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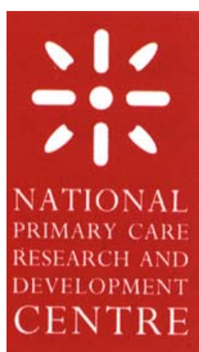

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ACCESS TO CARE

Deb,P., & Trivedi,P.K. (2008). Provider networks and primary-care signups: do they restrict the use of medical services? ***Health Economics 18th December 2008***

http://dx.doi.org/10.1002/hec.1432

http://pmid.us/19097145

This article analyzes the effect of gatekeeper and network restrictions on use of health-care services using simulation-based estimation methods. Data from the Community Tracking Survey (1996-1997) show significant evidence of selection into plans with gatekeeper and/or network restrictions. Enrollees in plans with networks of physicians have fewer office-based visits to non-physician medical professionals, but more emergency room visits and hospital stays. Individuals in plans that require signups with a primary-care provider have more visits to non-physician providers of care, more surgeries and hospital stays but substantially fewer emergency room visits. Enrollees of plans that do not pay for out-of-network services have more office-based and emergency room visits, but less surgeries and hospitalizations. Copyright (c) 2008 John Wiley & Sons, Ltd

Godager,G., & Luras,H. (2008). Dual job holding general practitioners: the effect of patient shortage. ***Health Economics*** **Epub 19/8/2008**

http://dx.doi.org/10.1002/hec.1418

http://pmid.us/18973224

In 2001, a listpatient system with capitation payment was introduced in Norwegian general practice. After an allocation process where each inhabitant was listed with a general practitioner (GP), a considerable share of the GPs got fewer persons listed than they would have preferred. We examine whether GPs who experience a shortage of patients to a larger extent than other GPs seek to hold a second job in the community health service even though the wage rate is low compared with the wage rate in general practice. Assuming utility maximization, we model the effect of patient shortage on a GP's decision to contract for a second job in the community health service. The model predicts a positive relationship between patient shortage and participation in the community health service. This prediction is tested by means of censored regression analyses, taking account of labour supply as a censored variable. We find a significant effect of patient shortage on the number of hours the GPs supply to community health service. The estimated marginal effect is 1.72 hours per week.

Gravelle,H., & Siciliani,L. (2008). Third degree waiting time discrimination: optimal allocation of a public sector healthcare treatment under rationing by waiting. *Health Economics* 30/10/2008

http://dx.doi.org/10.1002/hec.1423

http://pmid.us/18973149

In many public healthcare systems treatments are rationed by waiting time. We examine the optimal allocation of a fixed supply of a given treatment between different groups of patients. Even in the absence of any distributional aims, welfare is increased by third degree waiting time discrimination: setting different waiting times for different groups waiting for the same treatment. Because waiting time imposes dead weight losses on patients, lower waiting times should be offered to groups with higher marginal waiting time costs and with less elastic demand for the treatment. Copyright (c) 2008 John Wiley & Sons, Ltd

O'Donnell C, & et al (2008). Asylum seekers' expectations of and trust in general practice: a qualitative study. *British Journal of General Practice* Advance Online Publications November 2008

http://dx.doi.org/10.3399/bjgp08X376104

Background The UK has substantial minority populations of short-term and long-term migrants from countries with various types of healthcare systems. Aim This study explored how migrants' previous knowledge and experience of health care influences their current expectations of health care in a system relying on clinical generalists performing a gatekeeping role. Design of study Two qualitative methods. Setting Glasgow, UK. Method Focus groups or semi-structured interviews were conducted with 52 asylum seekers. Analyses identified several areas where previous experience affected current expectations. An overview of health systems in each country of origin was established by combining responders' accounts with World Health Organization statistics. Results Asylum seekers had previous experience of a diverse range of healthcare systems, most of which were characterised by a lack of GPs and direct access to hospital-based specialists. For some responders, war or internal conflict resulted in a complete breakdown of healthcare systems. Responders' accounts also highlighted the difficulties that marginalised groups had in accessing health care. Although asylum seekers were generally pleased with the care they received from the NHS, there were areas where they experienced difficulties: confidence in their GP and access to hospital-based specialists and medication. These difficulties encountered might be explained by previous experience. Conclusion GPs and other healthcare professionals need to be aware that experience of different systems of care can have an impact on individuals' expectations in a GP-led system. If these are not acknowledged and addressed, a lack of confidence and trust in the GP may undermine the effectiveness of the clinical consultation.

CHRONIC ILLNESS

Brown,K., et al (2008). Older people with complex long-term health conditions. Their views on the community matron service: a qualitative study. ***Quality in Primary Care*****,** ***16*****(6), 409-417.**

http://pmid.us/ 19094416

Background: The Department of Health in the UK has suggested that older people with complex health problems may benefit from a case-management approach to meet their needs. The NHS has since invested heavily in community matrons as one method of tackling managed care. Matrons are highly trained nurses, able to diagnose, prescribe and manage patients with long-term conditions within primary care. Early evidence suggests that the matron approach does not achieve the government targets of reducing unplanned hospital admissions. AIM: To explore the experiences and attitudes of older people who have a community matron so that we may gain an understanding of the successes and failures of this form of case management. Design of study: Qualitative study using one-to-one interviews with patients and carers. Setting Nottingham and surrounding rural areas during 2006-2007. Method: A purposive sample of patients recruited from community matron caseloads. In-depth semi-structured interviews were audiotaped and transcribed. Analysis for emergent themes used a template approach and was validated by discussion with lay advisors and community matrons and by separate analysis of a sample of interviews by an independent researcher. Results: Twenty-four participants were recruited. They often valued their matron as a personal friend as well as a professional. Many suggested that matrons improved their global health, reduced the workload of general practitioners, kept them out of residential care, reduced the need for social and psychological care, and supported their carers. Some were unclear why they had been selected for the matron service and knew of others they felt would benefit more than them. Conclusions: Matrons seem to be generally highly valued on a professional and personal level, almost filling the role of family doctor vacated by changing practices in modern primary care. Participants suggested several reasons why matrons could be economically justified, which need further investigation. The methods of case selection for these services also need to be questioned

Cooper, J.G., et al (2008). Quality of care for patients with type 2 diabetes in primary care in Norway is improving. Results of cross-sectional surveys of 33 general practices in 1995 and 2005. ***Diabetes Care*****. 13/10/2008**

http://dx.doi.org/10.2337/dc08-0605

http://pmid.us/18852338

Objective: To assess changes in the quality of care in Norway for patients with type 2 diabetes. Research design and methods: Two cross-sectional surveys that identified all patients (n = 1470 in 1995, n = 2699 in 2005) with type 2 diabetes attending 33 general practices. Results: Between 1995 and 2005 there were significant improvements in the

proportion of patients for whom important laboratory analyses, smoking habits, height, weight and referral to eye examination were recorded. Mean HbA1c declined from 7.74 to 7.15%, mean systolic blood pressure declined from 150.0 to 140.4 mmHg and mean cholesterol declined from 6.28 to 5.0 mmol/l ($p<0.001$, age and gender adjusted). The 10 year risk for coronary heart disease for an average male patient declined from 42 to 29%. Conclusion: There have been substantial improvements in type 2 diabetes primary care in Norway that are potentially related to major improvements in health outcomes

Evans,P., Langley,P., & Gray,D.P. (2008). Diagnosing Type 2 diabetes before patients complain of diabetic symptoms--clinical opportunistic screening in a single general practice. *Family Practice*, *25*(5), 376-381.

