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**March-April 2008**



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## ACCESS TO CARE

**Haggerty JL, et al (2008). Practice features associated with patient-reported accessibility, continuity, and coordination of primary health care. *Annals of Family Medicine* ;6: (2) 116-23.**

<http://dx.doi.org/10.1370/afm.802>

<http://pmid.us/18332403>

Purpose: On the eve of major primary health care reforms, we conducted a multilevel survey of primary health care clinics to identify attributes of clinic organization and physician practice that predict accessibility, continuity, and coordination of care as experienced by patients. Methods: Primary health care clinics were selected by stratified random sampling in urban, suburban, rural, and remote locations in Quebec, Canada. Up to 4 family or general physicians were selected in each clinic, and 20 patients seeing each physician used the Primary Care Assessment Tool to report on first-contact accessibility (being able to obtain care promptly for sudden illness), relational continuity (having an ongoing relationship with a physician who knew their particulars), and coordination continuity (having coordination between their physician and specialists). Physicians reported on aspects of their practice, and secretaries and directors reported on organizational features of the clinic. We used hierarchical regression modeling on the subsample of regular patients at the clinic. Results: One hundred clinics participated (61% response rate), for a total of 221 physicians and 2,725 regular patients (87% response and completion rate). First-contact accessibility was most problematic. Such accessibility was better in clinics with 10 or fewer physicians, a nurse, telephone access 24 hours a day and 7 days a week, operational agreements to facilitate care with other health care establishments, and evening walk-in services. Operational agreements and evening care also positively affected relational continuity. Physicians who valued continuity and felt attached to the community fostered better relational continuity, whereas an accessibility-oriented style (as indicated by a high proportion of walk-in care and high patient volume) hindered it. Coordination continuity was also associated with more operational agreements and continuous telephone access, and was better when physicians practiced part time in hospitals and performed a larger range of medical procedures in their office. Conclusions: The way a clinic is organized allows physicians to achieve both accessibility and continuity rather than one or the other. Features that achieve both are offering care in the evenings and access to telephone advice, and having operational agreements with other health care establishments

**Liu, JJ, et al (2008) Bypass of local primary care in rural counties: effect of patient and community characteristics. *Annals of Family Medicine* ;6 (2) :124-30.**

**Doi: <http://dx.doi.org/10.1370/afm.794>**

**<http://pmid.us/18332404>**

Purpose: This national study sought information from rural patients (1) to assess the prevalence of bypass, a pattern of seeking health care outside the local community; (2) to examine the impact of locally available primary care physicians (PCPs) and hospital size on the odds of bypass; and (3) to identify patient demographic and geographic factors associated with bypass. This study also ascertained the reasons patients give for bypass and their suggestions for how hospitals can retain patients locally. Methods: We analyzed data from a 2005 telephone survey of 1,264 adults, aged 18 years or older, who lived within 20 miles of 25 randomly selected Critical Access Hospitals and were linked with a Health Professional Shortage Area and 2004 census data. Respondents were asked about demographic characteristics, travel time and distance to local hospitals, and insurance status, as well as for suggestions of what local hospitals could do to retain patients. Results: Overall, 32% of respondents bypassed local primary care; the rate ranged from 9% to 66% across the Critical Access Hospital service areas. Factors associated with bypass included age, education, marital status, satisfaction with the local hospital, admission to a hospital in the past 12 months, hospital size, and local density of PCPs. Compared with residents in areas with a higher density of PCPs (=3,500 residents per PCP), residents in areas with a low density (>4,500 residents per PCP) were more likely to bypass local care (odds ratio, 1.58; 95% confidence interval, 1.02-2.46). Lack of specialty care and limited services were most frequently mentioned as reasons why patients bypassed local hospitals. Conclusions: The sizable variation in bypass rates among this sample of Critical Access Hospital service areas suggests that strategies to reduce bypass behavior should be directed at the local community or facility level. Changing rural residents' perception of their local care, helping them gain a better understanding of the function of primary care, and increasing the number of PCPs might help hospitals retain patients and rural communities stay healthy

**O' Reilly, D.,et al (2007). Consultation charges in Ireland deter a large proportion of patients from seeing the GP: Results of a cross-sectional survey. *The European Journal of General Practice* , 13, (4), 231-236. Doi: <http://dx.doi.org/10.1080/13814780701815082>**

**<http://pmid.us/18324505>**

Aim: To estimate the effect of a consultation charge on the health-seeking behaviour of patients. Methods: Cross-sectional survey of patients carried out in Northern Ireland, where services are free at the point of delivery, and the Republic of Ireland, where 70% of the population are charged a consultation fee to see the general practitioner (GP). Results: There were 11 870 respondents to the survey (response rate 52%). In the Republic of Ireland, 18.9% of patients (4.4% of non-paying patients and 26.3% of paying patients) had a medical problem in the previous year but had not consulted the doctor

because of cost; this compares with only 1.8% of patients in Northern Ireland. Because those in the Republic of Ireland on low income are entitled to free care, the effects of the consultation charge were most marked in the middle of the income distribution, with such patients being over four times as likely to have been deterred as those in the most affluent group. However, amongst paying patients, it was the poorest and those with the worst health who were most affected. Compared to the most affluent patients and those without depression, the likelihood of not having seen the GP due to cost was 6.75 (95% confidence interval [CI] 3.79, 11.09) for the poorest patients and 2.01 (95% CI 1.53, 2.52) for those with depression. Conclusion Even in countries with exemptions for the poor and more vulnerable, a consultation charge can deter a large proportion of poorer and less healthy patients from seeing their GP

**Pope, C., 2008. Improving access to primary care: eight case studies of introducing Advanced Access in England. *Journal of Health Services Research Policy*, 13, (1), 33-39. <http://dx.doi.org/10.1258/jhsrp.2007.007039>**

<http://pmid.us/18325154>

Objective: To examine the implementation of 'Advanced Access' as a means of improving access to primary care. Methods: Qualitative case studies of eight English general practices undertaken as part of a mixed method study. Results: There was considerable variation in the interpretation and implementation of Advanced Access. Practices claiming to operate this system often did not follow its key principles. Differences between practice access systems centred on the use of 'same-day' appointments. The association of Advanced Access with same-day appointment systems was problematic as it both created antagonism to, and diverged from, the Advanced Access model. Practice staff did not necessarily share the conceptualisation of demand that underpinned Advanced Access. Other policies and targets provided further incentives to diverge from the model and these factors were compounded by informal organizational behaviours, notably the exercise of discretion, which led to adaptation. Conclusion: Advanced Access was diluted because it became confused with same-day appointment systems and other incentives and targets. Its guiding philosophy of 'manageable demand' appeared counter-intuitive to staff in the context of general practice, which made its implementation problematic. As a result, the system was adapted and modified

**Smits T et al 2008 Defining frequent attendance in general practice BMC Family Practice 9:21 Doi: <http://dx.doi.org/10.1186/1471-2296-9-21>**

<http://pmid.us/18412954>

Background General practitioners (GPs) or researchers sometimes need to identify frequent attenders (FAs) in order to screen them for unidentified problems and to test specific interventions. We wanted to assess different methods for selecting FAs to identify the most feasible and effective one for use in a general (group) practice. Methods In the second Dutch National Survey of General Practice, data were collected on 375 899 persons registered with 104 practices. Frequent attendance is defined as the top 3% and 10% of enlisted patients in each one-year age-sex group measured during the

study year. We used these two selections as our reference standard. We also selected the top 3% and 10% FAs (90 and 97 percentile) based on four selection methods of diminishing preciseness. We compared the test characteristics of these four methods. Results Of all enlisted patients, 24 % did not consult the practice during the study year. The mean number of contacts in the top 10% FAs increased in men from 5.8 (age 15-24 years) to 17.5 (age 64-75 years) and in women from 9.7 to 19.8. In the top 3% of FAs, contacts increased in men from 9.2 to 24.5 and in women from 14 to 27.8. The selection of FAs becomes more precise when smaller age classes are used. All selection methods show acceptable results (kappa 0.849 - 0.942) except the three group method. **Conclusions** To correctly identify frequent attenders in general practice, we recommend dividing patients into at least three age groups per sex.

## CHRONIC ILLNESS

**Al-hussein, F. A. (2008). A tale of two audits: statistical process control for improving diabetes care in primary care settings. *Quality in Primary Care*, 16, (1), 53-60.**

Background Diabetes constitutes a major burden of disease globally. Both primary and secondary prevention need to improve in order to face this challenge. Improving management of diabetes in primary care is therefore of fundamental importance. Objective The objective of these series of audits was to find means of improving diabetes management in chronic disease mini-clinics in primary health care. In the process, we were able to study the effect and practical usefulness of different audit designs - those measuring clinical outcomes, process of care, or both. Setting King Saud City Family and Community Medicine Centre, Saudi National Guard Health Affairs in Riyadh city, Saudi Arabia. Methods Simple random samples of 30 files were selected every two weeks from a sampling frame of file numbers for all diabetes clients seen over the period. Information was transferred to a form, entered on the computer and an automated response was generated regarding the appropriateness of management, a criterion mutually agreed upon by care providers. The results were plotted on statistical process control charts, *p* charts, displayed for all employees. Data extraction, archiving, entry, analysis, plotting and design and preparation of *p* charts were managed by nursing staff specially trained for the purpose by physicians with relevant previous experience. Results Audit series with mixed outcome and process measures failed to detect any changes in the proportion of non-conforming cases over a period of one year. The process measures series, on the other hand, showed improvement in care corresponding to a reduction in the proportion non-conforming by 10% within a period of 3 months. Non-conformities dropped from a mean of 5.0 to 1.4 over the year ( $P < 0.001$ ). Conclusion It is possible to improve providers' behaviour regarding implementation of given guidelines through periodic process audits and feedbacks. Frequent process audits in the context of statistical process control should be supplemented with concurrent outcome audits, once or twice a year.

**Briggs M et al (2008). A feasibility study of a combined nurse/pharmacist-led chronic pain clinic in primary care. *Quality in Primary Care*, 16, (2), 91-94.**

Chronic pain is common and management hampered by lack of resources in primary and secondary care. Nurse- or pharmacist-led clinics have been shown to lead to improvements in care for patients with chronic pain. This study showed that a combined nurse/pharmacist-led clinic for managing chronic pain in primary care can lead to improvements in management of pain, reduction in use of secondary care resources and high rates of satisfaction

**Cho, H. J. and Wessely, S. (2007). The prevalence and associations of unexplained chronic fatigue in Brazilian primary care. *Primary Care & Community Psychiatry*, 12, (2), 81-87.**

**Doi: <http://dx.doi.org/10.1080/17468840701680413>**

Background: Unexplained chronic fatigue (UCF) and chronic fatigue syndrome (CFS) have been reported to be associated with female gender, older age, lower socioeconomic status and psychiatric disorders by previous studies, mostly conducted in Western developed countries. To date, there have been very few studies of UCF/CFS in Brazil. Aim: We examined the prevalence and associations of UCF in Brazilian primary care. The main question was whether the profile of risk factors for UCF in Brazil is similar to that reported in Western developed countries. Methods: A cross-sectional survey was conducted at two general practices in So Paulo. 304 consecutive attenders, aged 18-45 years, completed questionnaires on fatigue, psychological distress and sociodemographic characteristics. Those with substantial fatigue lasting 6 months or more were interviewed to ascertain the presence of CFS and psychiatric disorders. Patients suffering from substantial fatigue for 6 months or more with no medical explanation and no psychiatric exclusion diagnoses for CFS were classified as cases of UCF. Results: The prevalence of UCF and CFS was respectively 10.9% and 1.3%. Psychological distress was significantly correlated with fatigue. Older age, female gender and higher education level were independent risk factors for UCF. Conclusion: The prevalence of UCF and CFS in Brazilian primary care was comparable to that reported by the previous studies in Western affluent countries. However, while age and gender followed the previously observed pattern of association, an opposite pattern was found regarding education. Possible reasons for this unusual finding were discussed

**Davies, M. J., et al. (2008). Effectiveness of the diabetes education and self management for ongoing and newly diagnosed (DESMOND) programme for people with newly diagnosed type 2 diabetes: cluster randomised controlled trial *British Medical Journal* , 336, (7642), 491-495.**

**Doi: <http://dx.doi.org/10.1136/bmj.39474.922025.BE>**

**<http://pmid.us/18276664>**

Objective: To evaluate the effectiveness of a structured group education programme on biomedical, psychosocial, and lifestyle measures in people with newly diagnosed type 2

diabetes. Design: Multicentre cluster randomised controlled trial in primary care with randomisation at practice level. Setting: 207 general practices in 13 primary care sites in the United Kingdom. Participants: 824 adults (55% men, mean age 59.5 years). Intervention: A structured group education programme for six hours delivered in the community by two trained healthcare professional educators compared with usual care. Main outcome measures: Haemoglobin A(1c) levels, blood pressure, weight, blood lipid levels, smoking status, physical activity, quality of life, beliefs about illness, depression, and emotional impact of diabetes at baseline and up to 12 months. Main results Haemoglobin A(1c) levels at 12 months had decreased by 1.49% in the intervention group compared with 1.21% in the control group. After adjusting for baseline and cluster, the difference was not significant: 0.05% (95% confidence interval -0.10% to 0.20%). The intervention group showed a greater weight loss: -2.98 kg (95% confidence interval -3.54 to -2.41) compared with 1.86 kg (-2.44 to -1.28),  $P=0.027$  at 12 months. The odds of not smoking were 3.56 (95% confidence interval 1.11 to 11.45),  $P=0.033$  higher in the intervention group at 12 months. The intervention group showed significantly greater changes in illness belief scores ( $P=0.001$ ); directions of change were positive indicating greater understanding of diabetes. The intervention group had a lower depression score at 12 months: mean difference was -0.50 (95% confidence interval -0.96 to -0.04);  $P=0.032$ . A positive association was found between change in perceived personal responsibility and weight loss at 12 months ( $\beta=0.12$ ;  $P=0.008$ ). Conclusion: A structured group education programme for patients with newly diagnosed type 2 diabetes resulted in greater improvements in weight loss and smoking cessation and positive improvements in beliefs about illness but no difference in haemoglobin A(1c) levels up to 12 months after diagnosis.

**Dijkstra R, Braspenning J, and Grol R (2008). Implementing diabetes passports to focus practice reorganization on improving diabetes care. *International Journal for Quality in Health Care*, 20, (1), 72-77.**

**Doi:** <http://dx.doi.org/10.1093/intqhc/mzm051>

Objective. Although an active role of the patient is often stressed in diabetes care, it is not easily implemented in daily practice. The aim of the study was to measure the effects of introducing a diabetes passport to patients after embedding the passport in the organization of care. Design. Randomized controlled trial. Setting. Forty general practice in The Netherlands. Participants. Pre- and post-intervention data were obtained from 993 patients with type 2 diabetes mellitus. Patients treated in secondary care and patients over 80 years of age were excluded. Intervention. The intervention consisted of clarifying the diabetes care tasks for all practice staff and embedding the diabetes passports in the structured care. Main outcome measure. Self-reported use of the diabetes passport. Results. Diabetes passports were issued to 87% of the patients. After 15 months, 76% of the patients reported that the passport was being used during clinic visits. The process indicators of care improved by 10% on average in the intervention group. However, there were no changes in the outcome measures. Conclusion. Diabetes passports can be introduced successfully in structured primary care and they lead to improved effect measures for medical behaviour.

**Gucciardi, E., et al (2008). Factors contributing to attrition behavior in a diabetes self-management program: a mixed method approach. *BMC Health Services Research*, 8, (1), 33. Doi: <http://dx.doi.org/10.1186/1472-6963-8-33>**

<http://pmid.us/18248673>

Background: Diabetes self-management education is a critical component in diabetes care. Despite worldwide efforts to develop efficacious DSME programs, high attrition rates are often reported in clinical practice. The objective of this study was to examine factors that may contribute to attrition behavior in diabetes self-management programs. Methods: We conducted telephone interviews among individuals with Type 2 diabetes (n=267) and attended a diabetes education centre. Multivariable logistic regression was performed to identify factors associated with attrition behavior. Forty-four percent of participants (n=118) withdrew prematurely from the program and were asked an open-ended question regarding their discontinuation of services. We used content analysis to code and generate themes, which were then organized under the Behavioral Model of Health Service Utilization. Results: Working full and part-time, being over 65 years of age, having a regular primary care physician or fewer diabetes symptoms were contributing factors to attrition behavior in our multivariable logistic regression. The most common reasons given by participants for attrition from the program were conflict between their work schedules and the centre's hours of operation, patients' confidence in their own knowledge and ability when managing their diabetes, apathy towards diabetes self-management education, distance to the centre, forgetfulness, regular physician consultations, low perceived seriousness of diabetes, and lack of familiarity with the centre and its services. There was considerable overlap between our quantitative and qualitative findings. Conclusion: Reducing attrition behavior requires a range of strategies targeted towards delivering convenient and accessible services, familiarizing individuals with these services, increasing communication between centres and their patients, and creating better partnerships between centres and primary care physicians

**Khunti, K.. (2007). Quality of diabetes care in the UK: comparison of published quality-of-care reports with results of the Quality and Outcomes Framework for Diabetes. *Diabetes Medicine* 24, (12), 1436-1441.**

Doi: <http://dx.doi.org/10.1111/j.1464-5491.2007.02276.x>

<http://pmid.us/17971182>

Aims: To conduct a systematic review of published observational studies of quality of diabetes care in primary care in the UK and to compare the results with the quality of care data from the Quality and Outcomes Framework (QOF) of the new General Practice Contract in the UK. Methods: medline and embase were searched for articles published from 1999 to June 2006. We also searched for reference lists of studies that fitted our inclusion criteria. All members of the Primary Care Diabetes Europe were contacted and asked to send lists of any relevant published articles. Abstracts were reviewed and data were collected independently by two authors. Results: Abstracts of 742 papers were identified, of which six papers fulfilled the final selection criteria. The total number of

people included in the six published studies was 83 098 (a range of 504 to 54 180 people) compared with the UK QOF data of 1.8 million people with diabetes. The quality indicators for assessment of care varied between different published studies, making comparisons more difficult. Overall, there was a trend towards improvement in both process and outcome of care in the published studies. The quality of care achieved as a result of QOF was greater than that found in published studies. Conclusions: There have been improvements in both process and outcome measures recorded in publications of quality of diabetes care in the UK between 2000 and 2004. Modest financial incentives in primary care are a successful method of improving care for people with diabetes

**Laws, R., et al. (2008). "Should I and Can I"?: A mixed methods study of clinician beliefs and attitudes in the management of lifestyle risk factors in primary health care. *BMC Health Services Research*, 8, (1), 44.**

**Doi:** <http://dx.doi.org/10.1186/1472-6963-8-44>

<http://www.biomedcentral.com/1472-6963/8/44>

<http://pmid.us/18298865>

**Background:** Primary health care (PHC) clinicians have an important role to play in addressing lifestyle risk factors for chronic diseases. However they intervene only rarely, despite the opportunities that arise within their routine clinical practice. Beliefs and attitudes have been shown to be associated with risk factor management practices, but little is known about this for PHC clinicians working outside general practice. The aim of this study was to explore the beliefs and attitudes of PHC clinicians about incorporating lifestyle risk factor management into their routine care and to examine whether these varied according to their self reported level of risk factor management. **Methods:** A cross sectional survey was undertaken with PHC clinicians (n=59) in three community health teams. Clinicians' beliefs and attitudes were also explored through qualitative interviews with a purposeful sample of 22 clinicians from the teams. Mixed methods analysis was used to compare beliefs and attitudes for those with high and low levels of self reported risk factor management. **Results:** Role congruence, perceived client acceptability, beliefs about capabilities, perceived effectiveness and clinicians' own lifestyle were key themes related to risk factor management practices. Those reporting high levels of risk factor screening and intervention had different beliefs and attitudes to those PHC clinicians who reported lower levels. **Conclusions:** PHC clinicians' level of involvement in risk factor management reflects their beliefs and attitudes about it. This provides insights into ways of intervening to improve the integration of behavioural risk factor management into routine practice

