement. Our research suggests that practice nurse work is changing to reflect a more medical (and masculine) orientation to service delivery. At the same time, nursing work is described as routine and template driven, which may limit claims to 'professional' status. The reaction of some practice nurses to Health Care Assistants encroaching on what was previously practice nurse territory suggests a policing of boundaries, rather than an inclusive approach to colleagues within the nursing team. This resonates with Davies' (Davies, C. (1995). *Gender and the professional predicament in nursing*. Bucks: Open University Press) suggestion that professionalisation as a process involves compliance with a masculine notion of professionalism (autonomous, elite, individual, divisive, detached) which marginalises feminine attributes and devalues the work done by women. The study also raises questions about the role of caring in general practice settings where nurses choose to prioritise other concerns

Marchal,B., & Kegels,G. (2008). Focusing on the software of managing health workers: what can we learn from high commitment management practices? *International Journal of Health Planning and Management* 23(4), 299-311.

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<http://pmid.us/17624868>

Knowledge of what constitutes best practice in human resource management (HRM) in public-oriented services is limited and the operational aspects of managing health workers at provision level have been poorly studied. The magnet hospital concept offers some insights into HRM practices that are leading to high commitment. These have been shown to lead to superior performance in not only industrial business firms, but also service industries and the public service. The mechanisms that drive these practices include positive psychological links between managers and staff, organizational commitment and trust. Conditions for successful high commitment management (HiCoM) include health service managers with a strong vision and able to transmit this vision to their staff, appropriate decision spaces for healthcare managers and a pool of reasonable well-trained health workers. For this, adequate remuneration is the first condition. Equally important are the issues of cultural fit and of 'commitment'. What would staff expect from management in return for their commitment to the organization? Salary buys indeed time of employees, but other practices ensure their commitment. Only if these drivers are understood will managers be able to make their HRM practices more responsive to the needs and expectations of the health workers

Martin,G.P., Currie,G., & Finn,R. (2009). Reconfiguring or reproducing intra-professional boundaries? Specialist expertise, generalist knowledge and the ‘modernization’ of the medical workforce. *Social Science & Medicine*, 68(7), 1191-1198.

<http://dx.doi.org/10.1016/j.socscimed.2009.01.006>

<http://pmid.us/19201073>

Efforts to ‘modernize’ the clinical workforce of the English National Health Service have sought to reconfigure the responsibilities of professional groups in pursuit of more effective, joined-up service provision. Such efforts have met resistance from professions eager to protect their jurisdictions, deploying legitimacy claims familiar from the insights of the sociology of professions. Yet to date few studies of professional boundaries have grounded these insights in the specific context of policy challenges to the inter- and intra-professional division of labour, in relation to the medical profession and other health-related occupations. In this paper we address this gap by considering the experience of newly instituted general practitioners with a special interest (GPSIs) in genetics, introduced to improve genetics knowledge and practice in primary care. Using qualitative data from four comparative case studies, we discuss how an established intra-professional division of labour within medicine--between clinical geneticists and general practitioners--was opened, negotiated and reclosed in these sites. We discuss the contrasting attitudes towards the nature of genetics knowledge and its application of GPSIs and geneticists, and how these were used to advance conflicting visions of what the nascent GPSI role should involve. In particular, we show how the claims to knowledge of geneticists and GPSIs interacted with wider policy pressures to produce a rather more conservative redistribution of power and responsibility across the intra-professional boundary than the rhetoric of modernization might suggest

Poulton,B. (2009). Barriers and facilitators to the achievement of community-focused public health nursing practice: a UK perspective. *Journal of Nursing Management*, 17(1), 74-83.

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<http://pmid.us/19166525>

Aim: To explore the extent to which Community Health Nurses (CHN) engage in community-focused public health practice and the facilitators and barriers to such practice. Background: The government promotes the role of nurses in public health. However, there is confusion as to what constitutes public health; a lack of support to move from individual and family-focused practice to community-focused practice; and, inconsistency of the use of titles. Method: A 15% quota sample (n = 409), drawn from a population of 2668 CHNs, participated in a quantitative survey. RESULTS: Response rate was 67% (n = 275). Over half of CHN time was spent with individuals and families,

community level activity accounting for only 18%. Only 9% of respondents had completed a community needs assessment. Education was key to the promotion of community-focused practice with collection of individual activity data a major barrier. Conclusions: There is a gap between the rhetoric and reality of community public health nursing. Implications for nursing management: Development of a shared vision of public health nursing and commissioning of education to meet public health priorities is essential. Furthermore, strengthening public health nurse leadership to foster innovative practice and methods of measuring public health nursing outcomes is required