http://dx.doi.org/10.1093/fampra/cmn052

http://pmid.us/18765408

In the UK, patients normally see their general practitioner first and 86% of the health needs of the population are managed in general practice, with 14% being referred to specialist/hospital care. Early diagnosis is the privilege of general practice since general practitioners make most medical diagnoses in the NHS. Their historic aim has been to diagnose as early as possible and if possible before patients are aware of symptoms. Over time, diagnoses are being made earlier in the trajectory of chronic diseases and pre-symptomatic diagnoses through tests like cervical screening. Earlier diagnosis benefits patients and allows earlier treatment. In diabetes, the presence of lower HbA1c levels correlates with fewer complications. Methodologically, single practice research means smaller populations but greater ability to track patients and ask clinicians about missing data. All diagnoses of type 2 diabetes, wherever made, were tracked until death or transfer out. Clinical opportunistic screening has been undervalued and is more cost-effective than population screening. It works best in generalist practice. Over 19 consecutive years, all 429 patients with type 2 diabetes in one NHS general practice were analysed. The prevalence of type 2 diabetes rose from 1.1% to 3.0% of the registered population. Since 2000, 95.9% were diagnosed within the general practice and the majority (70/121 = 57.9%) of diagnoses were made before the patients reported any diabetes-related symptom. These patients had median HbA1c levels 1.1% lower than patients diagnosed after reporting symptoms, a clinically and statistically significant difference ($P = 0.01$)

Lutfey, K.E.,et al . (2008). How are patient characteristics relevant for physicians' clinical decision making in diabetes? An analysis of qualitative results from a cross-national factorial experiment. *Social Science and Medicine* *67*(9), 1391-1399.

http://dx.doi.org/10.1016/j.socscimed.2008.07.005

http://pmid.us/18703267

Variations in medical practice have been widely documented and are a linchpin in explanations of health disparities. Evidence shows that clinical decision making varies according to patient, provider and health system characteristics. However, less is known about the processes underlying these aggregate associations and how physicians interpret various patient attributes. Verbal protocol analysis (otherwise known as 'think-aloud') techniques were used to analyze open-ended data from 244 physicians to examine which patient characteristics physicians identify as relevant for their decision making. Data are from a vignette-based factorial experiment measuring the effects of: (a) patient attributes (age, gender, race and socioeconomic status); (b) physician characteristics (gender and years of clinical experience); and (c) features of the healthcare system in two countries (USA, United Kingdom) on clinical decision making for diabetes. We find that physicians used patients' demographic characteristics only as a starting point in their assessments, and proceeded to make detailed assessments about cognitive ability, motivation, social support and other factors they consider predictive of adherence with medical recommendations and therefore relevant to treatment decisions. These non-medical characteristics of patients were mentioned with much greater consistency than traditional biophysiologic markers of risk such as race, gender, and age. Types of explanations identified varied somewhat according to patient characteristics and to the country in which the interview took place. Results show that basic demographic characteristics are inadequate to the task of capturing information physicians draw from doctor-patient encounters, and that in order to fully understand differential clinical decision making there is a need to move beyond documentation of aggregate associations and further explore the mental and social processes at work

Martin,D., & Wright,J.A. Disease prevalence in the English population: A comparison of primary care registers and prevalence models. ***Social Science & Medicine*****, Online 18/11/2008**

http://dx.doi.org/10.1016/j.socscimed.2008.10.021

http://pmid.us/19019517

The Quality and Outcomes Framework (QOF) is a UK system for monitoring general practitioner (GP) activity and performance, introduced in 2004. The objective of this paper is to explore the potential of QOF datasets as a basis for better understanding geographical variations in disease prevalence in England. In an ecological study, prevalence estimates for four common disease domains (coronary heart disease (CHD), asthma, hypertension and diabetes) were derived from the 2004-2005 QOF primary care disease registers for 354 English Local Authority Districts (LADs). These were compared with synthetic estimates from four prevalence models and with self-reported measures of general health from the 2001 census. Prevalence models were recalculated for LADs using demographic and deprivation data from the census. Results were mapped spatially and cross-tabulated against a national classification of local authorities. The four disease domains display different spatial distributions and different spatial relationships with the corresponding prevalence model. For example, the prevalence model for CHD under-estimated QOF cases in northern England, but this north-south pattern was not evident for the other disease domains. The census-derived health measures were strongly correlated

with CHD, but not with the other disease domains. The relationship between modelled prevalence and QOF disease registers differs by disease domain, implying that there is no simple cross-domain effect of the QOF process on prevalence figures. Given reliable synthetic estimates of small area prevalence for the QOF disease domains, one potential application of the QOF dataset may be in assessing the geographical extent of under-diagnosis for each domain

Ogawa,H., et al (2008). Low-dose aspirin for primary prevention of atherosclerotic events in patients with type 2 diabetes: a randomized controlled trial. *JAMA*, *300*(18), 2134-2141.

http://dx.doi.org/10.1001/jama.2008.623

http://pmid.us/18997198

Context: Previous trials have investigated the effects of low-dose aspirin on primary prevention of cardiovascular events, but not in patients with type 2 diabetes. Objective: To examine the efficacy of low-dose aspirin for the primary prevention of atherosclerotic events in patients with type 2 diabetes. Design, setting, and participants: Multicenter, prospective, randomized, open-label, blinded, end-point trial conducted from December 2002 through April 2008 at 163 institutions throughout Japan, which enrolled 2539 patients with type 2 diabetes without a history of atherosclerotic disease and had a median follow-up of 4.37 years. Interventions: Patients were assigned to the low-dose aspirin group (81 or 100 mg per day) or the nonaspirin group. Main outcome measures: Primary end points were atherosclerotic events, including fatal or nonfatal ischemic heart disease, fatal or nonfatal stroke, and peripheral arterial disease. Secondary end points included each primary end point and combinations of primary end points as well as death from any cause. RESULTS: A total of 154 atherosclerotic events occurred: 68 in the aspirin group (13.6 per 1000 person-years) and 86 in the nonaspirin group (17.0 per 1000 person-years) (hazard ratio [HR], 0.80; 95% confidence interval [CI], 0.58-1.10; log-rank test, P = .16). The combined end point of fatal coronary events and fatal cerebrovascular events occurred in 1 patient (stroke) in the aspirin group and 10 patients (5 fatal myocardial infarctions and 5 fatal strokes) in the nonaspirin group (HR, 0.10; 95% CI, 0.01-0.79; P = .0037). A total of 34 patients in the aspirin group and 38 patients in the nonaspirin group died from any cause (HR, 0.90; 95% CI, 0.57-1.14; log-rank test, P = .67). The composite of hemorrhagic stroke and significant gastrointestinal bleeding was not significantly different between the aspirin and nonaspirin groups. Conclusion: In this study of patients with type 2 diabetes, low-dose aspirin as primary prevention did not reduce the risk of cardiovascular events.