**Moser, A., van der, B. H., Widdershoven, G., and Spreeuwenberg, C. (2008). Self-management of type 2 diabetes mellitus: a qualitative investigation from the perspective of participants in a nurse-led, shared-care programme in the Netherlands. *BMC Public Health*, 8, 91.**

**Doi:** <http://dx.doi.org/10.1186/1471-2458-8-91>

<http://pmid.us/18366665>

Background: Diabetes mellitus is a major public health problem. Little is known about how people with type 2 diabetes experience self-management in a nurse-led, shared-care programme. The purpose of this article is to report an empirically grounded conceptualization of self-management in the context of autonomy of people with type 2 diabetes. Methods: This study has a qualitative descriptive, and exploratory design with an inductive approach. Data were collected by means of in-depth interviews. The sample consisted of older adults with type 2 diabetes in a nurse-led, shared-care setting. The data analysis was completed by applying the constant comparative analysis as recommended in grounded theory. Results: People with type 2 diabetes use three kinds of self-management processes: daily, off-course, and preventive. The steps for daily self-management are adhering, adapting, and acting routinely. The steps for off-course self-management are becoming aware, reasoning, deciding, acting, and evaluating. The steps for preventive self-management are experiencing, learning, being cautious, and putting into practice. These processes are interwoven and recurring. Conclusion: Self-management consists of a complex and dynamic set of processes and it is deeply embedded in one's unique life situation. Support from diabetes specialist nurses and family caregivers is a necessity of self-managing diabetes

**O'Kane MJ, et al. 2008 Efficacy of self monitoring of blood glucose in patients with newly diagnosed type 2 diabetes (ESMON study): randomised controlled trial. British Medical Journal Online article 17/4/2008**

Doi: <http://dx.doi.org/10.1136/bmj.39534.571644.BE>

<http://pmid.us/18420662>

Objectives To assess the effect of self monitoring of blood glucose concentrations on glycaemic control and psychological indices in patients with newly diagnosed type 2 diabetes mellitus. Design Prospective randomised controlled trial of self monitoring versus no monitoring (control). Setting Hospital diabetes clinics. Participants 184 (111 men) people aged <70 with newly diagnosed type 2 diabetes referred to the participating diabetes clinics. Major exclusion criteria were secondary diabetes, insulin treatment, previous self monitoring of blood glucose. Interventions Participants were randomised to self monitoring or no monitoring (control) groups for one year with follow-up at three monthly intervals. Both groups underwent an identical structured core education programme. The self monitoring group received additional education on monitoring. Main outcome measures Between group differences in HbA1c, psychological indices, use of oral hypoglycaemic drugs, body mass index (BMI), and reported hypoglycaemia rates. Results 96 patients (55 men) were randomised to monitoring and 88 (56 men) to control. There were no baseline differences in mean (SD) age (57.7 (11.0) in monitoring group v 60.9 (11.5) in control group) or HbA1c (8.8 (2.1)% v 8.6 (2.3)%, respectively). Those in the monitoring group had a higher baseline BMI (34 (7) v 32 (6.2)). There were no significant differences between groups at any time point (12 months values given) in HbA1c (6.9 (0.8)% v 6.9 (1.2)%, P=0.69; 95% confidence interval for difference -0.25% to 0.38%), BMI (33.1 (6.4) v 31.8 (6.0); adjusted for baseline BMI, P=0.32), use of oral hypoglycaemic drugs, or reported incidence of hypoglycaemia. Monitoring was

associated with a 6% higher score on the depression subscale of the well-being questionnaire (P=0.01). Conclusions In patients with newly diagnosed type 2 diabetes self monitoring of blood glucose concentration has no effect on glycaemic control but is associated with higher scores on a depression subscale.

**Ockleford, E., et al (2008). Education and self-management for people newly diagnosed with type 2 diabetes: a qualitative study of patients' views. *Chronic Illness* 4, (1), 28-37.**

Doi: <http://dx.doi.org/10.1177.1742395307086673>

<http://pmid.us/18322027>

Objectives: We explored the perceptions, views and experiences of diabetes education in people with type 2 diabetes who were participating in a UK randomized controlled trial of methods of education. The intervention arm of the trial was based on DESMOND, a structured programme of group education sessions aimed at enabling self-management of diabetes, while the standard arm was usual care from general practices. Methods: Individual semi-structured interviews were conducted with 36 adult patients, of whom 19 had attended DESMOND education sessions and 17 had been randomized to receive usual care. Data analysis was based on the constant comparative method. Results: Four principal orientations towards diabetes and its management were identified: 'resisters', 'identity resisters, consequence accepters', 'identity accepters, consequence resisters' and 'accepters'. Participants offered varying accounts of the degree of personal responsibility that needed to be assumed in response to the diagnosis. Preferences for different styles of education were also expressed, with many reporting that they enjoyed and benefited from group education, although some reported ambivalence or disappointment with their experiences of education. It was difficult to identify striking thematic differences between accounts of people on different arms of the trial, although there was some very tentative evidence that those who attended DESMOND were more accepting of a changed identity and its implications for their management of diabetes. Discussion: No one single approach to education is likely to suit all people newly diagnosed with diabetes, although structured group education may suit many. This paper identifies varying orientations and preferences of people with diabetes towards forms of both education and self-management, which should be taken into account when planning approaches to education

**Parchman, M. I. et al. (2008). A group randomized trial of a complexity-based organizational intervention to improve risk factors for diabetes complications in primary care settings: study protocol. *Implementation Science*, 3, (1), 15.**

<http://dx.doi.org/10.1186/1748-5908-3-15>

<http://www.implementationscience.com/content/3/1/15>

<http://pmid.us/18321386>

Background: Most patients with type 2 diabetes have suboptimal control of their glucose, blood pressure (BP), and lipids - three risk factors for diabetes complications.

Although the chronic care model (CCM) provides a roadmap for improving these outcomes, developing theoretically sound implementation strategies that will work across diverse primary care settings has been challenging. One explanation for this difficulty may be that most strategies do not account for the complex adaptive system (CAS) characteristics of the primary care setting. A CAS is comprised of individuals who can learn, interconnect, self-organize, and interact with their environment in a way that demonstrates non-linear dynamic behavior. One implementation strategy that may be used to leverage these properties is practice facilitation (PF). PF creates time for learning and reflection by members of the team in each clinic, improves their communication, and promotes an individualized approach to implement a strategy to improve patient outcomes. Specific objectives The specific objectives of this protocol are to: evaluate the effectiveness and sustainability of PF to improve risk factor control in patients with type 2 diabetes across a variety of primary care settings; assess the implementation of the CCM in response to the intervention; examine the relationship between communication within the practice team and the implementation of the CCM; and determine the cost of the intervention both from the perspective of the organization conducting the PF intervention and from the perspective of the primary care practice. Intervention The study will be a group randomized trial conducted in 40 primary care clinics. Data will be collected on all clinics, with 60 patients in each clinic, using a multi-method assessment process at baseline, 12, and 24 months. The intervention, PF, will consist of a series of practice improvement team meetings led by trained facilitators over 12 months. Primary hypotheses will be tested with 12-month outcome data. Sustainability of the intervention will be tested using 24 month data. Insights gained will be included in a delayed intervention conducted in control practices and evaluated in a pre-post design. Primary and secondary outcomes To test hypotheses, the unit of randomization will be the clinic. The unit of analysis will be the repeated measure of each risk factor for each patient, nested within the clinic. The repeated measure of glycosylated hemoglobin A1c will be the primary outcome, with BP and Low Density Lipoprotein (LDL) cholesterol as secondary outcomes. To study change in risk factor level, a hierarchical or random effect model will be used to account for the nesting of repeated measurement of risk factor within patients and patients within clinics. This protocol follows the CONSORT guidelines and is registered per ICMJE guidelines:

**Qureshi, N. and Kai, J. (2008). Informing patients of familial diabetes mellitus risk: how do they respond? A cross-sectional survey. *BMC Health Services Research*, 8, (1), 37.**

Doi: <http://dx.doi.org/10.1186/1472-6963-8-37>

<http://pmid.us/18257922>

<http://www.biomedcentral.com/1472-6963/8/37>

Background: A strong family history of type 2 diabetes mellitus (DM) confers increased DM risk. This survey analysis determined whether patients who were informed by their doctors of familial DM risk acknowledged that risk and took steps to reduce it. Methods: We conducted an analysis of the National Health Styles 2004 mail survey. All non-

diabetic participants who responded to the question of whether their doctor had or had not informed them of their familial DM risk (n = 3,323) were compared for their risk-reducing behaviour and attitude to DM risk. Results: Forty-one percent (n = 616) of the question responders that had DM family histories were informed by their doctors of their familial risk; the chance of being informed increased with the number of relatives that had the disease. Members of the informed group were more likely than those in the non-informed group to report lifestyle changes to prevent DM (odds ratio [OR] 4.3, 95% confidence interval [CI] 3.5-5.2) and being tested for DM (OR 2.9, 95% CI 2.4-3.6), although no significant improvement occurred in their U.S.-recommended exercise activity (OR 0.9, 95% CI 0.7-1.1). Overall, informed responders recognised both their familial and personal DM risk; most discussed diabetes with their family (69%), though less so with friends (42%); however, 44% of them still did not consider themselves to be at risk. Conclusions: Responders who were informed by their doctors of being at familial DM risk reported greater incidences of lifestyle changes, DM screening, and awareness of risk than non-informed responders. Doctors were more likely to inform patients with stronger DM family histories. Identifying this higher risk group, either in isolation or in combination with other recognised risk factors, offers doctors the opportunity to target limited health promotion resources efficiently for primary DM prevention

**Reeves D et al (2008). Predicting who will benefit from an Expert Patients Programme self-management course. *British Journal of General Practice*, 58, (548), 198-203.**

<http://dx.doi.org/10.3399/bjgp08X277320>

<http://pmid.us/18339831>

**Background** In England, the Expert Patients Programme, a lay-led chronic disease self-management course, was developed to improve self-care support and skills. The course is designed for anyone with a self-defined long-term condition, and attracts a heterogeneous group of patients. A randomised controlled trial has demonstrated effectiveness in improving subjective health. However, it is not known whether particular patient characteristics predict the impact of the course. **Aim** To determine whether baseline characteristics predict clinical outcomes from attendance at a chronic disease self-management course; and to assess whether identification of such characteristics assists in targeting the course to individuals most likely to benefit. **Design of study** A post-hoc subgroup analysis of data from a randomised controlled trial to explore predictors of three trial outcomes: self-efficacy, energy, and health-related quality of life. **Setting** Participants with self-defined long-term conditions (n = 629) were recruited from community settings in all 28 strategic health authorities in England. **Method** Multiple regression was used to examine interactions between baseline variables and trial outcomes. **Results** The predictors demonstrating significant interactions were: age and general health, and baseline values for self-efficacy, energy levels, and health-related quality of life. **Conclusion** Participants with lower self-efficacy and health-related quality of life at baseline demonstrated more positive health outcomes. The Expert Patients Programme may have a protective effect on health-related quality of life for patients with

poor health and low confidence. Younger people benefited substantially more than older people. Results suggest that positive outcomes associated with the course will be demonstrated with a wide variety of patients, although it may be worthwhile encouraging attendance of younger patients, those lacking confidence, and those coping poorly with their condition.

**Rifas-Shiman, S., et al (2008). Diabetes and lipid screening among patients in primary care: a cohort study. *BMC Health Services Research*, 8, (1), 25.**

**Doi:** <http://dx.doi.org/10.1186/1472-6963-8-25>

<http://pmid.us/18234107>

<http://www.biomedcentral.com/1472-6963/8/25>

**Background:** Obesity is associated with increased cardiovascular diseases and diabetes mellitus. Guidelines call for intensified glucose and lipid screening among overweight and obese patients. Data on compliance with these guidelines are scarce. The purpose of this study was to assess rates of diabetes and lipid screening in primary care according to demographic variables and weight status. **Methods:** Over a 3-year follow-up period, we assessed screening rates for blood glucose, triglycerides, and HDL- and LDL-cholesterol among 5025 patients in primary care. From proportional hazards models we estimated screening rates among low, moderate, high, and very-high risk patients and compared them with recommendations of the American Diabetes Association (ADA), National Cholesterol Education Program (ATP III) and U.S. Preventive Services Task Force (USPSTF). **Results:** Mean (SD) age was 47.4 (15.6); 69% were female, 21% were non-white, and 30% of males and 25% of females were obese (BMI >30 kg/m<sup>2</sup>). For both diabetes and lipid screening, the adjusted hazard was 260-330% higher among >65 than <35 year-olds, 50-90% higher in persons with BMI >35 than <25 kg/m<sup>2</sup>, 10-30% lower for females than males, and not lower among racial/ethnic minorities. Screening rates were at least 80% among very-high risk persons, which we defined as 55-64 years old, BMI >35 kg/m<sup>2</sup>, non-white, with baseline hypertension. In contrast, high-risk persons who were younger (35-44 years old) and less obese (BMI 30-<35 kg/m<sup>2</sup>) were screened less often (43% for LDL-cholesterol among females to 83% for diabetes among males) even though ADA, ATP III and USPSTF recommend diabetes and lipid screening among them. **Conclusions** :Patients with higher BMI or age were more likely to be screened for cardiometabolic risk factors. Women were screened at lower rates than men. Even in a highly structured medical group practice, some obese patients were under-screened for diabetes and dyslipidemia

**Si D, Bailie R, and Weeramanthri, T. (2008). Effectiveness of chronic care model-oriented interventions to improve quality of diabetes care: a systematic review *Primary Health Care Research and Development*, 9, (1), 25-40.**

**Doi:** <http://dx.doi.org/10.1017/S1463423607000473>

**Background** The chronic care model (CCM) has been widely used in a variety of health care settings to guide system improvement for chronic illness care, including diabetes

care. However, the evidence base for the specific components of the model has not been systematically reviewed. This review aimed at examining the extent to which interventions featuring the CCM components improve diabetes care and determining the relative effectiveness of different CCM components. **Methods** We systematically searched MEDLINE (1966 to December 2004), the Cochrane Effective Practice and Organisation of Care and the Cochrane Controlled Trials Register to identify interventions featuring one or more system components of the CCM for diabetes care. Outcome measures included HbA1c, blood pressure and blood lipid control. We used random-effects meta-analysis and meta-regression for quantitative synthesis of data. **Results** In all, 69 studies (43 randomized controlled trials and 26 controlled before–after studies) met inclusion criteria and were included in this review. Overall, included studies reported a mean reduction of 0.46% (95% CI 0.38, 0.54) in HbA1c, mean reduction of 2.2 (95% CI 0.9, 3.5) mmHg in systolic blood pressure, mean reduction of 1.3 (95% CI 0.6, 2.1) mmHg in diastolic blood pressure and mean reduction of 0.24 (95% CI 0.06, 0.41) mmol/L in total cholesterol. For specific CCM components, interventions that addressed delivery system design reported the largest improvements in patient outcomes, followed by those employing a self-management support component. Interventions involving decision support or clinical information systems reported relatively smaller effect sizes. **Conclusions** Interventions featuring CCM components for diabetes care produced small-to-moderate improvements in a range of patient intermediate outcomes. The findings support the concept of the CCM in which the state of development of various aspects of primary care service systems defined in this model appear to be important factors in the quality of care provided to people with diabetes. (Received April 2007)

**Siriwardena, A., et al (2008). Drivers for change in primary care of diabetes following a protected learning time educational event: interview study of practitioners. *BMC Medical Education*, 8, (1), 4**

**Doi:** <http://dx.doi.org/1186/1472-6920-8-4>

<http://www.biomedcentral.com/1472-6920/8/4>

<http://pmid.us/18205947>

**Background:** A number of protected learning time schemes have been set up in primary care across the United Kingdom but there has been little published evidence of their impact on processes of care. We undertook a qualitative study to investigate the perceptions of practitioners involved in a specific educational intervention in diabetes as part of a protected learning time scheme for primary health care teams, relating to changing processes of diabetes care in general practice. **Methods:** We undertook semistructured interviews of key informants from a sample of practices stratified according to the extent they had changed behaviour in prescribing of ramipril and diabetes care more generally, following a specific educational intervention in Lincolnshire, United Kingdom. Interviews sought information on facilitators and barriers to change in organisational behaviour for the care of diabetes. **Results:** An interprofessional protected learning time scheme event was perceived by some but not all

participants as bringing about changes in processes for diabetes care. Participants cited examples of change introduced partly as a result of the educational session. This included using ACE inhibitors as first line for patients with diabetes who developed hypertension, increased use of aspirin, switching patients to glitazones, and conversion to insulin either directly or by referral to secondary care. Other reported factors for change, unrelated to the educational intervention, included financially driven performance targets, research evidence and national guidance. Facilitators for change linked to the educational session were peer support and teamworking supported by audit and comparative feedback .Conclusions: This study has shown how a protected learning time scheme, using interprofessional learning, local opinion leaders and early implementers as change agents may have influenced changes in systems of diabetes care in selected practices but also how other confounding factors played an important part in changes that occurred in practice

**Taylor D, Lahey M (2008). Increasing the involvement of specialist physicians in chronic disease management. *Journal of Health Services Research and Policy*, 13, (Supplement 1), 52-56**

**Doi: <http://dx.doi.org/10.1258/jhsrp.2007.007068>**

Background: The Capital Health (CH) region in Alberta serves the population of the Edmonton area as well as a large referral population in western Canada. CH is responsible for the delivery of the spectrum of patient care, from inpatient to outpatient services. Growth in outpatient care, in particular, has led to the development of several ambulatory care facilities from which the delivery of care to several populations with a chronic disease will be coordinated. Assessment of problem: The traditional model of care delivery is unsuited to the management of chronic diseases. Physicians must be part of the planning and implementation of new models if they are to be successful and sustainable. The concept of integration into a delivery team is not well understood or practised. This is not conducive to the integration of specialist physicians into multidisciplinary teams in ambulatory care that serves the needs of patients from a large geographic area. Results: Chronic disease management using the Chronic Care Model has proven to be an effective method of delivering care to this wide population. Specialist physicians have not always taken advantage of opportunities to be involved in the planning and development of such new health care projects. In CH, physician integration in the planning, development and implementation of this new model has proven vital to its success. Strategies for change: We based our strategy for change on Wagner's Chronic Care Model. This involved eight steps, the first four of which have been completed and the fifth and sixth are underway. Lessons and messages: Five factors contributed to the successful integration of specialist physicians in chronic disease management: collaboration between disciplines and organizations; creating patient-centred services; organizational commitments; strong clinical leadership; and early involvement of clinicians.

van Bastelaar, et al . (2008). Web-based cognitive behavioural therapy (W-CBT) for diabetes patients with co-morbid depression: design of a randomised controlled trial. *BMC Psychiatry*, 8, (1), 9. Doi: <http://dx.doi.org/10.1186/1471-244X-8-9>

<http://dx.doi.org/10.1186/1471-244X-8-9>

<http://www.biomedcentral.com/1471-244X/8/9>

<http://pmid.us/18284670>

Background: Depression is common among people with diabetes, negatively affecting quality of life, treatment adherence and diabetes outcomes. In routine clinical care, diabetes patients have limited access to mental health services and depression therefore often remains untreated. Web-based therapy could potentially be an effective way to improve the reach of psychological care for diabetes patients, at relatively low costs. This study seeks to test the effectiveness of a web-based self-help depression programme for people with diabetes and co-morbid depression. Methods / Design The effectiveness of a web-based self-help course for adults with diabetes with co-morbid depression will be tested in a randomised trial, using a waiting-list controlled design. The intervention consists of an 8-week, moderated self-help course that is tailored to the needs of persons living with diabetes and is offered on an individual basis. Participants receive feedback on their homework assignments by e-mail from their coach. We aim to include 286 patients (143/143), as power analyses showed that this number is needed to detect an effect size of 0.35, with measurements at baseline, directly after completing the web-based intervention and at 1, 3, 4 and 6 months follow-up. Patients in the control condition are placed on a waiting list, and follow the course 12 weeks after randomisation. Primary outcomes are depressive symptoms and diabetes-specific emotional distress. Secondary outcomes are satisfaction with the course, perceived health status, self-care behaviours, glycaemic control, and days in bed/absence from work. Questionnaires are administered via the Internet. Discussion: The intervention being trialled is expected to help improve mood and reduce diabetes-specific emotional distress in diabetes patients with depression, with subsequent beneficial effects on diabetes self-care and glycaemic outcomes. When proven efficacious, the intervention could be disseminated to reach large groups of patients with diabetes and concurrent depressive symptoms.