Rogers,A., et al (2008). The United Kingdom Expert Patients Programme: results and implications from a national evaluation. *Medical Journal of Australia.*, *189*(10), 21-24.

http://pmid.us/19012546

The Expert Patients Programme (EPP) is a central element of chronic disease management policy in the United Kingdom. It aims to deliver self-care support by developing peoples' self-care skills, confidence and motivation to take more effective control over their long-term conditions. A large, national randomised controlled trial found that the EPP's lay-led skills training was effective in improving self-efficacy and energy levels among patients with long-term conditions, and was likely to be cost-effective. Key questions remain as to whether existing outcome measures capture the core outcomes that are important to patients with long-term conditions. The development and evaluation of self-care support initiatives should take into account the extent to which self-care support initiatives can be integrated into peoples' everyday lives, and the degree of fit with patients' existing adaptations and strategies. Rather than being concentrated on a single course, central resources for self-management support should be directed at a variety of systems and interventions that are able to meet the wide range of needs of patients with chronic conditions

Sidorov,J.E. (2008). The patient-centered medical home for chronic illness: is it ready for prime time? *Health Affairs (Millwood)*, *27*(5), 1231-1234.

http://dx.doi.org/10.1377/hlthaff.27.5.1231

http://pmid.us/18780905

Robert Berenson and colleagues caution that the patient-centered medical home (PCMH) faces many challenges. Its successful adoption will depend on its being precisely defined and demonstration that it is cost saving and scalable across varied clinical settings. Until these issues are addressed in current and upcoming pilot programs, caution about the PCMH's role in the care of people with chronic illnesses is warranted

Somerville,S., (2008). Content and outcome of usual primary care for back pain: a systematic review. *British Journal of General Practice 58*(556), 790-7vi.

http://dx.doi.org/10.3399/bjgp08X319909

http://pmid.us/19000402

Background: Most patients seeking help for back pain are managed in primary care. Aim To describe the content and outcome of 'usual care' for low back pain in primary care trials. Design of study: A systematic review of randomised controlled trials published since 1998. Setting: Primary care. Method: Randomised controlled trials of back pain in adults were scrutinised to obtain data on treatment and outcome measures in groups receiving usual primary care. A narrative review of the resulting heterogeneous data was undertaken. Results: Thirty-three papers were identified for analysis. Overall the exact nature of the treatment received in the 'usual' primary care group was poorly recorded. Medication was frequently used, and there were suggestions that levels of opioid

prescription were higher than might be expected from clinical guidelines. Requesting of plain-film X-rays occurred more often than recommended. There was very little information to suggest that doctors were promoting physical activity for patients with back pain. Disability scores (Roland-Morris Disability Questionnaire) and pain scores improved over time for patients with acute or subacute back pain, but not for those with chronic pain. Conclusion: Treatment received by patients with back pain was varied and often not in line with back-pain guidelines, particularly with respect to opioid prescription and X-ray investigation. The content of the 'usual care' arm in trials is crucial to interpreting the outcome of studies, but was poorly described in the papers reviewed. Future trials should more fully describe the 'usual care' arm

Stone, M.A., et al (2008). Impact of comorbid diabetes on quality of life and perception of angina pain in people with angina registered with general practitioners in the UK. *Quality of Life Research 17*(6), 887-894.

http://dx.doi.org/10.1007/s11136-008-9363-0

http://pmid.us/18560992

Aims: To investigate the impact of comorbid diabetes on general and angina-related quality of life (QoL) in people with angina. Methods: We analysed data for a subset of patients with angina, from a randomised controlled trial conducted in UK primary care. SF36 scores and Seattle Angina Questionnaire scores were compared for people with and without diabetes. We adopted a robust statistical approach, using nonparametric quantile regression to adjust for the influence of potential confounders. Results: Data were available for 904 cases of whom 181 (20%) had diabetes. Presence of comorbid diabetes was significantly associated with reduced generic QoL for all SF36 domains and Seattle Angina Questionnaire physical limitation scores (estimated regression coefficient -12.33), but not for the other angina-related scores. Greater frequency of perceived angina was strongly correlated with reduced QoL ($P<0.001$) and angina frequency was similar in people with and without diabetes ($P=0.576$). Conclusions: Our results confirm the cumulative impact of having multiple chronic diseases on QoL. Though limited by the data available, our finding of similar angina frequency in patients with and without diabetes contributes to the debate regarding the influence of autonomic neuropathy on perception of angina in people with diabetes

Tsasis,P., & Bains,J. (2008). Management of complex chronic disease: facing the challenges in the Canadian health-care system. *Health Services Management Research 21*(4), 228-235.

http://dx.doi.org/10.1258/hsmr.2008.008001

http://pmid.us/18957400

This paper discusses the challenges that those living with complex chronic disease present to the Canadian health-care system. The literature suggests home care and the management of complex chronic disease can together ease many of the present and future

pressures facing the health-care system in dealing with this new health-care phenomenon. A review of current literature and dialogue with key informants reveals that the current level of investment and the present policy environment are not sustainable to support the health-care system. In this paper, changes to policy and resource allocation to the home care sector are suggested to help manage complex chronic disease and thus improve the effectiveness of the Canadian health-care system. A case is made for a reorganization and increased commitment to the home care sector for a more efficient and patient-centred health-care delivery system

van Bruggen, R., et al (2008). Implementation of locally adapted guidelines on type 2 diabetes. *Family Practice*, *25*(6), 430-437.

http://dx.doi.org/10.1093/fampra/cmn045

Objective. To assess the effects of a facilitator enhanced multifaceted intervention to implement a locally adapted guideline on the shared care for people with type 2 diabetes. Methods. During 1 year a cluster-randomized trial was performed in 30 general practices. In the intervention group, nurse facilitators enhanced guideline implementation by analysing barriers to change, introducing structured care, training practice staff and giving performance feedback. Targets for HbA1c%, systolic blood pressure as well as indications for angiotensin converting enzyme/angiotensin receptor blocking agent prescription differed from the national guidelines. In the control group, GPs were asked to continue the care for people with diabetes as usually. Generalized estimating equations were used to control for the clustered design of the study. Results. In the intervention group, more people were seen on a 3-monthly basis (88% versus 69%, $P < 0.001$) and more blood pressure and bodyweight measurements were performed every 3 months (blood pressure 83% versus 66%, $P < 0.001$ and bodyweight 78.9% versus 48.5%, $P < 0.001$). Apart from a marginal difference in mean cholesterol, differences in HbA1c%, blood pressure, body mass index and treatment satisfaction were not significant. Conclusion. Multifaceted implementation of locally adapted shared care guidelines did improve the process of diabetes care but hardly changed intermediate outcomes. In the short term, local adaptation of shared care guidelines does not improve the cardiovascular risks of people with type 2 diabetes

COMMISSIONING

Coleman A, & et al (2008). Health scrutiny and practice-based commissioning: contradictory or complementary? *Journal of Integrated Care* 16 (5) (pp.18-21).

The *Local Government Act (2000)* introduced new Overview and Scrutiny Committees, composed of elected non-executive councillors, that can respond to proposals from the NHS for changes in services and also set their own agendas for more detailed scrutiny, including of the NHS. Limited capacity has meant that the focus of scrutiny has often

been on statutory consultations from the NHS, service provision, NHS organisations and only occasionally on wider issues. However, it is commissioning that is officially seen as the main vehicle for shaping NHS services, so health scrutiny ought logically to address itself more to commissioning than to investigating providers. Practice-based Commissioning (PBC) was introduced in 2004 with the aim of engaging front-line clinicians in commissioning health care, though most such commissioning is being undertaken by groups of practices joining together to form consortia, rather than by individual GPs. In principle, this makes it more practicable for health scrutiny to include PBC, but consortia are not statutory bodies and cannot be compelled to participate. We suggest ways in which this omission might be addressed.

Thomas,P., et al (2008). Combined horizontal and vertical integration of care: a goal of practice-based commissioning. ***Quality in Primary Care*, *16*(6), 425-432.**

http://pmid.us/19094418

Practice-based commissioning (PBC) in the UK is intended to improve both the vertical and horizontal integration of health care, in order to avoid escalating costs and enhance population health. Vertical integration involves patient pathways to treat named medical conditions that transcend organisational boundaries and connect community-based generalists with largely hospital-sited specialists, whereas horizontal integration involves peer-based and cross-sectoral collaboration to improve overall health. Effective mechanisms are now needed to permit ongoing dialogue between the vertical and horizontal dimensions to ensure that medical and nonmedical care are both used to their best advantage. This paper proposes three different models for combining vertical and horizontal integration - each is a hybrid of internationally recognised ideal types of primary care organisation. Leaders of PBC should consider a range of models and apply them in ways that are relevant to the local context. General practitioners, policy makers and others whose job it is to facilitate horizontal and vertical integration must learn to lead such combined approaches to integration if the UK is to avoid the mistakes of the USA in over-medicalising health issues

COMORBIDITY

Katon,W.J. (2008). The comorbidity of diabetes mellitus and depression. ***American Journal of Medicine*, *121*(11 Suppl 2), S8-15.**

http://dx.doi.org/10.1016/j.amjmed.2008.09.008

http://pmid.us/18954592

Several factors, including sedentary lifestyle, obesity, and an aging population, contribute to epidemic rates of type 2 diabetes mellitus. Depression frequently occurs comorbidly with diabetes although it is unrecognized and untreated in approximately two thirds of patients with both conditions. The course of depression in patients with both diabetes and depression is chronic and severe. Up to 80% of patients with diabetes and depression will experience a relapse of depressive symptoms over a 5-year period. Depression is associated with nonadherence to diabetes self-care--including following dietary restrictions, medication compliance, and blood glucose monitoring--resulting in worse overall clinical outcomes. Due to potential negative health consequences associated with comorbid diabetes and depression, both conditions should be optimally treated to maximize patient outcomes

EMPOWERMENT

Fisher,P., & Owen,J. (2008). Empowering interventions in health and social care: Recognition through 'ecologies of practice'. *Social Science & Medicine*, *67*(12), 2063-2071.

http://dx.doi.org/10.1016/j.socscimed.2008.09.035

http://pmid.us/18950920

This article considers findings from two recent qualitative studies in the UK, identifying parallels in the ways in which [`]ecologies of practice' in two high-profile areas of health-related intervention underpin processes of empowerment and recognition. The first project focused on policy and practice in relation to teenage motherhood in a city in the North of England. The second project was part of a larger research programme, Changing Families, Changing Food, and investigated the ways in which [`]family' is constructed through policy and practice interventions concerning food and health. While UK Government health policy stresses that health and social care agencies should [`]empower' service users, it is argued here that this predominantly reflects a managerialist discourse, equating citizenship with individualised self-sufficiency in the [`]public' sphere. Drawing critically on Honneth's politics of recognition (Honneth, A. (2001). Recognition or redistribution? Changing perspective on the moral order of society. Theory, Culture and Society, 18(2-3), 43-55.), we suggest that formal health policy overlooks the inter-subjective processes that underpin a positive sense of self, emphasising instead an individualised ontology. While some research has positioned practitioners as one-dimensional in their adherence to the current audit culture of the public sector in the UK, our study findings demonstrate how practitioners often circumvent audit-based [`]economies of performance' with more flexible [`]ecologies of practice.' The latter open up spaces for recognition through inter-subjective processes of

identification between practitioners and service users. Ecologies of practice are also informed by practitioners' experiential knowledge. However, this process is largely unacknowledged, partly because it does not fall within a managerialist framework of [`]performativity' and partly because it often reflects taken-for-granted, gendered patterns. It is argued here that a critical understanding of [`]empowerment', in community-based health initiatives, requires clear acknowledgment of these inter-subjective and gendered dimensions of [`]ecologies of practice'

EVIDENCE BASED PRACTICE

Visentin,G. (2008). Towards evidence-based practice via practice-based evidence: the Italian experience. ***Family Practice*** **2/10/2008 Epub ahead or print**

http://dx.doi.org/10.1093/fampra/cmn079

http://pmid.us/19033181

Background: Research is a fundamental tool for GPs' clinical practice. Independent research should be the answer to important questions on population needs not yet answered. To have a democratic approach, the results of the studies should be available not only to GPs but also to patients participating to the research. Research has also a formative value for investigators: a process of learning by doing. Risk and Prevention Study is a model of the 'Italian experience' in doing research in primary health care. Objective: To describe the collaboration between Centro Studi e Richerche in Medicina Generale and Mario Negri Institute in producing observational and experimental research in the setting of family medicine such the Risk and Prevention Study. MethodS: Risk and Prevention Study has two main aims and two different methods: the first, to establish the effectiveness of an intensive recommended treatment and lifestyle advice in cardiovascular (CV) prevention is an observational design. The second, the efficacy of n-3 polyunsaturated fatty acid in patients with CV risk is a randomized controlled trial design. Results: The Risk and Prevention trial has enrolled up until now 860 Italian GPs and over 12 500 high CV risk patients that will be followed during 5 years. They will visit their GP at least once a year. The first year of follow-up of the study has been completed. Relatively few patients (2.5%) have withdrawn. The treatment was well tolerated. Conclusions: Enrolment of large number of GPs in research appears feasible when an independent design with clear benefit for the patient's needs is offered

HEALTH ECONOMICS

Charlson, M.E., et al (2008). The Charlson comorbidity index is adapted to predict costs of chronic disease in primary care patients. ***Journal of Clinical Epidemiology 61*****(12), 1234-1240.**

http://dx.doi.org/10.1016/j.jclinepi.2008.01.006

http://pmid.us/18619805

Objective: (1) To determine chronic illness costs for large cohort of primary care patients, (2) to develop prospective model predicting total costs over one year, using demographic and clinical information including widely used comorbidity index. Study design and setting: Data including diagnostic, medication, and resource utilization were obtained for 5,861 patients from practice-based computer system over a 1-year period beginning December 1, 1993, for retrospective analysis. Hospital cost data were obtained from hospital cost accounting system. Results: Average annual per patient cost was $2,655. Older patients and those with Medicare or Medicaid had higher costs. Hospital costs were $1,558, accounting for 58.7% of total costs. In the predictive model, individuals with higher comorbidity incurred exponentially higher annual costs, from $4,317 with comorbidity score of two, to $5,986 with score of three, to $13,326 with scores greater than seven. To use an adapted comorbidity index to predict total yearly costs, four conditions should be added to the index: hypertension, depression, and use of warfarin with a weight of one, skin ulcers/cellulitis, a weight of two. Conclusion: The adapted comorbidity index can be used to predict resource utilization. Predictive models may help to identify targets for reducing high costs, by prospectively identifying those at high risk

Hollingsworth,B. (2008). The measurement of efficiency and productivity of health care delivery. *Health Economics*, *17*(10), 1107-1128.

http://dx.doi.org/10.1002/hec.1391

http://pmid.us/18702091

The measurement of efficiency and productivity of health service delivery has become a small industry. This is a review of 317 published papers on frontier efficiency measurement. The techniques used are mainly based on non-parametric data envelopment analysis, but there is increasing use of parametric techniques, such as stochastic frontier analysis. Applications to hospitals and other health care organizations and areas are reviewed and summarised, and some meta-type analysis undertaken. Cautious conclusions are that public provision may be potentially more efficient than private, in certain settings. The paper also considers conceptualizations of efficiency, and points to dangers and opportunities in generating such information. Finally, some criteria for assessing the use and usefulness of efficiency studies are established, with a view to helping both researchers and those assessing whether or not to act upon published results

Meddings,J.A., & McMahon,L.F.J. Measuring quality in pay-for-performance programs: from 'one-size-fits-all' measures to individual patient risk-reduction scores. *Disease Management & Health Outcomes 2008;16(4):205-216*, *16*(4), 205-216.

'Pay for performance' is a strategy to improve the quality of healthcare by rewarding physicians who deliver higher-quality service. Pay for performance appears to be a simple and logical solution to address both healthcare quality and cost problems.