Wasson, J. H., Johnson, D. J., and Mackenzie, T. (2008). The impact of primary care patients' pain and emotional problems on their confidence with self-management. *Journal of Ambulatory Care Management*, 31, (2), 120-127.

Doi: <http://dx.doi.org/10.1097/01.JAC.0000314702.57665.a0>

<http://pmid.us/18360173>

There is a paucity of information about confidence with self-management in primary care practice. This study examines changes over time in patient-reported confidence with self-management on the basis of 1047 patients aged 50-69 who had common chronic diseases,

bothersome pain, or emotional problems. We examined the relationship between patients' self-reported confidence, their experiences of medical care, and health outcomes after adjustment for baseline characteristics. We observed that, over a 2-year period, about a third of the patients remained confident and a third remained not confident. Change in pain or emotional problems was strongly associated with whether a patient was confident or not at the end of the follow-up period ( $P < .001$ ). Persistently good confidence or improved confidence was strongly associated with measures of high-quality medical care. For patients with diabetes, persistent confidence was more often associated with control of blood glucose ( $P = .004$ ) compared with the control in patients who were not as confident. Confident patients were likely to be fully engaged in everyday work and activities ( $P < .001$ ). The results suggest that for the majority of patients in primary care practices, the status of their self-reported confidence with self-management persists over time. Their confidence is impacted by their pain or emotional state and strongly associated with their medical care experiences and some outcomes of care

**Watson, J. and Hamilton W (2008). Clinical features of type 2 diabetes before diagnosis and pathways to the diagnosis: a case–control study. *Primary Health Care Research and Development*, 9, (1), 41-48.**

**Doi:** <http://dx.doi.org/10.1017/S1463423607000552>

**Aim** To identify and quantify clinical features associated with a future diagnosis of type 2 diabetes, and to record pathways to the diagnosis of diabetes. **Background** The risk of type 2 diabetes posed by particular symptoms is largely unknown, especially in unselected populations like primary care. The current mode and setting of diagnosis in the UK are undescribed. **Methods** This was a population-based case–control study in seven general practices in Bristol, UK. In this study, 105 cases with newly diagnosed diabetes, and 105 age- and sex-matched controls were studied. Their primary care records for two years before diagnosis were examined for symptoms previously reported to be associated with diabetes and for abnormal investigations. Differences between cases and controls were analysed by conditional logistic regression. In cases, the pathways to the diagnosis of diabetes were categorised. **Findings** In all, 42 (40%) adults with newly diagnosed diabetes were asymptomatic at diagnosis and 84 (80%) were first detected in primary care. Five clinical features were independently associated with diabetes in multivariable analyses. Likelihood ratios for these were: thirst 36 (95% confidence interval 3.0, 440),  $P = 0.005$ ; weight loss 5.7 (1.3, 26),  $P = 0.022$ ; skin infections 4.6 (1.7, 12),  $P = 0.002$ ; fasting glucose  $>5.6$  mmol/L 38 (2.2, 640),  $P = 0.012$ ; and random glucose  $>5.6$  mmol/L 15 (2.5, 94),  $P = 0.003$ . The median time period between the onset of symptoms and diagnosis was short (8 days) in patients presenting with thirst, but much longer for those with weight loss (294 days) and skin infections (463 days). Over a quarter of patients had raised blood glucose readings, which were not followed up in the two years before diagnosis was made. **Conclusions** Most patients with type 2 diabetes are diagnosed in primary care. Many are asymptomatic at diagnosis. Earlier diagnosis of diabetes may be possible by considering diabetes in patients with weight loss and skin infections, and ensuring that borderline abnormal tests are adequately followed up.

## EMPOWERMENT

**Alegria, M. P., et al. (2008). Evaluation of a patient activation and empowerment intervention in mental health care. *Medical Care*, 46, (3), 247-256.**

**Doi: <http://dx.doi.org/10.1097/MLR.0b013e318158af52>**

**<http://pmid.us/18388839>**

Background: Evidence suggests that minority populations have lower levels of attendance and retention in mental health care than non-Latino whites. Patient activation and empowerment interventions may be effective in increasing minority patients' attendance and retention., Objectives: This study developed and evaluated a patient self-reported activation and empowerment strategy in mental health care., Research Design: The Right Question Project-Mental Health (RQP-MH) trainings consisted of 3 individual sessions using a pre/post test comparison group design with patients from 2 community mental health clinics. The RQP-MH intervention taught participants to identify questions that would help them consider their role, process and reasons behind a decision; and empowerment strategies to better manage their care., Subjects: A total of 231 participated, completing at least the pretest interview (n = 141 intervention site, 90 comparison site)., Measures: Four main outcomes were linked to the intervention: changes in self-reported patient activation; changes in self-reported patient empowerment; treatment attendance; and retention in treatment., Results: Findings show that intervention participants were over twice as likely to be retained in treatment and over 3 times more likely than comparison participants to have scheduled at least 1 visit during the 6-month follow-up period. Similarly, intervention participants demonstrated 29% more attendance to scheduled visits than comparison patients. There was no evidence of an effect on self-reported patient empowerment, only on self-reported patient activation., Conclusions: Results demonstrate the intervention's potential to increase self-reported patient activation, retention, and attendance in mental health care for minority populations. By facilitating patient-provider communication, the RQP-MH intervention may help minorities effectively participate in mental health care.,

**Aujoulat, I., et al (2008). Reconsidering patient empowerment in chronic illness: A critique of models of self-efficacy and bodily control. *Social Science and Medicine*, 2008 66, (5), 1228-1239.**

**Doi: <http://dx.doi.org/10.1016/j.socscimed.2007.11.034>**

**<http://pmid.us.18155338>**

Studies that focus on patient empowerment tend to address more specifically two issues of patients' experience of illness: managing regimens and relating to health-care providers. Other aspects of illness experience, such as coming to terms with disrupted identities, tend to be overlooked. The outcome of empowerment is therefore usually referred to as achieving self-efficacy, mastery and control. We conducted an inductive

exploratory study, based on individual in-depth interviews with 40 chronically ill patients in Belgium and Italy, in order to understand the process of empowerment as it may occur in patients whose experience of illness has at some point induced a feeling of powerlessness, which we conceptualised as a threat to their senses of security and identity. Our findings show that empowerment and control are not one and the same thing. We describe patient empowerment as a process of personal transformation which occurs through a double process of (i) "holding on" to previous self-representations and roles and learning to control the disease and treatment, so as to differentiate one's self from illness on the one hand, and on the other hand (ii) "letting go", by accepting to relinquish control, so as to integrate illness and illness-driven boundaries as being part of a reconciled self. Whereas the process of separating identities ("holding on") was indeed found to be linked to efforts aimed at taking control and maintaining or regaining a sense of mastery, the process of reconciling identities ("letting go") was found to be linked to a need for coherence, which included a search for meaning and the acceptance that not everything is controllable. We argue that the process of relinquishing control is as central to empowerment as is the process of gaining control. As a "successful" process of empowerment occurs when patients come to terms with their threatened security and identity, not only with their treatment, it may be facilitated by health-care providers through the use of narratives

**Booker, S., Morris, M., and Johnson, A. (2008). Empowered to change: evidence from a qualitative exploration of a user-informed psycho-educational programme for people with type 1 diabetes. *Chronic Illness* 4, (1), 41-53.**

Doi: <http://dx.doi.org/10.1177/1742395307086695>

<http://pmid.us/18322029>

Objectives: To evaluate the impact of a user-informed psycho-educational programme for people with type 1 diabetes. Methods: Qualitative data derived from repeated interviews and diaries enabled an appraisal of participants' unique, individual experiences. Results: Thematic analysis elicited a number of themes from each type of data (interview and diaries) which bore similarities in their representation of a process whereby change was desired, solutions were found to bring about that change, and then the process was planned or embarked upon. Discussion: The acquisition of trustworthy information and a repertoire of coping skills accompanied by regular contact with other people with type 1 diabetes meant that participants achieved an increased sense of control in their lives and were empowered to change

**Bradbury-Jones,C.; Sambrook,S, Irvine F, . (2008) Power and empowerment in nursing: a fourth theoretical approach *Journal of Advanced Nursing* 62(2) 258-266**

Doi: <http://dx.doi.org/10.1111/j.1365-2648.2008.04598.x>

<http://pmid.us/18394038>

Aim: This paper is a discussion of the use of poststructuralism as a means of exploring power and empowerment in nursing. Background: Power and empowerment are well-researched areas of nursing practice, but the issue of how to empower nurses and patients continues to cause debate. Power and empowerment are complex issues and other researchers have provided some clarity by proposing three theoretical approaches: critical social theory, organizational theory and social psychological theory. We support their work and propose an additional poststructural approach as a means of analyzing power and empowerment in nursing. Discussion: The concept of power in nursing may be critiqued by drawing on the work of Michel Foucault and paying particular attention to two areas: disciplinary power and knowledge/power relationships. Foucault's contention was that behaviour is standardized through disciplinary power and that power and knowledge are intertwined. Nurses who seek an understanding of empowerment must first grasp such workings as hierarchical observation, normalizing judgement, the examination, and power/knowledge relationships, and that cognizance of such issues can promote nursing practice that is empowering. They need to adopt a more critical stance to understanding power and empowerment in nursing, and one way of fostering such criticism is to view nursing practice through a poststructural lens. Conclusion: A poststructural approach merits a place alongside other approaches to understanding power and empowerment in nursing.

**Fisher, P. (2008). Wellbeing and empowerment: the importance of recognition. *Sociology of Health and Illness* 30 (4) , 583–598**

Doi: <http://dx.doi.org/10.1111/j.1467-9566.2007.01074.x>

<http://pmid.us/18298628>

Health and wellbeing are now located within a policy framework that emphasises the empowerment of the individual 'consumer'. Within this paradigm, empowerment is writ large and wellbeing is seen as a 'civic duty'. The role of the health and social care services has been identified as one of enabling service users to promote their own wellbeing. In this paper, it is argued that dominant narratives relating to 'achievement' and 'normality' may result in forms of 'misrecognition' that act to undermine the positive sense of self that is crucial for self-empowerment. It is suggested that while the parents of disabled babies often act reflexively to create empowering life narratives within the private sphere, this is not always facilitated by their encounters with health and social care organisations where neo-liberal ideas and biomedical narratives, based on a modernist view of identity as individual and existing prior to society, mean that parents and children are attributed 'deficient' identities in ways that undermine empowerment. With reference to 'the politics of recognition', it is argued that services that seek to empower must value diversity and alterity whilst respecting human dependency on intersubjective recognition

**Sigurdardottir, A. K. and Jonsdottir, H. (2008). Empowerment in diabetes care: towards measuring empowerment. *Scandinavian Journal of Caring Sciences* .  
Online Early Article    Online Early Article**

Doi: <http://dx.doi.org/10.1111/j.1471-6712.2007.00506.x>

<http://pmid.us/18298619>

The aim of this study was to measure validity and reliability of the Icelandic version of the Diabetes Empowerment Scale (DES) among people with diabetes and to develop knowledge about Icelandic people with diabetes. For this purpose, DES was distributed along with the Diabetes Knowledge Test and the Problem Area in Diabetes scale in four diabetes clinics in Iceland after the study received ethical approval from the National Bioethical Committee. Of the 101 allocated questionnaires, 92 were returned and 90 questionnaires were useable, resulting in 89% response rate. The Cronbach's alpha coefficient for DES was 0.84, and for the three subscales: Managing the Psychosocial Aspects of Diabetes (alpha = 0.76), Assessing Dissatisfaction and Readiness to Change (alpha = 0.63) and Setting and Achieving Diabetes Goals (alpha = 0.79). There was a criterion validity between level of education and DES. Mean value for DES was 3.68 +/- 0.52 on a scale of 1-5 where a higher score indicates increased empowerment. Range was from 2.43 to 4.68, indicating that the instrument demonstrates neither floor nor ceiling effects. This study indicates that the DES, the only available instrument to measure the concept of empowerment in diabetes care, is a sufficiently reliable and valid instrument in the Icelandic culture. However, it needs further testing. Empowerment is highly valued within the clinical arena, as well as when health professionals study patients' capacity to deal with health problems

## HEALTH ECONOMICS

**Richardson, G. et al. (2008). Cost effectiveness of the Expert Patients Programme (EPP) for patients with chronic conditions. *Journal of Epidemiology and Community Health*, 62, (4), 361-367.**

Doi: <http://dx.doi.org/10.1136/jech.2006.057430>

<http://pmid.us/18339831>

**Objective** To assess the cost effectiveness of the Expert Patients Programme (EPP) intervention compared to a treatment as usual alternative. **Design** Two-arm pragmatic randomised controlled trial design with waiting list control. **Setting** Community settings in England. **Patients** Patients with a wide range of self-defined long-term conditions. **Intervention** The EPP based on the US chronic disease self management program (CDSMP), a lay-led self-care group involving six weekly sessions to teach self-care support skills. **Main outcome measures** Costs estimated over a 6-month period from a societal perspective. Health outcomes estimated in terms of quality adjusted life years (QALYs) generated by patients' response to the EQ5D at baseline and 6-month follow-up. **Results** The intervention group is associated with better patient outcomes, at slightly lower cost. Specifically, the intervention group has a 0.020 QALY gain compared with the control group, and a reduced cost of around {pound}27 per patient. The intervention

would therefore be considered dominant. While the QALYs gained are small in absolute terms, an additional 0.02 QALY is equivalent to an extra one week of perfect health per year. When the value of a QALY is {pound}20 000 the EPP has a probability of 94% of being cost effective. Indeed, for all plausible values of willingness-to-pay for a QALY the EPP group is more likely to be cost effective than the control group. Conclusions The EPP intervention evaluated in this trial is very likely to provide a cost effective alternative to usual care in people with long-term conditions

## INFORMATION AND COMMUNICATIONS TECHNOLOGY

**Finch, T. L. (2008). Future patients? Telehealthcare, roles and responsibilities. *Health and Social Care in the Community*, 16, (1), 86-95**

**Doi: <http://dx.doi.org/10.1111/j.1365-2524.2007.00726.x>**

**<http://pmid.us/18181818>**

Increasing use of information and communication technologies is said to be transforming health care. Telehealthcare enables medical consultations to be conducted between patients and health professionals across different locations. Such technologies imply new relationships between patients and health professionals. This study aimed to understand how policy and practice in relation to telehealthcare suggests new conceptualisations of 'the patient'. In-depth semistructured interviews (n = 38) were conducted with key informants from across the UK, known to have involvement or interest in telehealthcare from a variety of perspectives: health professionals (n = 11), patient advocates (n = 7), telemedicine experts (n = 6), policy-makers (n = 4), administrators (n = 4), researchers (n = 3) and technologists (n = 3). Interviews were conducted either in person or over the telephone, and were audio-recorded. Data were analysed thematically with ongoing cross-validation of data interpretation between members of the research team. The results indicated divergent views about the role of the patient, although accounts of patients becoming 'educated self-managers', taking on a more active role in their healthcare, were predominant. Beliefs about the impact of telehealthcare on patients were focused on perceived 'priorities' such as access, location of services, confidentiality and choice; however, there remains little understanding of the trade-offs that patients are willing to make in the context of technologically mediated health care. The results also highlight ideas around how patients relate to technologies; the extent to which technologies might fragment care and medicine in new or unexpected ways, and participation and absence of patients in decision-making about policies and services. The results of this study have important implications for the ways in which relationships between health professionals and patients are managed in practice, and raise important questions for public participation in service development

**Hannan A (2008). The paradigm shift in healthcare - Overcoming challenges in giving patients access to their electronic records. *Journal of Communication in Healthcare*, 1, (1), 7-19.**

As the delivery of healthcare by an increasing number of service providers becomes more complex, there is an increasing need for patients to understand their treatment plans and to compare them with what they should expect to receive. Changes in society mean that patients may now have the opportunity and desire to view their electronic health record and share it with others electronically. This is the basis of the paradigm shift in healthcare. But patients, clinicians and managers need to consider how to do this safely and responsibly. There are a number of challenges that need to be overcome including informing patients and empowering them, understanding the financial model to support this as well as the change management and data protection issues, understanding how information is recorded in the record, producing tools to encourage patients to be active participants, reducing the digital divide, enabling easy identification of high-quality information, producing a framework for enabling safe sharing of information, understanding the role of a local care record development board which helps to manage the change, enabling semantic interoperability in a global market and understanding how we can assess its success. This heralds a new era of 'real-time digital medicine'.

**Nilsson, G. H., et al . (2008). Patients, general practitioners, diseases and health problems in urban general practice: a cross-sectional study on electronic patient records. *Primary Health Care Research & Development*, 9, (2), 119-125.**

**Doi: <http://10.1017/S1463423608000649>**

**Background** Statistics from primary health care in Sweden, as well as from other Nordic countries, have been sparse. The electronic patient records (EPR) will be an increasingly important source of clinical information. The aim of this study was to investigate types of encounters, managed diseases and health problems, and characteristics of patients and general practitioners (GPs) in everyday general practice using EPR. **Methods** A multi-centre, cross-sectional database study of EPR in primary health care in Stockholm, Sweden. Twenty-six randomly selected GPs with 20 randomly selected encounters each. **Main outcome measures** were the number and distribution of diseases and health problems, age and gender of patients and GPs, and type of encounter. **Results** The mean age of the patients was 51.2 years, 30.2% were aged 75 years or older, and 57.5% were women. The mean number of managed problems per encounter was 1.4. The most common specific diagnoses were essential hypertension (9.3% of the encounters) and acute upper respiratory infections (8.8%). Older patients had more health problems in each encounter ( $P = 0.000001$ ). GPs differed regarding the characteristics of their patients, including sex, age and number of health problems managed at each encounter. The patients of different GPs differed regarding sex, age and number of health problems managed. Female and male patients had different diagnostic panoramas and they had a tendency to encounter a GP of the same sex (odds ratio 1.5,  $P = 0.053$ ). **Conclusions** We found that two diagnoses (essential hypertension and acute upper respiratory infections), four diagnostic groups, women and the elderly are predominant. Female and

male patients have different diagnostic panoramas and they have a tendency to encounter a GP of the same sex. GPs differ regarding the characteristics of their patients, including sex, age and number of health problems managed at each encounter

**Oudshoorn, N. (2008). Diagnosis at a distance: the invisible work of patients and healthcare professionals in cardiac telemonitoring technology**  
**143. *Sociology of Health and Illness*, 30, (2), 272-288**

Doi: <http://dx.doi.org/10.1111/j.1467-9566.2007.01032.x>

<http://pmid.us/18290936>

Although patients are often absent in discourses on telemedicine, many telemonitoring applications constitute a new medical practice in which patients are expected to play an active role. The paper is based on a study of the use of one specific telemonitoring device, an ambulatory ECG recorder introduced to diagnose infrequent irregularities of the heart rhythm. It seeks to examine all the invisible work it takes to produce patients who are active and responsible as participants in the diagnosis of their heart problem. In particular, I address the question of how we can understand that individuals who are anxious about their heart function manage to adopt the role of 'diagnostic agent'. This research shows that, although many patients managed to become competent users of the new technology, there are important patterns of selective use patients invented to integrate the technology in their daily life. In conclusion, the paper suggests that most patients were able to adopt the role of diagnostic agent not only because of their individual motivation but because of their location in the socio-technical network of this technology, in which the invisible work of home-care nurses and physicians at the telemedical centre made all the difference

## **MEDICINES MANAGEMENT**

**Guillaume, L., et al. (2008). Supplementary prescribing by community and primary care pharmacists: an analysis of PACT data, 2004-2006. *Journal of Clinical Pharmacy & Therapeutics*, 33, (1), 11-16.**