However, pay for performance in action is often neither simple nor logical. Pay-for-performance programs grade and reward physicians based on whether their patients receive particular healthcare services and achieve certain treatment goals., We illustrate pay for performance in action by applying a common set of performance measures, physician scoring, and earned incentives to two patient cases. Using 'one-size-fits-all' treatment goals to award incentives, pay-for-performance programs may not detect, and thus may discourage, evidence-based care provided to patients with complex medical and social co-morbidities. Targeting and rewarding ideal treatment goals in a patient with complex needs who may never reach incentive-achieving treatment goals may encourage providers to focus on health status improvements that are significantly less than those obtained by complication-risk-reducing care. Applying evidence from the track records of pay-for-performance programs to date, we recommend performance measures and data collection methods to reliably assess physician and healthcare organization behavior, and to avoid provider penalty for non-modifiable patient characteristics of disease severity and self-management capacity. We recommend scoring healthcare quality based on individualized patient risk reduction rather than one-size-fits-all treatment goals, using calculated risk assessments when possible. Performance measures should also be prioritized in scoring to give more weight to measures with stronger evidence to influence risk reduction (e.g. blood pressure control has a stronger impact on reducing cardiovascular events than the influence of glucose control). By re-focusing pay for performance on quality improvement through risk reduction, we aim to prevent patients with complex healthcare needs from becoming financial liabilities to the physician.,

HEALTH INEQUALITIES

Ashworth,M., Medina,J., & Morgan,M. (2008). Effect of social deprivation on blood pressure monitoring and control in England: a survey of data from the quality and outcomes framework. ***British Medical Journal*** **,** ***337*** **a2030. 28th October 2008**

http://dx.doi.org/10.1136/bmj.a2030

http://pmid.us/18957697

Objective: To determine levels of blood pressure monitoring and control in primary care and to determine the effect of social deprivation on these levels. Design: Retrospective longitudinal survey, 2005 to 2007. SETTING: General practices in England. Participants: Data obtained from 8515 practices (99.3% of all practices) in year 1, 8264 (98.3%) in year 2, and 8192 (97.8%) in year 3. Main outcome measures: Blood pressure indicators and chronic disease prevalence estimates contained within the UK quality and outcomes framework; social deprivation scores for each practice, ethnicity data obtained from the 2001 national census; general practice characteristics. Results: In 2005, 82.3% of adults (n=52.8m) had an up to date blood pressure recording; by 2007, this proportion had risen to 88.3% (n=53.2m). Initially, there was a 1.7% gap between mean blood pressure recording levels in practices located in the least deprived fifth of communities compared with the most deprived fifth, but, three years later, this gap had narrowed to 0.2%.

Achievement of target blood pressure levels in 2005 for practices located in the least deprived communities ranged from 71.0% (95% CI 70.4% to 71.6%) for diabetes to 85.1% (84.7% to 85.6%) for coronary heart disease; practices in the most deprived communities achieved 68.9% (68.4% to 69.5%) and 81.8 % (81.3% to 82.3%) respectively. Three years later, target achievement in the least deprived practices had risen to 78.6% (78.1% to 79.1%) and 89.4% (89.1% to 89.7%) respectively. Target achievement in the most deprived practices rose similarly, to 79.2% (78.8% to 79.6%) and 88.4% (88.2% to 88.7%) respectively. Similar changes were observed for the achievement of blood pressure targets in hypertension, cerebrovascular disease, and chronic kidney disease. Conclusions: Since the reporting of performance indicators for primary care and the incorporation of pay for performance in 2004, blood pressure monitoring and control have improved substantially. Improvements in achievement have been accompanied by the near disappearance of the achievement gap between least and most deprived areas

Craig,P.M., Hanlon,P., & Morrison,J.M. Can primary care reduce inequalities in mental health? *Public Health*, In Press,16/12/2008

http://dx.doi.org/10.1016/j.puhe.2008.10.009

http://pmid.us/19091362

Summary Objectives To explore the contributions that primary care could make to reducing and preventing inequalities in mental health through policy, local strategy and practice. Study design The study used an interpretive policy analysis framework to investigate the ways in which inequalities in mental health and inequalities in health were interpreted by health and social policies, incorporated into a local strategic process in a primary care organization, and understood and acted upon by frontline primary care and mental health practitioners. The study involved analysis of nine health and social policy documents, observation of a mental health needs assessment process, and interviews with 21 frontline professionals from 14 different disciplines. Methods Data were collected using document analysis, observation, and interviews with frontline staff which included a vignette. Data were sorted using the Atlas-ti software programme, and a grounded theory approach guided the data collection and analysis. Results Policy documents demonstrated a disjointed picture of definitions and actions, and lacked a clear overall interpretation of inequalities in health or inequalities in mental health. The mental health needs assessment did not incorporate discussion about inequalities in mental health, despite some individual steering group members demonstrating concerns about inequalities in mental health. Frontline professionals defined inequalities as being linked to access to health services rather than social factors, and were often uncomfortable about discussing inequalities in mental health. A small minority suggested that they would explore or take action on the social circumstances of a patient presenting with potential mental health problems. Conclusions The study found that policies were not driving practice for reducing inequalities in mental health within primary care, and the primary care organization studied was not conducive to addressing inequalities in mental health. However, some building blocks were in place at all levels that have the potential to be developed to enable primary care to address inequalities in mental health

Goyder,E., et al (2008). Evaluating the impact of a national pilot screening programme for type 2 diabetes in deprived areas of England. ***Family Practice*****,** ***25*****(5), 370-375.**

http://dx.doi.org/10.1093/fampra/cmn054

http://pmid.us/18765406

Background. A pilot programme designed to systematically screen for type 2 diabetes was introduced in 24 general practices in England selected for their high levels of socio-economic deprivation and multi-ethnic populations. Objective. To evaluate the impact of screening on the prevalence of type 2 diabetes. Methods. A prospective audit of screening activity in pilot practices and comparison of the change in prevalence of diabetes in pilot and comparison practices were conducted. Results. Of 41 400 individuals invited for screening from a population of 165 828 in pilot practices, 25 356 (61%) were screened. Three hundred and fifty-eight (0.22%) new cases of diabetes were detected among those screened. Only 69% of those with a positive screening test had diagnostic testing recorded and only 19% had a record of an oral glucose tolerance test. The absolute increase in the prevalence of diagnosed diabetes was 0.53% in pilot practices and 0.42% in comparison practices. Conclusions. The real world' nature of the programme and dependence on routine data collection systems makes results more difficult to interpret but also enabled problems with implementation, not evident from previous research, to be identified. It is likely that the low diagnostic yield was largely due to a high level of ad hoc screening activity outside the pilot protocol and inadequate access to diagnostic testing after a positive screening test. In particular, implementation of screening for diabetes in primary care should not be undertaken without robust assessment of the resources required for diagnostic testing and follow-up and adequate clinical audit

HEALTH POLICY

Greener I (2008). Towards a history of choice in UK health policy. ***Sociology of Health and Illness*** **3/12/2008 Epub ahead of print**

http://dx.doi.org/10.1111/j.1467-9566.2008.01135.x

This paper examines health policy documents from the period in which the NHS was planned through to New Labour's reforms, to examine how the terms 'choice' and 'responsiveness' are used to position both users and the public in particular roles. It suggests that health consumerism is a process that has gradually appeared in the NHS through an extension of the choices offered to patients and the terms on which they were

offered. Utilising Hirschman's classic framework of exit, voice and loyalty, we suggest that although there appears to be a strong relationship between the introduction of choice with the aim of securing greater responsiveness, that does not necessarily work in the opposite direction because the analysis of responsiveness suggests that there are other means of achieving this goal other than increasing choice through consumerist approaches to organisation. The implications of this analysis are explored for contemporary health service reform.

Peckham,S., & Hann,A. (2008). General practice and public health: Assessing the impact of the new GMS contract. *Critical Public Health*, *18*(3), 347-356.

http://dx.doi.org/10.1080/09581590802178028

Over the past 30 years, the important role of primary care in public health has been widely recognised, and in the UK a range of measures to support public health in general practice have been introduced since the late 1980s. In 2004 a new general medical services contract was introduced changing the way general practitioners are reimbursed in the NHS. The new contract shifted the emphasis from the individual practitioner to the practice and introduced a new performance incentive framework, the Quality Outcomes Framework, which rewards performance through targeted financial payments. The performance framework identifies specific areas of clinical and organisational performance and patient experience activities including a number of health promotion activities and practices attract points for attaining performance targets. This paper examines the experience and impact of the new GMS contract on public health activities in general practice. While the contract has only been operating for three full years, there is emerging evidence to suggest that it may have a negative impact on public health activities in general practice. The use of financial incentives appears to be skewing practice towards areas that are rewarded, which may not be those that maximise health outcomes, and there is some emerging evidence suggesting that there is a negative effect on health inequalities. This paper reviews current evidence on public health incentives in general practice within a wider context of the impact of incentives for public health

INFORMATION AND COMMUNICATIONS TECHNOLOGY

McGowan, J., et al . (2008). Just-in-time information improved decision-making in primary care: a randomized controlled trial. *PLoS ONE.*, *3*(11), e3785.

http://dx.doi.org/10.1371/journal.pone.0003785

http://pmid.us/19023446

Background: The "Just-in-time Information" (JIT) librarian consultation service was designed to provide rapid information to answer primary care clinical questions during patient hours. This study evaluated whether information provided by librarians to answer clinical questions positively impacted time, decision-making, cost savings and satisfaction. Methods and finding: A randomized controlled trial (RCT) was conducted between October 2005 and April 2006. A total of 1,889 questions were sent to the service by 88 participants. The object of the randomization was a clinical question. Each participant had clinical questions randomly allocated to both intervention (librarian information) and control (no librarian information) groups. Participants were trained to send clinical questions via a hand-held device. The impact of the information provided by the service (or not provided by the service), additional resources and time required for both groups was assessed using a survey sent 24 hours after a question was submitted. The average time for JIT librarians to respond to all questions was 13.68 minutes/question (95% CI, 13.38 to 13.98). The average time for participants to respond their control questions was 20.29 minutes/question (95% CI, 18.72 to 21.86). Using an impact assessment scale rating cognitive impact, participants rated 62.9% of information provided to intervention group questions as having a highly positive cognitive impact. They rated 14.8% of their own answers to control question as having a highly positive cognitive impact, 44.9% has having a negative cognitive impact, and 24.8% with no cognitive impact at all. In an exit survey measuring satisfaction, 86% (62/72 responses) of participants scored the service as having a positive impact on care and 72% (52/72) indicated that they would use the service frequently if it were continued. Conclusions: In this study, providing timely information to clinical questions had a highly positive impact on decision-making and a high approval rating from participants. Using a librarian to respond to clinical questions may allow primary care professionals to have more time in their day, thus potentially increasing patient access to care. Such services may reduce costs through decreasing the need for referrals, further tests, and other courses of action.

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

http://dx.doi.org/10.1002/hpm.882

http://pmid.us/17624868

Knowledge of what constitutes best practice in human resource management (HRM) in public-oriented services is limited and the operational aspects of managing health workers at provision level have been poorly studied. The magnet hospital concept offers some insights into HRM practices that are leading to high commitment. These have been shown to lead to superior performance in not only industrial business firms, but also service industries and the public service. The mechanisms that drive these practices include positive psychological links between managers and staff, organizational commitment and trust. Conditions for successful high commitment management (HiCoM) include health service managers with a strong vision and able to transmit this vision to their staff, appropriate decision spaces for healthcare managers and a pool of

reasonable well-trained health workers. For this, adequate remuneration is the first condition. Equally important are the issues of cultural fit and of 'commitment'. What would staff expect from management in return for their commitment to the organization? Salary buys indeed time of employees, but other practices ensure their commitment. Only if these drivers are understood will managers be able to make their HRM practices more responsive to the needs and expectations of the health workers. Copyright (c) 2007 John Wiley & Sons, Ltd

MEDICINES MANAGEMENT

Geitona,M., et al (2008). Medication use and patient satisfaction: a population-based survey. *Family Practice*, *25*(5), 362-369.

http://dx.doi.org/10.1093/fampra/cmn068

http://pmid.us/18930914

Background. In recent years, there is a growing interest to assess patients' satisfaction which further triggers the existing debate on the severe methodological issues regarding the interpretation of comparative surveys results. Objective. This cross-sectional national survey aimed to examine satisfaction of Greek households with specific aspects of medication use and their correlates. Methods. Between November 2004 and February 2005, telephone interviews were used for collecting information about socio-demographic and health-related characteristics in a systematic sample of 1000 Greek households. Respondents were classified into three categories: chronic or short-term prescribed medication use, occasional medication use and no medication use during the 3 months preceding the survey. Satisfaction was assessed through various aspects of medication use like physician's consultation, physician's response to adverse events, consultation and advice by pharmacists, symptoms' resolution, route of drug administration, drug tolerability and drug cost. Results. The prescribed drugs' use in the 3 months preceding the survey interview was 36.9%; 28.6% for subjects under chronic treatment and 8.3% under short-term treatment. During the same time period, 52.8% of the respondents reported the occasional self-use of over the counter drugs for minor symptoms. A high prevalence of hypertension, cardiovascular, musculoskeletal and endocrine disorders has been observed. In general, respondents expressed a high degree of satisfaction with all aspects of medication use examined, the only exception being costs. Age, area of residence, social insurance scheme and self-reported health status were associated with specific aspects of patient satisfaction. Conclusions. Patient satisfaction with the aspects of medication use examined seems to be influenced by demographic and social factors; this points out to the necessity of taking into account socio-cultural variations and the structure of the health-care system in policymaking

South,J., et al (2008). Can social prescribing provide the missing link? *Primary Health Care Research & Development*, *9*(04), 310-318.

http://dx.doi.org/10.1017/S146342360800087X

Background The voluntary sector has long been recognised as making an important contribution to individual and community health. In the UK, however, the links between primary health care services and the voluntary and community sector are often underdeveloped. Social prescribing is an innovative approach, which aims to promote the use of the voluntary sector within primary health care. Social prescribing involves the creation of referral pathways that allow primary health care patients with non-clinical needs to be directed to local voluntary services and community groups. Such schemes typically use community development workers with local knowledge who are linked to primary health care settings. Social prescribing therefore has the potential to assist individual patients presenting with social needs to access health resources and social support outside of the National Health Service. Aim The aim of this paper is to explore the concept of social prescribing and discuss its value as a public health initiative embedded within general practice .Methods The rationale for social prescribing and existing evidence are briefly reviewed. The paper draws on a case study of a pilot social prescribing scheme based in general practice. Data collected during the development, implementation and evaluation of the scheme are used to illustrate the opportunities and limitations for development in UK primary health care. Findings The potential for social prescribing to provide a mediating mechanism between different sectors and address social need is discussed. The paper argues that social prescribing can successfully extend the boundaries of traditional general practice through bridging the gap between primary health care and the voluntary sector. The potential for wider health gain is critically examined. The paper concludes that social prescribing not only provides a means to alternative support but also acts as a mechanism to strengthen community and professional partnerships. More research is needed on the benefits to patients and professionals

MENTAL HEALTH

Backenstrass,M., et al (2007). The care of patients with subthreshold depression in primary care: is it all that bad? A qualitative study on the views of general practitioners and patients. *BMC Health Services Research 7* 190.