Doi: <http://dx.doi.org/10.1111/j.1365-2710.2008.00869.x>

<http://pmid.us/18211611>

Background and objective: Pharmacist prescribing is a relatively new initiative in the extension of prescribing responsibilities to non-medical healthcare professionals. Pharmacist supplementary prescribing was introduced in 2003 and allowed prescribing in accordance with a clinical management plan agreed with a medical practitioner and patient to improve patient access to medicines and better utilize the skills of healthcare professionals. The objective of this research was to examine the volume, cost and trends

in pharmacist prescribing in community and primary care using Prescription Analysis and Cost (PACT) data and to suggest possible reasons for the trends. Methods: Using PACT data at national, chapter and subchapter level for 2004-2006 the volume, costs and trends for pharmacist prescribing were obtained. Supplemental data and statistical analysis from other sources, relating to prescribing of individual drugs, were also utilized. Results: The total number of items prescribed by pharmacists in community and primary care increased from 2706 in 2004 to 31 052 in 2006. In 2006, pharmacist prescribing represented only 0.004% of all prescribing in the community and primary care setting. Cardiovascular medicines were the most frequently prescribed therapeutic class followed by central nervous system, respiratory, endocrine and gastrointestinal medicines. Conclusion: Pharmacist prescribing is increasing but represents an extremely small proportion of primary care prescribing. PACT data between 2004 and 2006 reflects pharmacist supplementary prescribing alone and has been in the anticipated therapeutic areas of drugs which treat chronic conditions such as hypertension

**Macbride-Stewart, S. P., Elton, R., and Walley, T. (2008). Do quality incentives change prescribing patterns in primary care? An observational study in Scotland. *Family Practice* 25, (1), 27-32.**

Doi: <http://dx.doi.org/10.1093/fampra/cmm074>

<http://pmid.us/18245796>

Background. The 2004 General Medical Services (GMS) contract introduced financial incentives for the management of chronic illnesses in 10 clinical areas. The effect of the scheme on prescribing is unknown. Objectives. To quantify the impact of the latest GMS contract, which incorporates additional payments for quality outcomes, on prescribing patterns in GP practices. Methods. This retrospective observational study of prescribing compared the defined daily doses (DDDs) for drugs mentioned or implied within the Quality and Outcomes Framework (QOF) of the latest GMS contract (QOF drugs) to the DDDs for all other drugs listed within the first 10 chapters on the British National Formulary (non-QOF drugs) for four financial years; two before and two after the introduction of the latest GMS contract. These measures were calculated for 92 GP practices of 100 in the Lothian region of Scotland, and the rate of change of prescribing was calculated from regression slopes within the log-scale interrupted time series analyses. Results. The prescribing of QOF drugs increased significantly faster than the non-QOF drugs both before and after the introduction of the latest GMS contract but the rate of increase for the QOF drugs slowed significantly after April 2005 unlike prescribing of non-QOF drugs. Conclusions. The prescribing of relevant drugs increased before the introduction of the 2004 GMS contract; the increase continued in the first 2 years of the new contract but at a significantly lower level

**Mason, A. (2008). New medicines in primary care: a review of influences on general practitioner prescribing. [Review] [47 refs]. *Journal of Clinical Pharmacy & Therapeutics*, 33 , (1), 1-10.**

Background and objective: The uptake of new medicines is slower in the UK than in many other countries. Previous research found that cost and price have little influence on general practitioner (GP) behaviour, but recent UK government policy may have heightened cost-consciousness. Focussing on new medicines, this review aimed to explore the determinants of uptake, the causes of geographical variations, and the influence of price, cost and financial incentives on prescribing behaviour. Methods: Two separate searches were conducted on nine electronic databases. Strategy 1, an update of a previous review, used key terms for primary care physicians, uptake, medicines and 'new'. Strategy 2 focussed on terms relating to incentives and prescribing. Records were screened for eligibility and data from relevant papers were extracted using Bonair and Persson's typology for determinants of the diffusion of innovation, which classified influences into three groups: actors, structural/environmental characteristics and product characteristics. Results: The searches identified 550 records and 28 studies were included in the updated review. Prescribing of new medicines needs to be understood in the context of individual patient-centred care, which is characterized by stability and continuity. Hospital doctors, pharmaceutical representatives and prescribing advisers are all influential, but GP attitudes towards these actors vary and there are notable differences between high and low prescribers of new pharmaceuticals. Support systems can help provide appropriate guidance and increase the uptake of new medicines by identifying patients who may benefit from pharmaceutical therapy. There is evidence of a shift in GP attitudes towards central policy initiatives, with doctors slowly accepting the need for external scrutiny and national standards. Although cost does appear to inform prescribing decisions, it is typically of lower importance than both safety and efficacy concerns and does not represent a significant barrier to uptake of new medicines. The impact of financial incentives on prescribing behaviour remains unclear, but is unlikely to be straightforward. No evidence exploring the reasons for geographical variations in GP uptake of new medicines was found. Conclusion: General practitioner care has historically been patient-centred, and it is unclear whether and how GPs consider the impact of their decisions upon the wider patient population. Incorporating cost considerations into GP decision making is one way to reflect the broader impact of individual treatment decisions. Current UK government policies use incentives to improve quality and encourage financial responsibility. Although these initiatives may help foster cost-consciousness, there is a risk that unintended consequences may ensue. Therefore, future policy evaluations should assess benefits, harms and costs so that the overall impact is transparent. [References: 47]

**Rashidian, A., Eccles, M. P., and Russell, I. (2008). Falling on stony ground A qualitative study of implementation of clinical guidelines' prescribing recommendations in primary care. *Health Policy*, 85, (2), 148-161.**

Doi: <http://dx.doi.org/10.1016/j.healthpol.2007.07.011>

<http://pmid.us/17767976>

Objectives We aimed to explore key themes for the implementation of guidelines' prescribing recommendations .Methods We interviewed a purposeful sample of 25 participants in British primary care in late 2000 and early 2001. Thirteen were academics

in primary care and 12 were non-academic GPs. We asked about implementation of guidelines for five conditions (asthma, coronary heart disease prevention, depression, epilepsy, menorrhagia) ensuring variation in complexity, role of prescribing in patient management, GP role in prescribing and GP awareness of guidelines. We used the Theory of Planned Behaviour to design the study and the framework method for the analysis .Results Seven themes explain implementation of prescribing recommendations in primary care: credibility of content, credibility of source, presentation, influential people, organisational factors, disease characteristics, and dissemination strategy. Change in recommendations may hinder implementation. This is important since the development of evidence-based guidelines requires change in recommendations. Practitioners do not have a universal view or a common understanding of valid `evidence'. Credibility is improved if national bodies develop primary care guidelines with less input from secondary care and industry, and with simple and systematic presentation. Dissemination should target GPs' perceived needs, improve ownership and get things right in the first implementation attempt. Enforcement strategies should not be used routinely. Conclusions GPs were critical of guidelines' development, relevance and implementation. Guidelines should be clear about changes they propose. Future studies should quantify the relationship between evidence base of recommendations and implementation, and between change in recommendations and implementation. Small but important costs and side effects of implementing guidelines should be measured in evaluative studies

**Strickland-Hodge, B. (2008). Nurse prescribing: the elephant in the room? *Quality in Primary Care*, 16, (2), 103-109.**

Nurse prescribing has become established in the UK, though the number of prescriptions written in primary care in 2006 by nurses remained small at 0.8% of the total. Healthcare teams employ nurse prescribers to streamline the service and improve patients' access to medicines. As the range of medicines available to nurses for prescribing increases, so questions about the need for more training in pharmacology arises. Old-style hierarchical relationships may still exist, and the term non-medical prescriber helps to maintain this. The prescribing process is shown to consist of much more than the issuing of a prescription, and the nurse is well suited to this holistic approach to patient management. Nurse prescribing is a natural extension of the work of many nurses, removing the need for them to obtain a doctor's signature. Nurse prescribing enhances the nurses' role and benefits the patient in their ease of access to healthcare professionals and also potentially to medicines and continuity of care.

## **MENTAL HEALTH**

**Bermejo, I., et al. (2007). Stability of the effects of guideline training in primary care on the identification of depressive disorders. *Primary Care & Community Psychiatry*, 12, (3-4), 99-107.**

**Doi; <http://10.1080/17468840701680769>**

Background: Depressive disorders are a highly important group in primary care. However, patients with depressive disorders are often not diagnosed correctly. There is evidence that detection and correct diagnosis rates can be improved by implementing diagnostic guidelines within practical skills training. Aim: To analyse short- and medium-term effects of guideline training on the identification of depressive syndromes by GPs. Methods: In a naturalistic controlled clinical trial, 2585 primary care patients were screened for depressive disorders, and GPs' diagnoses (n = 29) were assessed. Evidence-based guidelines for depressive disorders were implemented, and training for diagnostic skills was given within a multifaceted intervention. The primary outcome was the identification of depressive patients, assessed as the congruence between GPs' diagnoses and patients' self-assessment. Results: Following the training, the identification rate of depressive disorders improved significantly in the intervention group. The improvement increased further in the 1-year follow-up, although this was not statistically significant. At the same time, the diagnostic odds ratios indicate no alteration of diagnostic accuracy, i.e. correct allocation of depressive versus non-depressive patients. Although the odds ratios of the improvements do speak in favour of intervention, this could not be statistically verified. Conclusions: Guideline implementation improves the accuracy of GPs' diagnostic behaviour regarding depressive disorders in the short term and possibly in the medium term. Limitations result from the naturalistic design of the study

**Byng, R., Bury, C., and Weaver, L. (2007). Patients' experiences of consultations for depression and predictors of adherence to antidepressants. *Primary Care & Community Psychiatry*, 12, (3-4), 109-115.**

**<http://dx.doi.org/10.1080/17468840701686287>**

Background: Guidance on management of depression in primary care has focussed mainly on medication and more recently on talking therapies. Poor adherence to antidepressants is seen as a barrier to better outcomes in depression. Aim: To examine the content of consultations for depression, as perceived by patients, and impact of care on adherence to medication. Methods: A cross-sectional study with a questionnaire completed by 107 patients who had been diagnosed with depression by their GP. The questionnaire measured patients' recall of their GP's management with respect to provision of information, sharing decisions and following 'best' practice; it also inquired about their mental state and adherence to and concerns about medication prescribed. Results: Patients believed that GPs often omitted important components of the consultation. Information was often not reaching patients: 41% did not recall a discussion about side effects and 37% about non-addictive nature of antidepressants; 20% about how long medication would take to work, and 25% about benefits of continuing medication after improvement. 20% reported not being involved in decision making. Only one third recalled being asked about self-harm. 41% expressed concern about side effects of

antidepressants and 38% wished to cope alone, but reported adherence was relatively high with 64% taking medication as instructed. Conclusions: GPs need to communicate better about medication, perhaps providing more written information about depression and anti-depressants, and ensuring explanations are full and understood. Adherence is affected by key processes in the consultation as well as patient beliefs and background

**Chew-Graham C and et al (2008). GPs' and health visitors' views on the diagnosis and management of postnatal depression: a qualitative study. *British Journal of General Practice*, 58, (548), 169-177.**

**Doi: <http://dx.doi.org/10.3399/bjgp08X277212>**

**<http://pmid.us/18399021>**

**Abstract:** Background In the UK, 8â-15% of women suffer from postnatal depression, with long-term consequences for maternal mood and child development. Previous literature suggests that health visitors struggle with their conflicting roles with respect to mother and infant. Current policy is redirecting the emphasis and organisation of health visitor work, but guidelines state that health visitors and GPs should continue to have a major role in the detection and management of postnatal depression. Aim To explore the views of GPs and health visitors on the diagnosis and management of postnatal depression. Design of study A qualitative study nested within a multicentre randomised controlled trial. Setting Nine primary care trusts in Bristol, Manchester, and London. Method In-depth interviews with GPs and health visitors from primary care trusts participating in a randomised controlled trial of antidepressants versus health visitor-delivered non-directive counselling. Interviews were audiotaped and fully transcribed. Thematic analysis with an iterative approach was used to develop conceptual categories from the transcripts. Results Nineteen GPs and 14 health visitors were interviewed. GPs and health visitors described their work in making and negotiating the diagnosis of postnatal depression, the value of a long-term relationship with the woman, and how labelling affects management of women with postnatal depression. Responders described how they viewed others' roles in the management of postnatal depression, and how national policy and local organisational changes had an impact on patient care, so that no one health professional was assuming overall responsibility for the care of women with postnatal depression. Conclusion Ongoing organisational changes within primary care, such as the implementation of corporate working by health visitors, affect care provided to women after birth, which in turn has an impact on the diagnosis and management of postnatal depression.

**Chew-Graham, C., et al (2008). Loss of doctor-to-doctor communication: lessons from the reconfiguration of mental health services in England. *Journal of Health Services Research and Policy*, 13, (1), 6-12.**

**Doi: <http://dx.doi.org/10.1258/jhsrp.2007.006053>**

<http://pmid.us/18325150>

Objective: To explore the tensions across the primary - secondary interface when referral from primary care is to a team and to inform service developments in other specialties. Methods: A nested qualitative study within a randomized controlled trial of primary care and Community Mental Health Teams (CMHTs) in Croydon and Manchester, UK. For the qualitative study, interviews were carried out with general practitioners (GPs), psychiatrists and managers or clinical leads of the CMHTs. Results: GPs described the need for access to specialist knowledge, which they perceived to lie with the psychiatrist, and referral to a team was not perceived to allow this access. A personal threshold was identified by GPs after which they referred the patient to secondary care. CMHTs and psychiatrists recognized that this personal threshold differed between GPs, but their criteria for accepting referrals did not seem to allow for a flexible response to referral requests, leading to the referral being labelled as 'inappropriate'. The lack of direct doctor-to-doctor communication was perceived by respondents to contribute to a fragmentation of patient care. Strategies were described whereby the system was bypassed to achieve doctor-to-doctor communication, which undermined the team. Conclusions: Development of intermediate or 'Tier 2' services beyond the mental health services, where the GP refers to a team rather than to a specialist (hospital consultant) could benefit from reflecting on experiences with mental health services. There is a danger that new community services for the physically ill will engender the same level of confusion and discontent described by GPs and other health professionals in this study who are concerned with mental health care. Flexibility is needed within care pathways, including the provision of direct doctor-to-doctor communication together with approaches to minimize the marginalization of non-medical professionals

**Cohen A (2008). The primary care management of anxiety and depression: a GP's perspective. *Advances in Psychiatric Treatment*, 14, 98-105.**

Doi: <http://dx.doi.org/10.1192/apt.bp.107.003780>

The management of anxiety and depression in primary care presents significant issues for workload and understanding the patient in terms of a bio-psychosocial model. There is no shortage of policy in this area, but finding effective and innovative ways of implementing that guidance is only just beginning. This article discusses some of the ways that implementation is happening for adults of working age.

**Perry, M, Draskovic P et al (2008) Can an EASYcare based dementia training programme to improve diagnostic assessment and management of dementia by general practitioners and primary care nurses? The design of a randomised controlled trial *BMC Health Services Research* 8:71**

Doi: <http://dx.doi.org/10.1186/1472-6963-8-71>

<http://www.biomedcentral.com/1472-6963/8/71>

<http://pmid.us/18384675>

Early diagnosis of dementia benefits both patient and caregiver. However, dementia in primary care is currently under-diagnosed. Some educational interventions developed to improve dementia diagnosis and management were successful in increasing the number of dementia diagnoses and in changing attitudes and knowledge of health care staff. None of these interventions focussed on collaboration between GPs and nurses in dementia care. We developed an EASYcare-based Dementia Training Program (DTP) aimed at stimulating collaboration in dementia primary care. We expect this program to increase the number of cognitive assessments and dementia diagnoses and to improve attitudes and knowledge of GPs and nurses. **Methods** The DTP is a complex educational intervention that consists of two workshops, a coaching program, access to an internet forum, and a Computerized Clinical Decision Support System on dementia diagnostics. One hundred duos of GPs and nurses will be recruited, from which 2/3 will be allocated to the intervention group and 1/3 to the control group. The effects of implementation of the DTP will be studied in a cluster-randomised controlled trial. Primary outcomes will be the number of cognitive assessments and dementia diagnoses in a period of 9 months following workshop participation. Secondary outcomes are measured on GP and nurse level: adherence to national guidelines for dementia, attitude, confidence and knowledge regarding dementia diagnosis and management; on patient level: number of emergency calls, visits and consultations and patient satisfaction; and on caregiver level: informal caregiver burden and satisfaction. Data will be collected from GPs' electronic medical records, self-registration forms and questionnaires. Statistical analysis will be performed using the MANOVA Method Also, exploratory analyses will be performed, in order to gain insight into barriers and facilitators for implementation and the possible causal relations between the rate of success of the intervention components and the outcomes. **Discussion** We developed multifaceted dementia training programme. Novelties in this programme are the training in fixed collaborative duos and the inclusion of an individual coaching program. The intervention is designed according to international guidelines and educational standards. Exploratory analysis will reveal its successful elements. Selection bias and contamination may be threats to the reliability of future results of this trial. Nevertheless, the results of this trial may provide useful information for policy makers and developers of continuing medical education.

**Gask L et al (2008). Beyond the limits of clinical governance? The case of mental health in English primary care. *BMC Health Services Research*, 8, (63). Doi: 10.1186/1472-6963-8-63 PMID: 18366779**

Doi: <http://dx.doi.org/10.1186/1472-6963-8-63>

<http://www.biomedcentral.com/1472-6963/8/63>

<http://pmid.us/18366779>

**Background** Little research attention has been given to attempts to implement organisational initiatives to improve quality of care for mental health care, where there is a high level of indeterminacy and clinical judgements are often contestable. This paper

explores recent efforts made at an organisational level in England to improve the quality of primary care for people with mental health problems through the new institutional processes of clinical governance. **Methods** Framework analysis, based on the Normalisation Process Model (NPM), of attempts over a five year period to develop clinical governance for primary mental health services in Primary Care Trusts (PCTs). The data come from a longitudinal qualitative multiple case-study approach in a purposive sample of 12 PCTs, chosen to reflect a maximum variety of organisational contexts for mental health care provision. **Results** The constant change within the English NHS provided a difficult context in which to attempt to implement clinical governance. In the absence of clear evidence or direct guidance about what primary mental health care should be, and a lack of actors with the power or skills to set about realising it, the actors in clinical governance had little shared knowledge or understanding of their role in improving the quality of mental health care although some success was achieved in the monitoring of prescribing practice. There was a lack of ownership of mental health as an integral, normalised part of primary care. **Conclusions** Despite some achievements in regard to monitoring and standardisation of prescribing practice, mental health care in primary care seems to have so far largely eluded the gaze of clinical governance. Clinical governance in English primary mental health care has not yet become normalised. We make some policy recommendations which we consider would assist in the process normalisation and suggest other contexts to which our findings might apply.

**Gloster, A. T., et al. Psychometric properties of the Depression Anxiety and Stress Scale-21 in older primary care patients. *Journal of Affective Disorders*, In press,**

**Doi:** <http://dx.doi.org/10.1016/j.jad.2008.01.023>

<http://pmid.us/18304648>

The Depression Anxiety Stress Scale (DASS) was designed to efficiently measure the core symptoms of anxiety and depression and has demonstrated positive psychometric properties in adult samples of anxiety and depression patients and student samples. Despite these findings, the psychometric properties of the DASS remain untested in older adults, for whom the identification of efficient measures of these constructs is especially important. To determine the psychometric properties of the DASS 21-item version in older adults, we analyzed data from 222 medical patients seeking treatment to manage worry. Consistent with younger samples, a three-factor structure best fit the data. Results also indicated good internal consistency, excellent convergent validity, and good discriminative validity, especially for the Depression scale. Receiver operating curve analyses indicated that the DASS-21 predicted the diagnostic presence of generalized anxiety disorder and depression as well as other commonly used measures. These data suggest that the DASS may be used with older adults in lieu of multiple scales designed to measure similar constructs, thereby reducing participant burden and facilitating assessment in settings with limited assessment resources

**Haggarty, J., et al. (2008). A pilot study of a Canadian shared mental health care programme: Changes in patient symptoms and disability. *Primary Care & Community Psychiatry*, 13, (1), 27-35.**

**Doi: <http://dx.doi.org/10.1080/17468840801892645>**

Aim: To describe symptom improvement and change in function in patients referred to a shared mental health care service (SMHC) that provided psychiatric consultation and brief counselling. Method: Pre (N = 1,310) and post (N = 395) measurements and comparisons with normative samples using the Patient Health Questionnaire (PHQ) and World Health Organization's Disability Assessment Schedule (WHO DAS II) among individuals who received care with SMHC over the first 5 years of service. Cognitive-behavioural, psycho-education and supportive counselling were provided by a psychiatrist in collaboration with a multi-disciplinary mental health team. Mean number of visits was 7.3 per episode of care. Results: Following the intervention, patients had significantly fewer days with difficulty caused by mental illness within the previous month (mean difference = 9.23 days) and fewer days of total incapacity (mean difference = 3.81 days). Statistically significant reductions in PHQ diagnoses occurred for major depressive syndrome (89% reduction from baseline; P < 0.001), panic syndrome (75% reduction from baseline; P < 0.001), somatic disorder (74% reduction from baseline; P < 0.001) and alcohol abuse (30% reduction from baseline; P = 0.02). PHQ-9 and WHO DAS II mean at exit was significantly within or above one standard deviation from the community sample norm. Conclusions: SMHC intervention appeared effective. At exit from the programme, patients displayed significant reductions in symptoms on all measures relative to their scores at entry, returning to or close to community sample norms. Limitations with the research include lack of a control group and random assignment, and absence of data from many patients upon exit from the programme

**Haggarty, J., et al (2008). Clinical findings of a cluster randomised control pilot trial of a Canadian Shared Care service for those with chronic mental illness. *Primary Care & Community Psychiatry*, 13, (1), 19-25.**

**Doi: <http://dx.doi.org/10.1080/17468840801890060>**

Aim: To investigate the potential improvement of core patient outcomes of a pilot model of shared care, Transition into Primary care Psychiatry (TIPP). Method: To determine if TIPP patients have less symptoms, improved quality of wellbeing and decreased perceived need for care, we undertook a 12 month cluster randomised control trial (RCT) in two Canadian cities. Twenty-seven family physicians (FPs) having 49 eligible patients with severe and chronic mental health problems and recently discharged from outpatient psychiatry services were recruited. Outcomes reported are related to patient distress, quality of life (QoL) and perceived need for services. In both sites, treatment groups received the TIPP model of shared care from the FP with support from TIPP clinicians, and controls received 'care as usual' (CAU) from their FP. Results: Multivariate analysis showed no statistically significant change over 12 months when the combined dependent variables were examined. Univariate analysis revealed change over 12 months on the two Brief Symptom Inventory (BSI) subscales between treatment and control groups, with no

change on measures indexing QoL or mental health needs. TIPP intervention participants reported more symptoms, while the CAU group saw corresponding declines. Conclusions: While treatment group did not influence overall clinical outcome over 12 months, BSI detected increases in patient recognition of symptoms associated with the TIPP group. TIPP may have increased symptom recognition yet not severity. Future research should include use of larger samples, follow participants more than 12 months, and carefully consider selection of outcome measures and possible moderating factors

**Hansson, M., Bodlund, O., and Chotai, J. (2008). Patient education and group counselling to improve the treatment of depression in primary care: A randomized controlled trial. *Journal of Affective Disorders*, 105, (1-3), 235-240.**

**Doi:** <http://dx.doi.org/10.1016/j.jad.2007.04.007>

<http://pmid.us/17509694>

Background The Contactus program for depressed patients in primary care, consists of six lectures about depression, each followed by a group discussion. The aim of this study was to investigate if Contactus can improve treatment outcome in comparison to a control group. Methods Forty-six primary care centres in Sweden, each randomly allocated either to the Contactus group or to the control group, included depressed patients, 205 in the Contactus group and 114 in the control group. Besides regular treatment of depression, the Contactus group participated in the educational program. At start and after 6 weeks, patients filled in a questionnaire and the self-reports: HADS (Hospital Anxiety and Depression Scale) and GAF-self (Global Assessment of Functioning). Results After 6 weeks, clinically depressed patients (HAD-depression score > 10) had a mean improvement in HAD-D of 4.6 in Contactus vs. 3.0 in controls (p = 0.02), and 72% vs. 47% considered themselves to feel better (p = 0.01). Increase in GAF score was 11.8 vs. 5.8 (p = 0.04), respectively. According to HADS, 55% in Contactus were responders vs. 29% among controls (p = 0.006), and 42% vs. 21% (p = 0.02) were in remission. Limitations Only 40% of the patients in Contactus and 35% among controls were clinically depressed according to the HADS (> 10 points) at inclusion. Conclusions Patient education and group counselling contributes significantly to better improvement among depressed patients. Group treatment is inexpensive and could be implemented in the routine care of depressed patients in primary care

**Lester, H., et al (2008). Barriers and facilitators to partnership working between Early Intervention Services and the voluntary and community sector. *Health and Social Care in the Community*. Online Early Article**

<http://dx.doi.org/10.1111/j.1365-2524.2008.00760.x>

[PM:18328058](http://dx.doi.org/10.1111/j.1365-2524.2008.00760.x)

Partnership working between health and the voluntary and community sector has become an increasing political priority. This paper describes and explores the extent and patterns of partnership working between health and the voluntary and community sector in the context of Early Intervention Services for young people with a first episode of psychosis.

Data were collected from 12 Early Intervention Services and through semistructured interviews with 47 voluntary and community sector leads and 42 commissioners across the West Midlands of England. Most partnerships were described as ad hoc and informal in nature although four formal partnerships between Early Intervention Services and voluntary and community sector organizations had been established. Shared agendas, the ability to refer clients onto an organization that could provide a service they could not and shared training facilitated partnership working in this context. Barriers to closer working included differences in culture such as managing risk, the time required to make and maintain relationships and recognition of the advantages of remaining a small and autonomous organization. The four more formal partnerships were also built on the organizations' experience of working together informally, in one case through a specific pilot project. The voluntary and community organizations involved were also branches of larger national organizations for whom finding sustainable funding was less of an issue. In theoretical terms, eight Early Intervention Service: voluntary and community sector partnerships were at a stage of 'pre-partnership collaboration', three at 'partnership creation and consolidation' and one at 'partnership programme delivery'. The empirical data viewed through the lens of the partnership life-cycle model could help early intervention services, and voluntary and community sector professionals better understand where they are, why they are there and the conditions needed to realise the full potential of partnership working

**Richards, D. A., et al. (2008). Collaborative care for depression in UK primary care: a randomized controlled trial. *Psychological Medicine* , 38, (2), 279-287.**

**Doi: <http://dx.doi.org/10.1017/S0033291707001365>**

**<http://pmid.us/17803837>**

Background: Collaborative care is an effective intervention for depression which includes both organizational and patient-level intervention components. The effect in the UK is unknown, as is whether cluster- or patient-randomization would be the most appropriate design for a Phase III clinical trial. Method We undertook a Phase II patient-level randomized controlled trial in primary care, nested within a cluster-randomized trial. Depressed participants were randomized to 'collaborative care' - case manager-coordinated medication support and brief psychological treatment, enhanced specialist and GP communication - or a usual care control. The primary outcome was symptoms of depression (PHQ-9). Results: We recruited 114 participants, 41 to the intervention group, 38 to the patient randomized control group and 35 to the cluster-randomized control group. For the intervention compared to the cluster control the PHQ-9 effect size was 0.63 (95% CI 0.18-1.07). There was evidence of substantial contamination between intervention and patient-randomized control participants with less difference between the intervention group and patient-randomized control group (-2.99, 95% CI -7.56 to 1.58, p=0.186) than between the intervention and cluster-randomized control group (-4.64, 95% CI -7.93 to -1.35, p=0.008). The intra-class correlation coefficient for our primary outcome was 0.06 (95% CI 0.00-0.32). Conclusions: Collaborative care is a potentially powerful organizational intervention for improving depression treatment in UK primary care, the effect of which is probably partly mediated through the organizational aspects of

the intervention. A large Phase III cluster-randomized trial is required to provide the most methodologically accurate test of these initial encouraging findings

**Riley AJ et al (2008). Utilising theories of change to understand the engagement of general practitioners in service improvement: a formative evaluation of the Lewisham Depression Programme. *Quality in Primary Care*, 16, (1), 17-26.**

Background Mental health issues such as depression are commonly treated within primary care. In accordance with new UK National Institute for Health and Clinical Excellence (NICE) guidance, primary care practitioners have increased responsibilities to manage mild depression in primary care. This paper reports on an evaluation of a depression programme marketing strategy, and factors contributing towards practitioner engagement or non-engagement. Aims The main aims of the study were to conduct an evaluation that was programme specific, to immediately feed results back iteratively through early development and engagement of general practitioners (GPs) and nurses and their practices in a multifaceted programme, and to investigate decisions to participate or not participate in the depression recognition audit as a first point of engagement, in order to gain a better understanding of what motivates GPs and nurses to be involved and what prohibits involvement, in order to address any future potential barriers to improvement. Methods The methods for this formative evaluation can be categorised in three distinct ways: firstly, the iterative development of 'theories of change' (programme-based assumptions) using ethnographic techniques, which led to the development of a list of predefined theories of change and formed the basis of two questionnaires; secondly, questionnaires were sent to engaged GPs and nurses and a separate questionnaire was sent to a matched sample of GPs and nurses not engaged; finally, results were fed back on an ongoing basis to inform the ongoing programme development and evaluation and to produce final theories of change for engagement. Results The response rate to the questionnaire was 54%. Those involved in the audit reported individual motivation, team working, wider networks and method of engagement, all as positively influencing their decision to take part. Those not involved focused on practice organisational issues leading to non-participation, such as not having enough time, or being understaffed or busy with other initiatives. Conclusions The 'theories of change' method helped explore and shape assumptions around the Lewisham Depression Programme's marketing strategy as a basis for future marketing of programme activity. It also helped to develop a joint programme-evaluation forum by which programme team members were empowered to lead aspects of future research within the programme. There are some key messages for future programme makers to help engage GPs and nurses, such as the importance of having face-to-face practice meetings with a trained facilitator, the positive engagement of practice managers, and a launch meeting for the programme. The results also support targeted strategies to support poorly performing individuals and practice teams.

**Swenson, S. L. M., et al (2008). The influence of depressive symptoms on clinician-patient communication among patients with Type 2 diabetes. *Medical Care*, 46, (3), 257-265.**

<http://dx.doi.org/10.1097/MLR.0b013e31816080e9>

<http://pmid.us/18388840>

Background: Depression is associated with poor chronic illness outcomes, but it is unknown whether depression influences the quality of communication during the clinical encounter. We investigated whether diabetes patients with depressive symptoms, compared with those without depressive symptoms, report worse clinician-patient communication, and which domains of communication are most affected., Methods: We surveyed 231 ethnically diverse, English-speaking patients with diabetes to ascertain their experiences of communication with their primary care clinician. We selected measures from the interpersonal processes of care (IPC) instrument to assess communication and dichotomized the 7 subscales into "optimal" or "suboptimal" communication. We used the Clinical Epidemiologic Services for Depression (CES-D 10) to categorize patients as having no (CES-D 10 score <10), mild (CES-D 10 score 10-14), or severe (CES-D 10 score >14) depressive symptoms. We used multivariable logistic regression to evaluate the relationship between depressive symptoms and communication subscales., Results: Thirty-five percent of subjects reported severe depressive symptoms. Compared with those with no depressive symptoms, the presence of severe depressive symptoms was independently associated with suboptimal communication in 4 of 7 subscales: elicitation of patient problems, concerns, and expectations (adjusted odds ratio [AOR], 2.94; 95% confidence interval [CI], 1.14-7.61); explanations of condition (AOR, 3.79; 95% CI, 1.41-10.21); empowerment (AOR, 2.98; 95% CI, 1.35-6.58); and decision-making (AOR, 2.56; 95% CI, 1.14-5.78)., Conclusions: Diabetes patients with severe depressive symptoms are more likely than those without depressive symptoms to report suboptimal clinician-patient communication across multiple domains of communication, especially those that involve more interactive and "patient-centered" communication. Further investigation of this relationship may uncover explanatory mechanisms and help guide interventions for improving care for both conditions., (C) 2008 Lippincott Williams & Wilkins, Inc

## ORGANIZATIONS

**Filipe Amado, C. A. and Dyson, R. G. (2008). On comparing the performance of primary care providers. *European Journal of Operational Research*, 185, (3), 915-932.**

<http://dx.doi.org/10.1016/j.ejor.2006.02.052>

In the past few years primary health care has been characterised as central to the development of the National Health Service in the United Kingdom. Furthermore, performance assessment is seen as a way of achieving care of high standards. Performance indicators and targets are being developed to assess primary care providers, and to develop financial incentives. However, the number of studies that have compared the performance of primary care providers is limited and the existing approaches to evaluation are open to improvement. In this paper, we provide a critical review of the studies that have focused on the evaluation of primary health care providers, with

particular reference to the use of the non-parametric technique Data Envelopment Analysis. We conclude that most studies focus on structure and outputs, without consideration of outcomes - the ultimate measure of performance - and tend to be of a summative rather than formative nature

**Guro H, et al (2008) Whither British general practice after the 2004 GMS contract? : Stories and realities of change in four UK general practices. *Journal of Health Organization and Management*, 22, (1), 63-78.**

<http://dx.doi.org/10.1108/14777260810862416>

Purpose – The purpose of this article is to provide answers to two questions: what has been the impact of nGMS on practice organisation and teamwork; and how do general practice staff perceive the impact? Design/methodology/approach – The article is based on comparative in-depth case studies of four UK practices. Findings – There was a discrepancy between changes observed and the way practice staff described the impact of the contract. Similar patterns of organisational change were apparent in all practices. Decision-making became concentrated in fewer hands. Formally or informally constituted "elite" multidisciplinary groups monitored and controlled colleagues' behaviour for maximum performance and remuneration. This convergence of organisational form was not reflected in the dominant "story" each practice constructed about its unique ethos and style. The "stories" also failed to detect negative consequences to the practice flowing from its adaptation to the contract. Originality/value – The paper highlights how collective "sensemaking" in practices may fail to detect and address key organisational consequences from the nGMS.

**Lonsdale C and Watson G (2007). Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service. *Policy and Politics*, 35, (4), 683-700.**

Over recent years, a number of contributors to the public management literature have argued that the buyer-supplier relationships generated by the UK Private Finance Initiative (PFI) are qualitatively different from those generated by traditional contracting out. References have been made to equality, transparency, risk-sharing and trust. In this article, the authors test a contrary argument: that UK public managers negotiate and implement PFI contracts within an environment which is, to a significant extent, characterised by supplier opportunism, something that requires them to employ an extremely assiduous, if not necessarily distant, approach to contract and relationship management. The testing of this argument is undertaken with evidence from PFI construction contracts operated within the National Health Service.

**Mannion R, Marini G, and Street A (2008). Implementing payment by results in the English NHS: Changing incentives and the role of information. *Journal of Health Organization and Management*, 22, (1), 79-88.**

Doi: <http://dx.doi.org/10.1108/14777260810862425>

Purpose - This paper draws on economic theory and empirical evidence in order to explore the role of incentives and information in the successful implementation of the new hospital funding system in the NHS. Design/methodology/approach - The research is based on case studies in two strategic health authorities comprising in-depth interviews with key stakeholders and analysis of background statistics and documentation. Findings - The structure of tariffs under payment-by-results (PbR) provides high-powered incentives for providers to increase activity because they are rewarded for hospital activity, and payments for increases in activity are made at full average cost. However, there is a danger that hospitals will increase activity beyond affordable levels and possibly induce demand inappropriately. Practical implications - In future, as PbR is extended, it will be important to monitor its intended and unintended effects. Such evaluation should consider the extent to which commissioners are able to live within their budgets and whether hospitals are engaging in opportunistic behaviour and gaming the new funding system. Originality/value - This study has shed light on the incentive structure of PbR for NHS organisations and has provided insights for the development of information strategies for providers and commissioners in the NHS market. It also highlights a number of policy issues that need to be addressed as PbR is rolled out nationally as well as several important gaps in knowledge that are in need of more sustained investigation.

**Sadler M and Lester S (2008). NHS Direct - What challenges has it faced and how have they been overcome? *Journal of Communication in Healthcare*, 1, (1), 99-109.**

NHS Direct is a 24-hour, telephone, internet and digital television-based health advice and information service. In the nine years since it took its first call, the service has taken over 40 million calls, received over 60 million visits to the website and now has a digital television presence in over 16 million homes. It has also polarised opinion within the health service, and as the first totally new national service launched since the start of the National Health Service (NHS) in 1948, has been the subject of intense scrutiny, from public and professionals, media and politicians and national and international commentators. This paper explores some of the early and ongoing challenges in implementing a major new public service, some of the lessons learnt, and some of the successes and failures along the way.

**Walker S et al (2007). Benchmarking in National Health Service Procurement in Scotland . *Health Services Management Research*, 20, (4), 253-260.**

**Doi: <http://dx.doi.org/10.1258/095148407782219030>**

**<http://pmid.us/17958971>**

The paper reports the results of a study on benchmarking activities undertaken by the procurement organization within the National Health Service (NHS) in Scotland, namely National Procurement (previously Scottish Healthcare Supplies Contracts Branch). NHS performance is of course politically important, and benchmarking is increasingly seen as a means to improve performance, so the study was carried out to determine if the current benchmarking approaches could be enhanced. A review of the benchmarking activities

used by the private sector, local government and NHS organizations was carried out to establish a framework of the motivations, benefits, problems and costs associated with benchmarking. This framework was used to carry out the research through case studies and a questionnaire survey of NHS procurement organizations both in Scotland and other parts of the UK. Nine of the 16 Scottish Health Boards surveyed reported carrying out benchmarking during the last three years. The findings of the research were that there were similarities in approaches between local government and NHS Scotland Health, but differences between NHS Scotland and other UK NHS procurement organizations. Benefits were seen as significant and it was recommended that National Procurement should pursue the formation of a benchmarking group with members drawn from NHS Scotland and external benchmarking bodies to establish measures to be used in benchmarking across the whole of NHS Scotland.

## **PATIENT AND PUBLIC INVOLVEMENT**

**Bridgelal, R. M., Grocott, P. R., and Weir, H. C. (2008). Issues and challenges of involving users in medical device development. *Health Expectations* , 11, (1), 63-71.**

**Doi: <http://dx.doi.org/10.1111/j.1369-7625.2007.00464.x>**

**<http://pmid.us/18275403>**

Background: User engagement has become a central tenet of health-care policy. This paper reports on a case study in progress that highlights user engagement in the research process in relation to medical device development. Objectives: To work with a specific group of medical device users to uncover unmet needs, translating these into design concepts, novel technologies and products. To validate a knowledge transfer model that may be replicated for a range of medical device applications and user groups. Methods: In depth qualitative case study to elicit and analyse user needs. The focus is on identifying design concepts for medical device applications from unmet needs, and validating these in an iterative feedback loop to the users. Results: The case study has highlighted three interrelated challenges: ensuring unmet needs drive new design concepts and technology development; managing user expectations and managing the research process. Conclusion: Despite the challenges, active participation of users is crucial to developing usable and clinically effective devices

**Campbell S et al (2008). Bridging the gap between primary and secondary care: use of a clinical pathway for the investigation and management of deep vein thrombosis. *Journal of Health Services Research and Policy*, 13, (Supplement 1), 15-19.**

**Doi: <http://dx.doi.org/10.1258/jhsrp.2007.007015>**

**<http://pmid.us/18325163>**

*Background:* Clinical processes that span the boundary between primary and secondary care often suffer from poor standardization of practice and lines of communication. One example is the clinical management of suspected deep vein thrombosis (DVT). Making or excluding the diagnosis can be complex. Tools to investigate DVT were not available to family physicians so patients had to be referred to the hospital emergency department and endure a long wait which could exacerbate the condition. In addition, urgent referrals to the ultrasound department disrupted the scheduled list of patients. *Assessment of problem:* A team of stakeholders including all relevant specialties and professions from primary and secondary care was established. After reviewing the literature and interviewing those involved in delivering care, an evidence-based scoring system to calculate the clinical probability of a DVT was adopted and introduced as part of a clinical pathway from primary to secondary care. Its introduction was based on the Plan, Do, Study, Act (PDSA) cycle. *Results:* In the first year after the introduction of the clinical pathway, 70% of family physicians had used it and were very satisfied. Patients found it efficient (75%) with 96% very satisfied or satisfied. The waiting time in the emergency department fell from a mean of 379 minutes to 285 minutes. Although the incidence of initial investigations (D-Dimer tests) increased by 42%, the proportion of patients undergoing a subsequent ultrasound test found to have a DVT was unchanged (14%). This suggested the level of suspicion of a DVT in the community had risen. Referrals to the hospital's DVT clinic increased by 14% overall, driven partly by a large increase in those who had come from the new clinical pathway from primary care. *Lessons and messages:* Key lessons include the importance of including all relevant stakeholders and the benefits of using PDSA to make rapid changes during implementation. We are now seeking to extend the use of the clinical pathway to other hospitals and more family physicians. In addition, the clinical pathway approach will be applied to other conditions and interventions. We have demonstrated how a multidisciplinary group of stakeholders in a clinical care process can develop and introduce a clinical pathway that allows smooth transit of patients over the barriers between different sectors of the health care system and between independent disciplines. We have also demonstrated the use of untapped non-physician potential in the system to safely facilitate patient care.