http://dx.doi.org/10.1186/1472-6963-7-190

http://www.biomedcentral.com/1472-6963/7/190

http://pmid.us/18031573

Background: Studies show that subthreshold depression is highly prevalent in primary care, has impact on the quality of life and causes immense health care costs. Although this points to the clinical relevance of subthreshold depression, contradictory results exist

regarding the often self-remitting course of this state. However, first steps towards quality improvement in the care of subthreshold depressive patients are being undertaken. This makes it important to gather information from both a GPs' and a patients' point of view concerning the clinical relevance as well as the status quo of diagnosis and treatment in order to appraise the need for quality improvement research. Method: We conducted qualitative, semi-structured interviews for the questioning of 20 GPs and 20 patients with subthreshold depression on aspects of clinical relevance and on the status quo of diagnosis and treatment. Interviews were transcribed and analyzed on a content analytical theoretical background using Atlas.ti software. Results: Most of the GPs found subthreshold depression to be clinically significant. Although some problems in diagnosis and treatment were mentioned, the GPs had sensible diagnostic and treatment strategies at hand which resulted from the long and trustful relationship with the patients and which corresponded to the patients' expectations. The patients rather expected their GP to listen to them than to take specific actions towards symptom relief and, in the main, were satisfied with the GPs' care. Conclusion: The study shows that subthreshold depression is a clinically relevant issue for GPs but raises the possibility that quality improvement might not be as necessary as past studies showed. Further quantitative research using larger random samples is needed to determine the effectiveness of the strategies used by the GPs, patients' satisfaction with these strategies and the course of these patients' symptoms in primary care

Fuller-Thomson,E., & Nimigon,J. (2008). Factors associated with depression among individuals with chronic fatigue syndrome: findings from a nationally representative survey. ***Family Practice*****,** ***25*****(6), 414-422.**

http://dx.doi.org/10.1093/fampra/cmn064

http://pmid.us/18836094

Objectives. Most previous research regarding chronic fatigue syndrome (CFS) and depression has relied on clinical samples. The current research determined the prevalence and correlates of depression among individuals with CFS in a community sample. Methods. The nationally representative Canadian Community Health Survey, conducted in 2000/2001, included an unweighted sample size of 1045 individuals who reported a diagnosis of CFS and had complete data on depression. Respondents with CFS who were depressed (n = 369) were compared to those who were not depressed (n = 676). Chi-square analyses, t-tests and a logistic regression were conducted. Results. Thirty-six per cent of individuals with CFS were depressed. Among individuals with CFS, depression was associated with lower levels of mastery and self-esteem. In the logistic regression analyses, the odds of depression among individuals with CFS were higher for females, younger respondents, those with lower incomes and food insecurity and those whose activities were limited by pain. Two in five depressed individuals had not consulted with any mental health professional in the preceding year. Twenty-two per cent of depressed

respondents had seriously considered suicide in the past year. Individuals with CFS who were depressed were particularly heavy users of family physicians, with an average of 11.1 visits annually (95% confidence interval = 10.7, 11.6). Conclusion. It is important for clinicians to assess depression and suicidal ideation among their patients with CFS, particularly among females, those reporting moderate to severe pain, low incomes and inadequate social support

Gask,L., Lever-Green,G., & Hays,R. (2008). Dissemination and implementation of suicide prevention training in one Scottish region. *BMC Health Services Research*, *8*(1), 246.

http://dx.doi.org/10.1186/1472-6963-8-246

http://www.biomedcentral.com/1472-6963/8/246/abstract

http://pmid.us/19055769

Background: As part of a national co-ordinated and multifaceted response to the excess suicide rate, the Choose Life initiative, the Highland Choose Life Group launched an ambitious programme of training for National Health Service (NHS), Council and voluntary organisation staff. In this study of the dissemination and implementation of STORM [Skills-based Training On Risk Management], we set out to explore not only the outcomes of training, but key factors involved in the processes of diffusion, dissemination and implementation of the educational intervention. Methods: Participants attending STORM training in Highland Region provided by 12 trained facilitators during the period March 2004 to February 2005 were recruited. Quantitative data collection from participants took place at three time points; immediately before training, immediately post-training and six months after training. Semi-structured telephone interviews were carried out with the training facilitators and with a sample of course participants 6 months after they had been trained. We have utilized the conceptual model described by Greenhalgh and colleagues in a Framework analysis of the data, for considering the determinants of diffusion, dissemination and implementation of interventions in health service delivery and organization. Results:Some 203 individuals completed a series of questionnaire measures immediately pre (time 1) and immediately post (time 2) training and there were significant improvements in attitudes and confidence of participants. Key factors in the diffusion, dissemination and implementation process were the presence of a champion or local opinion leader who supported and directed the intervention, local adaptation of the materials, commissioning of a group of facilitators who were provided with financial and administrative support, dedicated time to provide the training and regular peer-support. Conclusions: Features that contributed to the success of STORM were related to both the context (the multi-dimensional support provided from the host organisation and the favourable policy environment) and the intervention (openness to local adaptation, clinical relevance and utility), and the dynamic interaction between context and the intervention

Hansen, E.C., et al (2008). General practitioners' experiences and understandings of diagnosing dementia: Factors impacting on early diagnosis. ***Social Science & Medicine*, *67*(11), 1776-1783.**

http://dx.doi.org/10.1016/j.socscimed.2008.09.020

http://pmid.us/18945531

This article reports findings from three linked qualitative research projects that explored how Australian general practitioners (GPs) spoke about their experiences in diagnosing dementia and their views on early diagnosis and barriers towards early diagnosis. The authors conducted this research with the aim of elucidating the GP perspective and using this to better understand the process of diagnosing dementia and delays in diagnosing dementia. Twenty-four GPs based in Australia participated in the study (eleven females and thirteen males). Six of these GPs worked in rural practices, eight in a large town and the remainder in urban practices in a capital city. The major themes in GPs' accounts of the diagnosis of dementia could be grouped under the headings of [`]recognizing dementia', [`]holistic viewpoint', [`]family members and patients' and [`]medication'. Key findings are that dementia is a complex condition that takes time to diagnose. Diagnosis may involve conflict between GPs, family members/carers and the person with dementia (PWD). GPs did not consider that diagnosing dementia early was particularly important and may in fact be harmful to some patients. They are skeptical about the advantages of dementia medications. GPs assess the need for a formal diagnosis of dementia within the broader context of their older patients' lives. They are more likely to pursue a formal diagnosis in situations where they see it leading to benefits for their patient such as accessing dementia specific services. Increasing the availability of support services for PWD and educating GPs about the benefits of a formal diagnosis of dementia for stakeholders other than PWD, for example family members and carers may increase the likelihood that they will diagnose dementia early

Henke,R.M., (2008). Clinician- and organization-level factors in the adoption of evidence-based care for depression in primary care. ***Health Care Management Review*, *33*(4), 289-299**

http://dx.doi.org/10.1097/01.HCM.0000318766.29277.49

http://pmid.us/18815494

Background and purpose: Although more individuals are receiving care for depression than those in the past, they often do not receive high-quality care. Strategies to improve quality have focused on changing clinician behavior and more recently on reducing practice barriers. Both strategies hold promise but have had widely varying success either because practices have not successfully removed barriers or because removing barriers alone is not sufficient for improving care. It is unknown under which circumstances clinicians with a high propensity toward recognizing depression and providing depression

care can overcome barriers. We explore organizational and clinician factors affecting patient receipt of guideline-concordant services. Methodology/approach: We use data from adult patients with major depression receiving care in a geographically diverse group of primary care practices participating in the Quality Improvement for Depression study. We estimate the effects of barriers and clinician propensity on six aspects of depression care and adequate treatment. Findings: Barriers and propensity interact in affecting depression services. In comparison with similar clinicians in practices with few barriers, high-propensity clinicians working in practices with more barriers are less likely to provide depression education and are likely to provide fewer follow-up calls and fewer follow-up visits. High-propensity clinicians are more likely to offer antidepressants in practices with more barriers. Practice implications: To improve the quality of care, efforts should both eliminate practice barriers and increase clinician propensity to provide care. Future research on factors associated with quality improvement can benefit from an approach which specifies how organizational and clinician factors interact to enact change