**Lewis R, Hinton, L (2008) Citizen and staff involvement in health service decision-making: have National Health Service foundation trusts in England given stakeholders a louder voice? *Journal of Health Services Research and Policy* 13 (1) 19-25**

Doi: <http://dx.doi.org/10.1258/jhsrp.2007.00703>

<http://pmid.us/18325152>

Objectives: National Health Service (NHS) foundation trusts have been created to decentralize the management of NHS provider organizations through the substitution of central government control with local accountability to citizens and employed staff. Our aim was to explore the roles adopted by elected and appointed governors of a first wave NHS foundation trust and the extent to which governors shared power with trust directors and influenced the management of the trust. Methods: A one-year case study of a single

NHS foundation trust (Homerton Hospital in East London) was conducted. Data were collected using face-to-face interviews with a sample of governors and directors, as well as through non-participant observation of public and private meetings of governors and documentary analysis. Results: Governors and directors found the new role of foundation trust governor ambiguous and difficult to define. This lack of clarity impeded the development of the new governance function. Governors perceived that they had made little impact on the decisions of the Trust during the year of study. However, evidence was found of an increased involvement of governors and the public in the activities of the Trust. Conclusions: Government plans to decentralize accountability of public hospitals to local communities appear problematic, at least in the short term. Unless the effectiveness of the new local governance arrangements is addressed, an accountability 'gap' may emerge as prior mechanisms for public accountability to the centre are dismantled. In these circumstances, decentralization may lead in practice to a loss of public accountability.

**Oliver, S. R., et al. (2008). A multidimensional conceptual framework for analysing public involvement in health services research. *Health Expectations* , 11, (1), 72-84.**

**Doi: <http://dx.doi.org/10.1111/j.1369-7625.2007.00476.x>**

**<http://pmid.us/18275404>**

Objective: To describe the development of a multidimensional conceptual framework capable of drawing out the implications for policy and practice of what is known about public involvement in research agenda setting. Background: Public involvement in research is growing in western and developing countries. There is a need to learn from collective experience and a diverse literature of research, policy documents and reflective reports. Methods: Systematic searches of research literature, policy and lay networks identified reports of public involvement in research agenda setting. Framework analysis, previously described for primary research, was used to develop the framework, which was then applied to reports of public involvement in order to analyse and compare these. Findings: The conceptual framework takes into account the people involved; the people initiating the involvement; the degree of public involvement; the forum for exchange; and methods used for decision making. It also considers context (in terms of the research focus and the historical, geographical or institutional setting), and theoretical basis. Conclusions: The framework facilitates learning across diverse experiences, whether reported in policy documents, reflections or formal research, to generate a policy- and practice-relevant overview. A further advantage is that it identifies gaps in the literature which need to be filled in order to inform future research about public involvement

## **PRIMARY/SECONDARY CARE INTERFACE**

**Einhorn, R., (2007). Referral patterns between the child health service, general practitioners, and secondary healthcare: A prospective descriptive study in the Netherlands. *European Journal of General Practice*, 13, (4), 225-230.**

Background: In the Netherlands, preventive child health service (CHS) screening plays an important role in the early detection of congenital, developmental, physical, and mental disorders. Objective: To obtain insight into the referral patterns of children from CHS to general practitioners and from general practitioners to medical specialists. Methods: Prospective study over 6 months in a semi-urban area in the Netherlands. All correspondence from the participating doctors was sticker marked and, after each contact, a registration card was sent to a central secretariat. The referral stream between general practitioners and specialists or allied health professionals was extracted from a central database. The general practitioners and the participating paediatricians were asked to complete a questionnaire about the quality and necessity of the referral. Results: Out of an estimated 2600 examinations, 45 children were referred to their general practitioners for further examination. The problems of eight children were settled by the GP, 10 children were referred to allied health professionals, and 24 children were referred to specialists. The median time span of showing up at the GP's office was 6.5 days. Sixteen per cent showed up long after having been referred by the CHS. The parents of three children did not comply. Of the 397 referrals from GPs to medical specialists and allied health professionals, 8.5% were initiated by the CHS

**Elwyn G (2008). Case management by nurses in primary care: analysis of 73 "success stories". *Quality in Primary Care*, 16, (2), 75-82.**

Background: There is interest as to whether case management reduces unplanned patient admission to hospital. However, very little is known about how the intervention is delivered and what the most salient outcome measures are. Design: Qualitative study embedded in a wider evaluation. Setting: Primary health care. Method: Analysis of case manager case reports in a service innovation evaluation study. Results: Case management provides home-based care to frail elderly patients using a process of assessment and medication review. This often leads to new diagnoses, to the co-ordination of further care and the tailoring of services to suit the needs of individuals. The benefits reported are complex and relate to improving a patient's quality of life more than the prevention or otherwise of admission to hospital. The type of attention provided by these roles seems to be absent from current NHS arrangements. The role enables time to be spent assessing the individual needs of patients who live at the margins of independent living. Conclusion: The case managers describe having the time and the skills to assess a mix of clinical and social problems, and then accessing the correct networks to help elderly people with multiple illnesses navigate a complex system of providers. More weight should be given to the ability of this intervention to result in improved quality of life for patients, and to the investigation of costs and benefits.

**Hansagi, H., Olsson, M., Hussain, A., and Ohlen, G. (2008). Is information sharing between the emergency department and primary care useful to the care of frequent emergency department users? *European Journal of Emergency Medicine* 15, (1), 34-39.**

Doi: <http://dx.doi.org/10.1097/MEJ.0b013e3282aa4115>

<http://pmid.us/18180664>

Objectives: To assess whether easy access to medical information of the emergency department's (ED) frequent users would be useful to patient care in the ED and at primary healthcare centres (PHCs), and if resource utilization in the following year would be affected. Methods: During a 6-month period, frequent users presenting to the ED of Karolinska University Hospital Huddinge, Sweden, were randomized by the electronic database system into an intervention (n=834) or control group (n=965), the definition being three or more visits in 12 months before the index visit. Printout case notes, from the intervention patients' last three visits, were made accessible to the ED physicians and optionally forwarded to the patient's PHC physician. Usefulness of this enhanced information was measured by questionnaires, whereas healthcare utilization was compiled from the electronic database. Results: The case notes of 59 (7.1%) intervention patients were forwarded to the respective PHCs. Of these, access to the enhanced patient information was deemed useful in 82% cases in the ED, versus 76% in PHCs. The mean number of ED visits in the following year did not differ significantly in the total intervention group as compared with the controls: 4.0 and 3.9, respectively (P=0.49). Nor were there any differences in utilization of other care resources. Conclusion: Although only a small subgroup's information was shared, yielding no decrease in overall healthcare utilization, the study indicated benefits of the enhanced information at the respective care level and also had important clinical and organizational implications

**Leighton Y, Clegg A, and Bee A (2008). Evaluation of community matron services in a large metropolitan city in England. *Quality in Primary Care*, 16, (2), 83-91.**

Investment in community matron service development is an important feature of health policy in the UK, and underpins a national strategy to improve care for people with long-term conditions. These new services are under pressure to demonstrate added value in terms of patient experience and a reduction in unplanned hospital bed usage. The focus of this article is an evaluation of community matron services in a large primary care trust. The results of this city-wide service evaluation demonstrated high levels of patient and general practitioner (GP) satisfaction with community matron services. The themes identified by patients and GPs included improved communications and co-ordination of services. In addition to this, patients and carers commented on increased levels of confidence as a result of responsive and accessible services, as well as a perception that there was a reduction in unnecessary hospital admissions.

**Peleg, R., et al. (2008). An intervention program to reduce the number of hospitalizations of elderly patients in a primary care clinic. *BMC Health Services Research*, 8, (1), 36.**

<http://dx.doi.org/10.1186/1472-6963-8-36>

<http://www.biomedcentral.com/1472-6963/8/36>

<http://pmid.us/18254972>

Background: The elderly population consumes a large share of medical resources in the western world. A significant portion of the expense is related to hospitalizations.

**Objectives.** To evaluate an intervention program designed to reduce the number of hospitalization of elderly patients by a more optimal allocation of resources in primary care. **Methods :** A multidimensional intervention program was conducted that included the re-engineering of existing work processes with a focus on the management of patient problems, improving communication with outside agencies, and the establishment of a system to monitor quality of healthcare parameters. Data on the number of hospitalizations and their cost were compared before and after implementation of the intervention program. **Results:** As a result of the intervention the mean expenditure per elderly patient was reduced by 22.5%. The adjusted number of hospitalizations/1,000 declined from 15.1 to 10.7 (29.3%). The number of adjusted hospitalization days dropped from 132 to 82 (37.9%) and the mean hospitalization stay declined from 8.2 to 6.7 days (17.9%). The adjusted hospitalization cost (\$/1,000 patients) dropped from \$32,574 to \$18,624 (42.8%). The overall clinic expense, for all age groups, dropped by 9.9%. **Conclusions:** Implementation of the intervention program in a single primary care clinic led to a reduction in hospitalizations for the elderly patient population and to a more optimal allocation of healthcare resources

## QUALITY OF CARE

**Chatwin J (2008). Hidden dimensions: the analysis of interactions in nurse-patient encounters. *Quality in Primary Care*, 16, (2), 109-116.**

**Background:** It is well established that the success of much healthcare provision is strongly linked to the quality of interaction that occurs between healthcare professionals and patients. Nurse-led consultations are becoming ever more common in primary care, and patient satisfaction with this type of clinical encounter is reportedly high. While many fields of health care have been the subject of detailed interactional and socio-linguistic analysis, nurse-patient encounters are currently under-represented. **Objective:** This article will outline how one particular socio-linguistic approach - conversation analysis (CA) - can be applied to the investigation of nurse-led consultations. It will illustrate how the unique perspective that this method offers can reveal aspects of behaviour that would otherwise be inaccessible, and discusses the practical implications that a greater understanding of these behaviours can have for improving quality of care. **Strategy:** The CA method is illustrated through the presentation and analysis of data collected as part of a recent study into nurse/patient interaction in a specialist wound dressing clinic. The sequential and treatment-related consequences of a simple interactional misalignment during the initial stages of a consultation are explored, and used to demonstrate how such misalignments can impact on treatment processes.

**Cheraghi-Sohi, S., et al. (2008). What patients want from primary care consultations: a discrete choice experiment to identify patients' priorities. *Annals of Family Medicine* , 6, (2), 107-115.**

<http://dx.doi.org/10.1370/afm.816>

<http://pmid.us/18332402>

Purpose: The consultation is fundamental to the delivery of primary care, but different ways of organizing consultations may lead to different patient experiences in terms of access, continuity, technical quality of care, and communication. Patients' priorities for these different issues need to be understood, but the optimal methods for assessing priorities are unclear. This study used a discrete choice experiment to assess patients' priorities. Methods: We surveyed patients from 6 family practices in England. The patients chose between primary care consultations differing in attributes such as ease of access (wait for an appointment), choice (flexibility of appointment times), continuity (physician's knowledge of the patient), technical quality (thoroughness of physical examination), and multiple aspects of patient-centered care (interest in patient's ideas, inquiry about patient's social and emotional well-being, and involvement of patient in decision making). We used probit models to assess the relative priority patients placed on different attributes and to estimate how much they were willing to pay for them. Results: Analyses were based on responses from 1,193 patients (a 53% response rate). Overall, patients were willing to pay the most for a thorough physical examination (\$40.87). The next most valued attributes of care were seeing a physician who knew them well (\$12.18), seeing a physician with a friendly manner (\$8.50), having a reduction in waiting time of 1 day (\$7.22), and having flexibility of appointment times (\$6.71). Patients placed similar value on the different aspects of patient-centered care (\$12.06-\$14.82). Responses were influenced by the scenario in which the decision was made (minor physical problem vs urgent physical problem vs ambiguous physical or psychological problem) and by patients' demographic characteristics. Conclusions: Although patient-centered care is important to patients, they may place higher priority on the technical quality of care and continuity of care. Discrete choice experiments may be a useful method for assessing patients' priorities in health care

**Cornford CS et al (2008). A survey of primary and specialised health care provision to prisons in England and Wales. *Primary Health Care Research and Development*. Online article**

<http://dx.doi.org/10.1017/S1463423608000583>

Background Prison health care in England, including primary care, is now incorporated into the National Health Service; the impetus for the change is in part due to concern about standards of health care within prisons. The demographic characteristics and health status of patients within prisons are relatively well understood, as are the problems faced by health care professionals. Less is known about current health care provision. Aims To describe the organisation of primary health care and specialised services in prisons and compare services available to different types of prison. Method A piloted questionnaire was sent to the governors of all prisons in England and Wales for completion by the health care manager. Findings Completed questionnaires were received from 122 (89%) of 138 prisons. The survey showed a low use of information technology (IT). Problems were reported with the recruitment and retention of general nurses in more than 50% of

prisons. Prisoners in category A/B (higher security) prisons had available to them a greater range of health care services compared with those in other prisons. The results suggest that provision of services for chronic diseases and improvements in IT are needed. Problems with the recruitment and retention of general nurses need addressing. The reasons why lower-security prisoners are receiving a narrower range of specialised health care services compared with higher-security prisoners need justifying.

**Geneau, R., et al (2008). Understanding the work of general practitioners: a social science perspective on the context of medical decision making in primary care. *BMC Family Practice*, 9, (1), 12.**

<http://dx.doi.org/10.1186/1471-2296-9-12>

<http://www.biomedcentral.com/1471-2296/9/12>

<http://pmid.us/18284700>

Background: The work of general practitioners (GPs) is increasingly being looked at from the perspective of the strategies and factors shaping it. This reflects the importance given to primary care services in health care system reform. However, the literature provides little insight into the medical decision making processes in general practice. Our main objective was to better understand how organizational and environmental factors influence the work of GPs. Methods: We interviewed 28 GPs working in contrasting organizational settings and environments. The data analysis involved using structuration theory to enrich the interpretation of empirical material. Results: We identified four main factors that influence the practice of GPs: mode of remuneration, peer-to-peer interactions, patients' demands and the availability of other medical resources in the environment. These four conditions of action, what we call primary effects, can directly influence the performance of medical acts and time management, as well as the degree of specialization of GPs. Decisions related to each of those aspects can have a variety of both intentional and non-intentional consequences - what we call secondary effects - that are then likely to become conditions for subsequent action. Conclusions: This qualitative study helps shed light on the complex causal loops of interrelated factors that shape the work of GPs.

**Guerra, C. E., et al . (2008). Effect of race on patient expectations regarding their primary care physicians. *Family Practice* , 25, (1), 49-55. Doi: <http://dx.doi.org/10.1093/fampra/cmn005>**

<http://pmid.us/18304974>

Background. Fulfilment of patients' expectations has been associated with greater patient satisfaction with care and greater adherence to medical advice. However, little is known about how race influences patient expectations. Objective. To determine the association between patient race and patient expectations of their primary care physician. Methods. The design was a cross-sectional study. Setting and participants were sample of 709 primary care patients from four clinic sites at the Philadelphia Veterans Affairs Medical Center and the University of Pennsylvania Health System. The measures were an

expectations instrument asking patients to rate the necessity of the physician performing 13 activities during the index visit, self-reported race, demographics, the Rapid Estimate of Adult Literacy in Medicine, the Charlson Comorbidity Index and SF-12. Results. After adjusting for age, sex, education, clinic site, comorbidity, health literacy and health status, African Americans were more likely to report it was absolutely necessary for the physician to refer them to a specialist [AOR 1.55 (95% confidence interval, CI, 1.092.21), P = 0.01], order tests [AOR 1.59 (95% CI 1.112.27), P = 0.01] and conduct each of the six physical exam components. Conclusions. African American race is associated with greater expectations of the primary care physicians. More research is needed to confirm the differential expectations by race and determine the reasons for the differential expectations

**Hogg, W., et al. (2008). Improving prevention in primary care: evaluating the effectiveness of outreach facilitation. *Family Practice* 25, (1), 40-48. Doi: <http://dx.doi.org/10.1093/fampra/emm070>**

<http://pmid.us/18209107>

Background. Outreach facilitation is designed to promote uptake of evidence-based guidelines. There is evidence indicating that outreach facilitation can be effective in improving implementation of preventive care in GPs' offices. In this trial, we test a modified version of an outreach facilitation intervention. Objective. To evaluate whether a comprehensive preventive intervention program using outreach facilitators improves preventive care delivery. Design. Match-paired, cluster-randomized controlled trial. Setting. Fee-for-service primary care practices in Eastern Ontario, Canada, at a time of physician shortage. Participants. Volunteer sample of 54 primary care practices. Main outcome measures. Mean difference between trial arms in practices' delivery of preventive manoeuvres, measured by preventive performance indices estimated from chart reviews and patient survey data. Results. No difference was detected between the trial's arms for the primary outcome's overall prevention index [2.0%; 95% confidence interval (CI) 3.2 to 7.3; P = 0.44]. A small significant difference between the arms was detected for the secondary outcome's overall prevention index (2.8%; 95% CI 0.74.8; P = 0.01). Conclusion. In contrast to similar facilitation trials, this outreach facilitation program did not produce improvements in the delivery of preventive care. This lack of effect may be due to differences in the intervention and context, or the practice's limited capacity to change. Our intervention simultaneously facilitated a high number of manoeuvres, blinded facilitators and physicians to the targeted tests and had a relatively short intervention period and large number of practices assigned per facilitator. Changes in the primary care service model in Ontario at the time of the trial could have also washed out the intervention effect

**Hudelson, P., (2008). What is quality and how is it achieved? Practitioners' views versus quality models. *Quality and Safety in Health Care*, 17, (1), 31-36.**

**Doi: <http://dx.doi.org/10.1136/qshc.2006.021311>**

<http://pmid.us/18245217>

Background: Quality improvement in healthcare organisations requires structural reorganisation and systems reform, and also the development of an appropriate organisational "culture". Beliefs and attitudes that are thought by experts to be conducive to quality improvement in hospitals include the understanding of healthcare as a complex system, recognition of the importance of coordination of healthcare processes, a positive attitude towards medical error, adherence to the concept of continuous improvement, and a central preoccupation with the patient's welfare. Objectives: To explore the ideas about quality held by hospital-based doctors and nurses in Geneva, Switzerland. Methods: Semi-structured interviews were conducted with 21 doctors and nurses in five hospital departments to explore their ideas about the definition of quality in healthcare, their perceptions about the main barriers to achieving quality healthcare, the factors that facilitate delivery of quality healthcare, and notions of responsibility for ensuring quality healthcare. Results and Conclusions: Thematic analysis of the interview data suggested that doctors' and nurses' ideas bear little resemblance to models of quality developed by quality experts. Study participants considered quality of care to be primarily the responsibility of individual practitioners. Quality was seen as mainly dependent on the practitioners' mastery of the technical and interpersonal aspects of care. In contrast, the healthcare system was seen primarily as a source of obstacles to good quality care, providing insufficient resources and imposing an excessive administrative burden. The paper discusses the potential implications of these ideas for the implementation of quality management initiatives

**McGovern, M. P., et al. (2008). The effect of the UK incentive-based contract on the management of patients with coronary heart disease in primary care. *Family Practice*, 25, (1), 33-39.**

**Doi:** <http://dx.doi.org/10.1093/fampra/cmm073>

<http://pmid.us/18222938>

Background. The new General Medical Services (nGMS) contract was introduced in April 2004 to improve care of chronic diseases such as coronary heart disease (CHD) and reduce differences in treatment between patient subgroups. Objective. To determine whether the recording of CHD-related health indicators and prescribing of medicines have increased following the introduction of the nGMS contract and whether differences in the treatment of patients of differing age, gender and deprivation have been affected. Methods. A serial cross-sectional study carried out with 310 general practices in Scotland. The subjects were patients with CHD as identified by their GP. Main outcome measures were the recording of CHD-related health indicators and prescribing of medicines at pre- and post-contract time points (covariates: gender, age, co-morbidity, deprivation and practice size). Results. The recording of CHD-related quality indicators and prescribing increased dramatically (mean absolute increase of 17.1%) after the introduction of the nGMS contract. Post-contract, disparities between patient subgroups, continued for certain components of care. Women were less likely to be recorded than men in 9 of 11 components of care, with older patients (7 of 11 components of care) and the most deprived (4 of 11 components of care) also less likely to have a record than the

youngest and least deprived, respectively. Conclusion. The introduction of the new contract was associated with a dramatic rise in the recording of CHD-related quality indicators. However, not all the population benefited equally for certain aspects of care

**Mead, N., Bower, P., and Roland, M. (2008). General Practice Assessment Questionnaire (GPAQ) - development and psychometric characteristics. *BMC Family Practice*, 9, (1), 13.**

**Doi:** <http://dx.doi.org/10.1186/1471-2296-9-13>

<http://www.biomedcentral.com/1471-2296/9/13>

<http://pmid.us/18289385>

Background: Continual quality improvement in primary care is an international priority. In the United Kingdom, the major initiative for improving quality of care is the Quality and Outcomes Framework (QoF) of the 2004 GP contract. Although the primary focus of the QoF is on clinical care, it is acknowledged that a comprehensive assessment of quality also requires valid and reliable measurement of the patient perspective, so financial incentives are included in the contract for general practices to survey patient views. One questionnaire specified for use in the QoF is the General Practice Assessment Questionnaire (GPAQ). This paper describes the development of the GPAQ (with post-consultation and postal versions) and presents a preliminary examination of the psychometric properties of the questionnaire. Methods: Description of scale development and preliminary analysis of psychometric characteristics (internal consistency, factor structure), based on a large dataset of routinely collected GPAQ surveys (n=190,038 responses to the post-consultation version of GPAQ and 20,309 responses to the postal version) from practices in the United Kingdom during the 2005-6 contract year. Results: The GPAQ scales demonstrated acceptable internal consistency. Respondents tend to report generally favourable ratings. Responses were particularly skewed on the GP communication scale, though no more so than for other questionnaires in current use in the UK for which data were available. Factor analysis identified 2 factors that clearly relate to core concepts in primary care quality (access and interpersonal care) that were common to both version of the GPAQ. The other factors related to enablement in the post-consultation version and nursing care in the postal version. Conclusions: This preliminary evaluation indicates that the scales of the GPAQ are internally consistent and that the items demonstrate an interpretable factor structure. Issues concerning the distributions of GPAQ responses are discussed. Potential further developments of the item content for the GPAQ are also outlined

**Milsom, K. M., et al (2008). The introduction of the new dental contract in England - a baseline qualitative assessment. *British Dental Journal*, 204, (2), 59-62.**

**Doi:** <http://dx.doi.org/10.1038/bdj.2008.1>

<http://pmid.us/18223578>

Objective: To record immediately prior to its inception the views of key stakeholders about the new dental contract introduced in April 2006. Method: Nineteen participants

(11 dental practice principals and eight primary care trust dental leads) were interviewed using a semi structured approach to find out their views and opinions about dental practice, the reasons for introducing the new dental contract, its implementation and content of the new dental contract. An analysis based upon the constant comparative method was used to identify the common themes about these topics. Results: Practice principals expressed satisfaction with working under pilot Personal Dental Services schemes but there was a concern among dental leads about a fall in dental activity among some dentists. All participants believed the new contract was introduced for political, financial and management reasons. All participants believed that it was introduced to limit and control the dental budget. Participants felt that implementation of the contract was rushed and there was insufficient negotiation. There were also concerns that the contract had not been tested. Dental practitioners were concerned about the calculation and future administration of the unit of dental activity system, the fixing of the budget and the fairness of the new dental charge scheme. Dental leads were concerned about patient access and retention and recruitment of dentists under the new contract. Conclusions: The study found a number of reasons for unease about the new dental contract; it was not perceived as being necessary, it was implemented at speed with insufficient negotiation and it was seen as being untested. Numerous and varied problems were foreseen, the most important being the retention of dentists within the NHS. Participants felt the contract was introduced for financial, political and managerial reasons rather than improving patient care. The initial high uptake of the new dental contract should not be viewed as indicating a high level of approval of its content

**O'Brien, K., et al (2008). Sickness certification in the general practice consultation: the patients' perspective, a qualitative study. *Family Practice* 25, (1), 20-26. Doi: <http://dx.doi.org/10.1093/fampra/cmm076>**

<http://pmid.us/18245795>

Background: Up to a third of general practice consultations involve issuing sickness certificates. Recent research has looked at the GPs' perspective of sickness certification but there has been no in-depth research exploring patients' views of these consultations. Aim: To explore patients' views of sickness certification within general practice consultations, and how these could be improved. Methods: A qualitative study was carried out with 12 general practices in South Wales; interview study of 19 patients who had recently received a sick note from a GP. Results: Patients rarely attended just for a sick note, more often wanting advice or an opportunity to ask questions. Patients valued continuity of care, a good doctor/patient relationship, adequate consultation time and discussion about their illness, social situation and work-related issues when consulting with their GP for a sick note. Many patients felt doctors did not have enough time or knowledge of the patient to be able to address this issue adequately and this increased feelings of anxiety. Patients did not feel that being questioned by their GP or discussing return to work threatened the doctor/patient relationship. Conclusions: GPs who simply give out sick notes without question or discussion are not necessarily giving the patient what they want. More time should be spent discussing work and illness-related issues. Policy makers should recognize that continuity of care a good doctor/patient relationship

and adequate consultation time are important to patients and any initiatives aimed at GPs to improve return to work rates should take these into consideration

**Offredy M et al (2008). Improving health and care for patients by redesigning services: the development and implementation of a clinical assessment service in Harrow Primary Care Trust. *Quality in Primary Care*, 16, (2), 95-102.**

The redesign of healthcare services in Harrow Primary Care Trust is due to a number of drivers including: centrally imposed targets as outlined in various policy documents; shifting the balance of care; service delivery in a challenging financial climate; response to national consultations which indicate that patients want services nearer to home; and local and national knowledge of providing different types of services. A local enhanced scheme was devised by the trust to support general practitioners to follow care pathways using evidence-based literature, best practice and discussions with clinicians, nurses and patient representatives. The result was an ambitious and innovative service which has attracted attention from neighbouring London primary care trusts, which are seeking to replicate the model.

**Parker, L. E.,et al . (2007). Balancing participation and expertise: a comparison of locally and centrally managed health care quality improvement within primary care practices. *Qualitative Health Research*, 17 (9), 1268-1279.**

<http://dx.doi.org/10.1177/1049732307307447>

<http://pmid.us/17968043>

In a longitudinal qualitative study, the authors evaluated two health care quality improvement (QI) methods that emphasized either participation (local approach) or expertise (central approach). They followed teams using these approaches to develop depression care QI programs for primary care practices over several years, observing their processes and outcomes and learning about participants' perceptions, beliefs, and experiences. Concordant with the literature, most participants preferred the local approach, but some were willing to relinquish some decision making to experts. Participants identified unique advantages of both the local (e.g., maximizes buy-in and local fit) and central (e.g., maximizes efficiency, reduces burden) approaches. The authors propose a hybrid model in which experts make strategic decisions about what practices to adopt and local site personal make tactical decisions about implementation. They believe that balancing participation and expertise provides the best formula for producing lasting QI for health care organizations across a wide variety of circumstances

**Reinders, M. E.,et al (2008). Development and feasibility of a patient feedback programme to improve consultation skills in general practice training. *Patient Education and Counseling*, In press.**

Doi: <http://dx.doi.org/10.1016/j.pec.2008.01.016>

<http://pmid.us/18337050>

**Objective** To develop an attractive and effective patient feedback training programme for general practice trainees (GPTs). **Methods** First, an exploratory study was conducted in which patients and GPTs were interviewed after they had worked with patient feedback. This contributed to the development of the patient feedback training programme. Subsequently, in a feasibility study, first-year GPTs asked patients to give feedback on their consultation skills by completing a questionnaire. The outcomes of group discussions with the GPTs and the results of the evaluation forms filled in by the GPTs were analysed. **Results** Forty-eight GPTs collected 878 questionnaires. GPTs and patients alike expected patient feedback to be a major tool for acquiring consultation skills. The GPTs encountered several obstacles in the organisation of this programme in their practice. They reported that the learning effects were more limited than they had expected because patients gave positively biased answers and because not all consultations provided an appropriate source of patient feedback. **Conclusion** The new patient feedback programme on consultation skills is feasible for patients and GPTs. **Practice implications** To optimise the educational potential and benefits of patient feedback, GPTs should ask for feedback from patients after challenging consultations, and should stimulate patients to be critical in their answers

**Schmacker, E. and McKay, N. L. (2008). Factors affecting productive efficiency in primary care clinics. *Health Services Management Research*, 21, (1), 60-70. Doi: 10.1258/hsmr.2007.007018 PMID: 18275665**

**Doi:** <http://dx.doi.org/10.1258/hsmr.2007.007018>

<http://pmid.us/18275665>

This study examines factors affecting the productive efficiency of primary care clinics. The empirical analysis uses a single-stage stochastic frontier regression model, in which factors affecting productive efficiency are specified as part of the inefficiency error component and estimated simultaneously with the production function. The study population includes primary care clinics in the US Military Health System from 1999 through 2003; the analytical data set is an unbalanced panel of 442 observations. The study's main results were that primary care clinics not associated with medical centres had significantly higher levels of productive efficiency than those associated with medical centres and that having proportionately more civilian staff (and thus less turnover) had a positive impact on productive efficiency. Due to their nature, these findings would be expected to also be applicable to the production of primary care in other settings. A key implication of the results is that improvements in productive efficiency should be a top priority, given the possibility for providing more primary care visits without increases in cost.

## **RESEARCH AND DEVELOPMENT**

**Beaulieu MD et al (2008). When Is knowledge ripe for primary care? *Evaluation and the Health Professions*, 31, (1), 22-42.**

**Doi:** <http://dx.doi.org/10.1177/0163278707311870>

<http://pmid.us/18245720>

The objectives of this study were to explore the meaning of scientific evidence as it is understood by primary care physicians. Individual interviews were conducted with actors chosen for their roles in the production and use of knowledge: 22 family physicians, 13 specialist physicians, and 6 researchers. Two situations served as points of reference for these discussions: screening for genetic breast cancer and treatment of hypertension. The results suggest that there may be a misunderstanding between the producers of knowledge and primary care practitioners with respect to what constitutes "evidence"— knowledge ready for integration into the clinical practice of primary care. These potential differences go beyond the issues of how information is disseminated. Rather, many of the questions raised by family physicians concern how knowledge is developed. In the interests of fostering better dissemination of new knowledge and encouraging its adoption, new links should be created between knowledge "producers" and potential users.

**Garcia-Campayo, J., Magallon, R., Monreal, A., Bolibar, B., and Zurro, A. M. (2007). The Spanish primary care collaborative research network (REDIAPP): a model of research on psychiatry in primary care for export? *Primary Care & Community Psychiatry*, 12, (3-4), 131-135.**

**Doi:** <http://dx.doi.org/10.1080/17468840701706549>

In January 2002, the most important Spanish biomedical research-financing agency developed a national program to co-ordinate biomedical researchers in different fields of knowledge by developing collaborative research networks. One of the most important, according to the number of members and funding obtained, was REDIAPP (in English, Research Network on Preventative Activities and Health Promotion), a primary care-based collaborative research network with a two-level structure: a geographical organisation parallel to the Spanish system of government, and thematic research organisation. This paper summarises the objectives, organisation, selection and development projects and specific characteristics of REDIAPP. Other Western countries have developed strategies to improve medical research at primary care level and, in general, these efforts have been successful. However, we consider that the Spanish model for improvement in primary care research, based on the REDIAPP scheme, has specific characteristics worth taking into account. The most outstanding of these is the availability of research for the members of the health system and the open organisation of the network

**Loxterkamp D, Kazal LA, Jr. (2008) Changing horses midstream: the promise and prudence of practice redesign. *Annals of Family Medicine* ;6 (2):167-70.**

**Doi:** <http://dx.doi.org/10.1370/afm.822>

<http://pmid.us/18332412>

Abstract: An emerging vision for primary care calls for the adoption of information technology and a strong business model to save a dying health care system. The authors are participants in the National Demonstration Project (NDP), a study sponsored by leading organizations in family medicine and directed by a for-profit subsidiary of the American Academy of Family Physicians, TransforMED. The NDP embraces the Future of Family Medicine Report and seeks to test the ability of existing practices to implement its basic tenets. The NDP will conclude in June 2008, but its findings and observations will likely ripple out for years. Our report is a personal reflection that looks beyond the question of whether busy practices and practitioners can change horses midstream. We ask, "Is this primary care, and is this what it needs?"

**McManus, R. J., et al (2008). How representative of primary care are research active practices? Cross-sectional survey. *Family Practice* , 25, (1), 56-62.**

**Doi:** <http://dx.doi.org/10.1093/fampra/cmm065>

<http://pmid.us/18048650>

Background. There has been a continued trend towards undertaking primary care-based research but the characteristics and generalizability of practices that participate in such research are not well known. Objective. To compare research active and non-active practices in terms of practice demographics, disease prevalence and quality scores from the Quality and Outcomes Framework. Design. Cross-sectional survey using publicly available data. Setting. A total of 973 general practices from the West Midlands, UK. Main outcome measures. Practice population characteristics, research status, disease prevalence, clinical and non-clinical quality scores. Results. Of 973 practices, 298 (31%) were defined as research active. Research active practices had younger populations (% over 65: 15.2% versus 16.2%,  $z = 3.95$ ,  $P < 0.0001$ ) compared to non-research active practices, were larger [median list size 6123 (interquartile range, IQR, 36429691) versus 4059 (IQR 26757060)  $z = 6.96$ ,  $P < 0.0001$ ] and more likely to be in deprived areas [median Townsend quintile 5 (IQR 35) versus 4 (IQR 35),  $z = 3.23$ ,  $P = 0.001$ ]. Disease prevalence was similar in both research active and non-active practices but the former attained higher median quality scores for both clinical [research active 534/550 (IQR 508546) versus non-research active 525/550 (IQR 483542)  $z = 4.00$ ,  $P < 0.0001$ ] and non-clinical [310/320 (IQR 283319) versus 296/320 (IQR 265314),  $z = 5.76$ ,  $P < 0.0001$ ] areas. Conclusion. General practices which participate in research are larger and located in more deprived areas than non-research active practices but disease prevalence is similar and research practices attain only modestly higher quality points. Research in research active practices is likely to be generalizable to the wider primary care community

**Themessl-Huber, M., et al (2008). Audio-visual recording of patient-GP consultations for research purposes: A literature review on recruiting rates and strategies. *Patient Education and Counseling*, In Press, Corrected Proof.**

Doi: <http://dx.doi.org/10.1016/j.pec.2008.01.015>

<http://pmid.us/18356003>

**Objective** To identify ethical processes and recruitment strategies, participation rates of studies using audio or video recording of primary health care consultations for research purposes, and the effect of recording on the behaviour, attitudes and feelings of participants. **Methods** A structured literature review using Medline, Embase, Cochrane Library, and Psychinfo. This was followed by extensive hand search. **Results** Recording consultations were regarded as ethically acceptable with some additional safeguards recommended. A range of sampling and recruitment strategies were identified although specific detail was often lacking. Non-participation rates in audio-recording studies ranged from 3 to 83% for patients and 7 to 84% for GPs; in video-recording studies they ranged from 0 to 83% for patients and 0 to 93% for GPs. There was little evidence to suggest that recording significantly affects patient or practitioner behaviour. **Conclusions** Research involving audio or video recording of consultations is both feasible and acceptable. More detailed reporting of the methodical characteristics of recruitment in the published literature is needed. **Practice implications** Researchers should consider the impact of diverse sampling and recruitment strategies on participation levels. Participants should be informed that there is little evidence that recording consultations negatively affects their content or the decisions made. Researchers should increase reporting of ethical and recruitment processes in order to facilitate future reviews and meta-analyses

## RESEARCH METHODS

**Renfrew, M. J., et al (2008). Developing evidence-based recommendations in public health--incorporating the views of practitioners, service users and user representatives. *Health Expectations* , 11, (1), 3-15.**

Doi: <http://dx.doi.org/10.1111/j.1369-7625.2007.00471.x>

<http://pmid.us/18275398>

**Background:** Guidance based on a systematic assessment of the evidence base has become a fundamental tool in the cycle of evidence-based practice and policy internationally. The process of moving from the formal evidence base derived from research studies to the formation and agreement of recommendations is however acknowledged to be problematic, especially in public health; and the involvement of practitioners, service commissioners and service users in that process is both important and methodologically challenging. **AIM:** To test a structured process of developing evidence-based recommendations in public health while involving a broad constituency of practitioners, service commissioners and service user representatives. **Methods:** As part of the development of national public health recommendations to promote and

support breastfeeding in England, the methodological challenges of involving stakeholders were examined and addressed. There were three main stages: (i) an assessment of the formal evidence base (210 studies graded); (ii) electronic and fieldwork-based consultation with practitioners, service commissioners and service user representatives (563 participants), and an in-depth analytical consultation in three 'diagonal slice' workshops (89 participants); (iii) synthesis of the previous two stages. Results and conclusions: The process resulted in widely agreed recommendations together with suggestions for implementation. It was very positively evaluated by participants and those likely to use the recommendations. Service users had a strong voice throughout and participated actively. This mix of methods allowed a transparent, accountable process for formulating recommendations based on scientific, theoretical, practical and expert evidence, with the added potential to enhance implementation

**Shaw, S. E., Greenhalgh, T. (2008). Best research - For what? Best health - For whom? A critical exploration of primary care research using discourse analysis. *Social Science & Medicine*, In Press, Corrected Proof.**

Doi: <http://dx.doi.org/10.1016/j.socscimed.2008.02.014>

<http://pmid.us/18378371>

Health research is fundamental to the development of improved health and healthcare. Despite its importance, and the role of policy in guiding the kind of research that gets addressed, there are very few empirical studies of health research policy. This paper redresses this, exploring the means by which one area of health research policy is shaped, enabled and constrained. We ask: what are the historical, social and political origins of research policy in primary care in England? What are the key discourses that have dominated debate; and what are the tensions between discourses and the implications this raises for practitioners and policymakers? To answer these questions we employed a Foucauldian approach to discourse analysis to explicitly recognise the historical, social and ideological origins of policy texts; and the role of power and knowledge in policy development. We adapted Parker's framework for distinguishing discourses as a means of selecting and analysing 29 key policy documents; 16 narrative interviews with historical and contemporary policy stakeholders; and additional contextual documents. Our analysis involved detailed deconstruction and linking across texts to reveal prevailing storylines, ideologies, power relations, and tensions. Findings show how powerful policy discourses shaped by historical and social forces influence the type of research undertaken, by whom and how. For instance, recent policy has been shaped by discourse associated with the knowledge-based economy that emphasises microscopic 'discovery', exploitation of information and the contribution of highly technological activities to 'UK plc' and has re-positioned primary care research as a strategic resource and 'population laboratory' for clinical research. Such insights challenge apolitical accounts of health research and reveal how health research serves particular interests

## SOCIAL CAPITAL

Engstrom, K., et al (2008). **Contextual social capital as a risk factor for poor self-rated health: A multilevel analysis.** *Social Science and Medicine* February 2008 Epub ahead of print Doi: <http://dx.doi.org/10.1016/j.socscimed.2008.01.019>

<http://pmid.us/18314238>

In this study, we critically examine whether contextual social capital (CSC) is associated with self-rated health, with an emphasis on the problem of confounding. We also examine different components of CSC and their association with self-rated health. Finally, we look at differences in susceptibility between different socio-demographic groups. We use the cross-sectional base line study of the Stockholm Public Health Cohort, conducted in 2002. A postal questionnaire was answered by 31,182 randomly selected citizens, 18-84 years old, in Stockholm County. We used four measures of social capital: horizontal (civic trust and participation), vertical (political trust and participation), cognitive (civic and political trust) and structural (civic and political participation). CSC was measured at parish level from aggregated individual data, and multilevel regression procedures were employed. We show a twofold greater risk of poor self-rated health in areas with very low CSC compared with areas with very high CSC. Adjustments for individual socio-demographic factors, contextual economic factors and individual social capital lowered the excess risk. Simultaneous adjustment for all three forms of confounding further weakened the association and rendered it insignificant. Cognitive and structural social capital show relatively similar associations with self-rated health, while horizontal CSC seems to be more strongly related to self-rated health than vertical CSC. In conclusion, whether there is none or a moderate association between CSC and self-rated health, depends on the extent to which individual social capital is seen as a mediator or confounder. The association with self-rated health is similar independent of the measure of CSC used. It is also similar in different socio-demographic groups

Stephens, C. (2008). **Social capital in its place: Using social theory to understand social capital and inequalities in health.** *Social Science and Medicine*, 66, (5), 1174-1184. Doi: <http://dx.doi.org/10.1016/j.socscimed.2007.11.026>

<http://pmid.us/18155335>

Social capital has been controversially linked to public health benefits, particularly as an explanation for the relationship between economic inequalities and health. This paper focuses on social capital in this context, particularly a recent emphasis on social capital in neighbourhoods and growing use of Bourdieu's social theory in empirical investigations. A review of some of this work is used to suggest the need for a more coherent theoretical approach to using Bourdieu and to introduce an ethnographic study of social connections in New Zealand. Forty-six residents of, a rural town, a deprived city suburb, or an affluent suburb, volunteered to be interviewed about their social connections. Their talk was transcribed and analysed in terms of everyday practice. The results of this study suggest that social connections are not necessarily located in neighbourhoods, and that

social capital will be better understood in a broader social context which includes competition for resources between deprived and non-deprived groups, and the practices of all citizens across neighbourhoods. When considering social capital, an exclusive focus on deprived neighbourhoods as sites for research and intervention is not helpful

**Wood, L., et al (2008). The anatomy of the safe and social suburb: an exploratory study of the built environment, social capital and residents' perceptions of safety.**

*Health Place*, 14, (1), 15-31. Doi:

<http://dx.doi.org/10.1016/j.healthplace.2007.04.004>

<http://pmid.us/17576088>

This study explored the relationship between social capital and aspects of the built environment, focusing in particular on the walkability of suburbs as determined by street network design and the mix of land uses. We measured social capital and feelings of personal safety in 335 residents of three suburbs in metropolitan Perth, WA, and collected objective and perceived data on the built environment. After adjustment for demographic factors, the built environment was found to have a significant but small effect on social capital and feelings of safety, particularly in relation to the number and perceived adequacy of destinations. A high level of neighbourhood upkeep was associated with both higher social capital and feelings of safety

## WORKFORCE

**Bach, S., Kessler, I., and Heron, P. (2008). Role redesign in a modernised NHS: the case of health care assistants. *Human Resource Management Journal*, 18, (2), 171-187.**

Doi: <http://dx.doi.org/10.1111/j.1748-8583.2007.00066.x>

This article examines role redesign in the National Health Service (NHS), which has been central to the Labour government's modernisation agenda, focusing on the role of health care assistants (HCAs). Drawing on data from two acute hospital trusts, this article focuses on variation in HCA roles between trusts, indicating that there may not have been a uniform expansion of the HCA role as the government's HR agenda and most commentators suggest. Although the modernisation agenda has curtailed registered nurses' role in direct care, there are significant variations in the degree to which HCAs undertake a relief, substitute or apprentice role at trust level. These variations in HCA role stem from distinctive models of the nursing workforce with differing assumptions about the respective roles of registered and non-registered nurses. The variations in HCA role have important consequences for the prospects for role redesign and HR policy in the NHS

**Hansson, A., et al (2008). Two sides of the coin - general practitioners' experience of working in multidisciplinary teams. *Journal of Interprofessional Care*, 22, (1), 5-16.**  
<http://dx.doi.org/10.1080/13561820701722808>

<http://pmid.us/18202982>

Multidisciplinary teamwork, defined as the collaboration between different professional groups to achieve a common purpose, is commonly regarded as a means to meet the complex tasks that medicine has to deal with today. However, many attempts to introduce the method in primary care have failed and this is supposed to be partly due to the fact that general practitioners (GPs) did not participate in the implementation of the method. The aim of this investigation was to get a deeper understanding of their attitude to teamwork by interviewing nine GPs at four Swedish health care centres, where successful teamwork had been ongoing since 1997. Themes and categories in the interviews were identified according to content analysis. Although the attitude in general was in favour of teamwork, four major themes: time-consuming versus time-saving; shared responsibility versus main responsibility; medical expert versus generalist; shared knowledge versus all knowing, could be identified, which all revealed ambivalence towards teamwork among the interviewees. It was concluded that, if teamwork is to be successfully introduced into primary care, the GPs' self-perception has to be taken into consideration as has the prestige and status associated with their traditional role and the benefits of teamwork to the profession of medicine. Apart from time, teamwork requires, professional supervision and doctors need to be trained in this method as early as in medical school

**Holt IGS (2008). Role transition in primary care settings. *Quality in Primary Care*, 16, (2), 117-126.**

Background: This paper reports on research that explored how nurses who are engaged in advanced practice adapt and adjust to their roles in primary and community health settings. Successive government policy has highlighted how the changing roles of nurses, who are engaged in advanced practice, are crucial to delivering high-quality patient care. The paper offers a framework for role transition which is potentially generalisable to doctors, physiotherapists and other healthcare professionals. The aim of the study was to enable an understanding of role transition, from a study of nurses going through changes to their roles or moving to new roles. The intended purpose of the study was to explore what was going on within role transition, and considers by what process(es) role transition evolves or is experienced. Method: Eleven nurses' actions, expectations, and experiences of role transition were explored, within three district nurse centres and two community NHS trusts. Data were collected from participant and non-participant observation, content analysis of job descriptions and from individual and group interviews, including semi-structured schedules and focus group techniques. Data were comparatively analysed to conceptualise and saturate core themes, which were discussed and developed with participants and healthcare managers. Results: A theory of role transition is proposed through a model representing the 'who', 'what', 'where' and 'how' of role transition, through four concepts of centring identity(ies); focusing role(s); enacting role(s); and shaping role(s). Identity was regarded by the participants as being the role, the person, and as part of a group. Current and anticipated role foci directed enactment of

role within given contexts and resources, while shaping of role involved a balance of role loss and role expansion. Conclusions: This article presents a theory of role transition for primary care professionals.

**Kjeldmand D, Holmstrom I (2008) . Balint groups as a means to increase job satisfaction and prevent burnout among general practitioners. *Annals of Family Medicine*. ;6(2) 138-45.**

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<http://pmid.us/18332406>

Purpose: General practitioners (GPs) occupy a central position in health care and often have demanding working situations. This corps shows signs of exhaustion, and many consider quitting their job or plan to retire early. It is therefore urgent to find ways of improving GP's satisfaction with their work. One approach might be Balint group participation. The aim of this study was to explore GPs' experience of participating in Balint groups and its influence on their work life. Methods: We conducted a descriptive, qualitative study. Nine GPs who had participated in Balint groups for 3 to 15 years were interviewed. A phenomenologic analysis was carried out to describe the phenomenon of Balint group participation. Results: The GPs perceived that their Balint group participation influenced their work life. Analyses revealed several interrelating themes: competence, professional identity, and a sense of security, which increased through parallel processes, creating a base of endurance and satisfaction, thus enabling the GPs to rediscover the joy of being a physician. Conclusions: The GPs in this study described their Balint group participation as beneficial and essential to their work life as physicians in several ways. It seemed to increase their competence in patient encounters and enabled them to endure in their job and find joy and challenge in their relationships with patients. Balint groups might thus help GPs handle a demanding work life and prevent burnout. These groups might not suit all GPs, however, and additional ways to reduce stress and increase job satisfaction should be offered

**Macdonald, W et al (2008) Practice nurses and the facilitation of self-management in primary care. *Journal of Advanced Nursing* 62(2) 191-199**

**Doi:** <http://dx.doi.org/10.1111/j.1365-2648.2007.04585.x>

<http://pmid.us/18394031>

Aim. This paper is a report of a study to explore practice nurse involvement in facilitation of self-management for long-term conditions. Background. In the United Kingdom chronic disease services have shifted from secondary care to general practice and from general practitioners to practice nurses. A new United Kingdom General Practice contract requires adherence to chronic disease management protocols, and facilitating self-management is recognized as an important component. However, improving self-management is a relatively new focus and little is known about the ways in which nurses engage with patient self-management and how they view work with patients in chronic

disease clinics. Method. Semi-structured interviews with 25 practice nurses were carried out in 2004–2005. Interviews were audio-taped and transcribed verbatim. Analysis was informed by the ‘trajectory model’ and ‘personal construct’ theories. Findings. Main themes in the early stages of work with patients were: categorization of patients, diagnosis, and patient education. First impressions appeared to determine expectations of self-management abilities, although these were amenable to change. Intermediate stages were ‘ways of working’ (breaking the task down, cognitive restructuring and addressing dissonance, modelling ‘good’ behaviour, encouragement, listening, involving carers and referral) and maintaining relationships with patients. However, in the longer-term nurses seemed to lack resources beyond personal experience and intuitive ways of working for encouraging effective self-care. Conclusion. The ways of working identified are unlikely to be sufficient to support patients’ self-management, pointing to a need for education to equip nurses with techniques to work effectively with patients dealing with longer-term effects of chronic illness.

**McDonald R, Harrison S, and Checkland K (2008). Incentives and control in primary health care: findings from English pay-for-performance case studies. *Journal of Health Organization and Management*, 22, (1), 48-62.**

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Purpose - The authors' aim was to investigate mechanisms and perceptions of control following the implementation of a new "pay-for-performance" contract (the new General Medical Services, or GMS, contract) in general practice. Design/methodology/approach - This article was based on an in-depth qualitative case study approach in two general practices in England. Findings - A distinction is emerging amongst ostensibly equal partners between those general practitioners conducting and those subject to surveillance. Attitudes towards the contract were largely positive, although discontent was higher in the practice which employed a more intensive surveillance regime and greater amongst nurses than doctors. Research limitations/implications - The sample was small and opportunistic. Further research is required to examine the longer-term effects as new contractual arrangements evolve. Practical implications - Increased surveillance and feedback mechanisms associated with new pay-for-performance schemes have the potential to constrain and shape clinical practice.

**McLean, T. (2008). Will reputational incentives stimulate a reversal of the physician brain drain? *Journal of Health Services Research and Policy*, 13, (1), 50-52.**

**Doi:** <http://dx.doi.org/10.1258/jhsrp.2007.007094>

<http://pmid.us/18325157>

An increased supply of physicians in high income countries both from domestic production and from immigration from low and middle income countries has made medical employment increasingly competitive. This has been heightened by the introduction of reputational incentives, such as public reporting of physicians' outcomes,

and the use of other health care professionals, such as nurses. An unanticipated consequence might be a reversal of the 'brain drain', with physicians migrating to low and middle income countries

**Sanders, T. and Harrison, S. (2008). Professional legitimacy claims in the multidisciplinary workplace: the case of heart failure care**  
**145. *Sociology of Health and Illness* 30, (2), 289-308.**

**Doi:** <http://dx.doi.org/10.1111/j.1467-9566.2007.01052.x>

<http://pmid.us/18290937>

The pattern of occupations engaged in the care of patients has grown steadily more complex, and is characterised by the creation of new occupations, additional specialisation within existing occupations, and extensions to existing occupational roles. This paper presents empirical data from a study of professionals working with heart failure patients in the English National Health Service, focusing on the discourses employed by nurses and by three different specialties within medicine to legitimise their occupational boundaries. We identify four themes that characterise such discourses, specialised expertise, competence, organisational efficiency and patient-centredness, though these are deployed to different degrees by the different professions. The findings point to a theory of 'occupational legitimization talk' in which newer occupations utilise a wider set of legitimacy claims as a means of strengthening their role and credibility within an increasingly complex and fluid healthcare environment

**Sepulveda, M. J., Bodenheimer, T., and Grundy, P. (2008). Primary care: can it solve employers' health care dilemma? *Health Affairs (Millwood)*, 27, (1), 151-158. Doi: 10.1377/hlthaff.27.1.151 [PM:18180490](http://pubmed.ncbi.nlm.nih.gov/18180490/)**

<http://dx.doi.org/10.1377/hlthaff.27.1.151>

<http://pmid.us/18180490>

Employers are beginning to recognize that investing in the primary care foundation of the health care system may help address their problems of rising health care costs and uneven quality. Primary care faces a crisis as a growing number of U.S. medical graduates are avoiding primary care careers because of relatively low reimbursement and an unsatisfying work life. Yet a strong primary care sector has been associated with reduced health care costs and improved quality. Through the Patient-Centered Primary Care Collaborative and other efforts, some large employers are engaged in initiatives to strengthen primary care

**Uncu, Y., Bayram, N., and Bilgel, N. (2007). Job related affective well-being among primary health care physicians. *European Journal of Public Health* 17, (5), 514-519. Doi: <http://dx.doi.org/10.1093/eurpub/ck1264>**

<http://pmid.us/17185328>

Background: Job related affective well-being is important for a healthy life and job satisfaction for all individuals, including physicians. The latter group, however, is most often compromised. Objectives: We aimed to investigate a group of Turkish primary health care physicians' job related emotional perceptions and to assess their reactions in terms of stress, anxiety and depression. Methods: A descriptive, cross-sectional, self-reported questionnaire study was conducted. A total of 60 primary health care centres and 274 general practitioners who were working at these centres participated in the study. The response rate was 74%. Printed questionnaires were completed by the participants anonymously. We used the Job Related Affective Well-Being Scale (JAWS) and Depression Anxiety Stress Scale (DASS 42). Correlation analysis and hierarchic regression were performed. Results: Correlations between JAWS and DASS total scores were negative and statistically significant ( $r = -0.52$ ;  $P < 0.01$ ). Low pleasure/high arousal (LPHA) and low pleasure/low arousal (LPLA) variations that describe negative emotional states show a positive and significant relationship with depression, anxiety and stress values. The highest mean score was obtained for the high pleasure/low arousal (HPLA) status that can be interpreted to mean that our study group was pleased with their job but was not motivated. Conclusions: Physician's job related negative emotional perceptions are associated with reactions in terms of stress, anxiety and depression. For this reason, it is critical to consider primary care physicians' job related affectations and job related stimuli

**Walshe C et al (2008). Judgements about fellow professionals and the management of patients receiving palliative care in primary care: a qualitative study. *British Journal of General Practice*, 58, (549), 264-272.**

Background Policies emphasise the importance of collaborative working in community palliative care. Collaborations are generally formed through formal and informal referral processes, but little is known about what influences professionals' decisions to refer to such services. Aim To explore the influences on referrals within general and specialist community palliative care services. Design of study Qualitative, multiple-case study. Setting Three primary care trusts in the north-west of England. Method Multiple data collection methods were employed, including documentary analysis, observation of referral team meetings and interviews. This paper primarily reports data from interviews with 47 health professionals, including GPs, district nurses, and specialist palliative care professionals. Results Judgements "positive and negative" about aspects of fellow professionals' performances appeared to influence referral decisions and ongoing collaboration and care. Attributes upon which these judgements were based included professional responsiveness and communication, respect, working and workload management practices, perceived expertise, and notions of elite practice. The effects of such judgements on referral and healthcare practices were altered by professional "game playing" to achieve professionals' desired outcomes. Conclusion Palliative care policies and protocols need to take account of these complex and subtle influences on referrals and collaboration. In particular, teamwork and partnership are encouraged within palliative care work, but critical judgements indicate that such partnerships may be difficult or fragile. It is likely that such judgemental attitudes and practices affect many aspects of primary care, not just palliative care.

**Williams E S et al (2007). Heavy physician workloads: impact on physician attitudes and outcomes. *Health Services Management Research*, 20, (4), 261-269.**  
**Doi: <http://dx.doi.org/10.1258/095148407782219067>**

**Doi: <http://dx.doi.org/10.1258/095148407782219067>**

**<http://pmid.us/17958972>**

The intensity of physician workload has been increasing with the well-documented changes in the financing, organization and delivery of care. It is possible that these stressors have reached a point where they pose a serious policy issue for the entire healthcare system through their diminution of physician's ability to effectively interact with patients as they are burned out, stressed and dissatisfied. This policy question is framed in a conceptual model linking workloads with five key outcomes (patient care quality, individual performance, absenteeism, turnover and organizational performance) mediated by physician stress and satisfaction. This model showed a good fit to the data in a structural equation analysis. Ten of the 12 hypothesized pathways between variables were significant and supported the mediating role of stress and satisfaction. These results suggest that workloads, stress and satisfaction have significant and material impacts on patient care quality, individual performance, absenteeism, turnover and organizational performance. Implications of these results and directions for future research are discussed.

**Xyrichis, A. and Lowton, K. (2008). What fosters or prevents interprofessional teamworking in primary and community care? A literature review. *International Journal of Nursing Studies* 45, (1), 140-153.**

**Doi: <http://dx.doi.org/10.1016/j.ijnurstu.2007.01.015>**

**<http://pmid.us/17383655>**

Background: The increase in prevalence of long-term conditions in Western societies, with the subsequent need for non-acute quality patient healthcare, has brought the issue of collaboration between health professionals to the fore. Within primary care, it has been suggested that multidisciplinary teamworking is essential to develop an integrated approach to promoting and maintaining the health of the population whilst improving service effectiveness. Although it is becoming widely accepted that no single discipline can provide complete care for patients with a long-term condition, in practice, interprofessional working is not always achieved. Objectives: This review aimed to explore the factors that inhibit or facilitate interprofessional teamworking in primary and community care settings, in order to inform development of multidisciplinary working at the turn of the century. Design: A comprehensive search of the literature was undertaken using a variety of approaches to identify appropriate literature for inclusion in the study. The selected articles used both qualitative and quantitative research methods. Findings: Following a thematic analysis of the literature, two main themes emerged that had an impact on interprofessional teamworking: team structure and team processes. Within these two themes, six categories were identified: team premises; team size and

composition; organisational support; team meetings; clear goals and objectives; and audit. The complex nature of interprofessional teamworking in primary care meant that despite teamwork being an efficient and productive way of achieving goals and results, several barriers exist that hinder its potential from becoming fully exploited; implications and recommendations for practice are discussed. Conclusions: These findings can inform development of current best practice, although further research needs to be conducted into multidisciplinary teamworking at both the team and organisation level, to ensure that enhancement and maintenance of teamwork leads to an improved quality of healthcare provision