Hooper, L.M., et al (2008). Virtual standardized patients: an interactive method to examine variation in depression care among primary care physicians. *Primary Health Care Research & Development*, *9*(04), 257-268.

http://dx.doi.org/10.1017/S1463423608000820

Background Some primary care physicians provide less than optimal care for depression (Kessler *et al*., *Journal of the American Medical Association* 291, 2581–90, 2004). However, the literature is not unanimous on the best method to use in order to investigate this variation in care. To capture variations in physician behaviour and decision making in primary care settings, 32 interactive CD-ROM vignettes were constructed and tested.Aim and method The primary aim of this methods-focused paper was to review the extent to which our study method – an interactive CD-ROM patient vignette methodology – was effective in capturing variation in physician behaviour. Specifically, we examined the following questions: (a) Did the interactive CD-ROM technology work? (b) Did we create believable virtual patients? (c) Did the research protocol enable interviews (data collection) to be completed as planned? (d) To what extent was the targeted study sample size achieved? and (e) Did the study interview protocol generate valid and reliable quantitative data and rich, credible qualitative data? Findings Among a sample of 404 randomly selected primary care physicians, our voice-activated interactive methodology appeared to be effective. Specifically, our methodology – combining interactive virtual patient vignette technology, experimental design, and expansive open-ended interview protocol – generated valid explanations for variations in primary care physician practice patterns related to depression care.

Iliffe,S.,et al (2008). General practitioners' understanding of depression in young people: qualitative study. *Primary Health Care Research & Development*, *9*(04), 269-279.

http://dx.doi.org/10.1017/S1463423608000868

Background Depression in young people is not necessarily self-limiting, and is frequently associated with affective disorders and impaired psychosocial functioning in adult life. Early recognition of and response to depression in teenagers could be an important task for general practitioners (GPs), but there are multiple obstacles to achieving this. Objectives To explore GPs perceptions of the opportunities and difficulties of working with teenagers, and of specifically recognizing and responding to depression. Setting and participants Nine GPs who had taken part in a developmental project on diagnosing and treating depression in young people. All worked in an Inner London Medical Centre. Methods Semi-structured interviews transcribed and analysed thematically. Findings Two over-arching themes that emerged from the interviews were that teenagers were perceived as being qualitatively different from adults in the ways they used general practice, and that GPs were uncomfortable with making a diagnosis of depression in young people. Within the first theme, we identified sub-themes, including failure of teenagers to engage with services, parental involvement, complex presentations and lack of time. Within the second theme, the sub-themes were surprise, normalization of depressed mood and challenge to the validity of psychiatric diagnosis in this age group. Conclusions Professional development in general practice that addresses this topic needs to modify two perceptions; that depressed mood is in some sense in this age group, and that teenagers are so different in their use of services that the management of depression (if it is recognized at all) is problematic

Lester,H., & Howe,A. (2008). Depression in primary care: three key challenges. *Postgraduate Medical Journal* *84*(996), 545-548.

http://dx.doi.org/10.1136/pgmj.2008.068387

http://pmid.us/19017840

The recognition and treatment of depression is a challenging area of clinical practice, especially in primary care where there are many patients with various presentations and a multitude of causes for distress. The prevalence of depression is increasing, and it is predicted to become second only to ischaemic heart disease as a cause of morbidity worldwide. Fortunately, the research evidence on effective approaches is increasing. This article looks at how we can best identify, treat and understand the perspectives of people with depression who are seen in primary care. Simple questionnaires can provide effective screening in generalist settings, particularly when targeting high-risk groups such as those with cardiovascular comorbidity or recurrent unexplained symptoms. Guidelines now exist for use of antidepressants and cognitive behavioural therapy for mild to moderate depression, although the latter needs effective policy implementation in clinical practice to maximise its impact for patients. However, there is also consistent evidence from service users that people with depression want individualised care which takes into account their preferences and concerns, even if this entails departure from guidelines. Adherence to treatment is low in many studies, and remodelling of services can easily lead to gaps in consistent approaches to personal care. The research challenges for the future include clarification of which patient groups merit proactive screening, how

to enhance adherence, and the relative merits and outcomes of pharmacological versus behavioural therapies. Changes in policy and service configuration can improve or destabilise effective care, but high-quality and flexible intervention with patients with mild to moderate depression is likely to be cost-effective in view of the high prevalence and disease burden of this distressing problem

Lovell,K., et al (2008) Developing guided self-help for depression using the Medical Research Council complex interventions framework: a description of the modelling phase and results of an exploratory randomised controlled trial. *BMC Psychiatry*, *8*(1), 91.

http://dx.doi.org/10.1186/1471-244X-8-91

http://www.biomedcentral.com/1471-244X/8/91

http://pmid.us/19025646

Background: Current guidelines for the management of depression suggest the use of guided self-help for patients with mild to moderate disorders. However, there is little consensus concerning the optimal form and delivery of this intervention. To develop acceptable and effective interventions, a phased process has been proposed, using a modelling phase to examine and develop an intervention prior to preliminary testing in an exploratory trial. This paper (a) describes the modelling phase used to develop a guided self-help intervention for depression in primary care and (b) reports data from an exploratory randomised trial of the intervention. Methods:A guided self-help intervention was developed following a modelling phase which involved a systematic review, meta synthesis and a consensus process. The intervention was then tested in an exploratory randomised controlled trial by examining (a) fidelity using analysis of taped guided self-help sessions (b) acceptability to patients and professionals through qualitative interviews (c) effectiveness through estimation of the intervention effect size. Results: Fifty eight patients were recruited to the exploratory trial. Seven professionals and nine patients were interviewed, and 22 tapes of sessions analysed for fidelity. Generally, fidelity to the intervention protocol was high, and the professionals delivered the majority of the specific components (with the exception of the use of feedback). Acceptability to both professionals and patients was also high. The effect size of the intervention on outcomes was small, and in line with previous analyses showing the modest effect of guided self-help in primary care. However, the sample size was small and confidence intervals around the effectiveness estimate were wide. Conclusion :The general principles of the modelling phase adopted in this study are designed to draw on a range of evidence, potentially providing an intervention that is evidence-based, patient-centred and acceptable to professionals. However, the pilot outcome data did not suggest that the intervention developed was particularly effective. The advantages and disadvantages of the general methods used in the modelling phase are discussed, and

possible reasons for the failure to demonstrate a larger effect in this particular case are outlined.

Menchetti,M., et al . Recognition and treatment of depression in primary care: Effect of patients' presentation and frequency of consultation. ***Journal of Psychosomatic Research*****,** ***In Press, Corrected Proof*****. 18/12/2008**

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

Objective Primary care physicians (PCPs) are expected to recognize depression and appropriately prescribe antidepressants. This article investigated the single and combined effects of different patient presentations and frequency of visits on detection and antidepressant use.Methods Data came from an Italian nationwide survey on depressive disorders in primary care, involving 191 PCPs and 1910 attenders. Two hundred fifty patients suffering from major or subthreshold depression were compared in relation to their presentation (psychological, physical, and pain) and frequency of visits (low and high).Results Recognition of depression significantly varied according to both presentation and frequency of visits. When compared to patients with psychological complaints, the odds ratios for nonrecognition of depression were higher for patients presenting with physical symptoms [2.3; 95% confidence interval (CI)=1.1-5.3] and with pain (4.1; 95% CI=1.6-9.9). Subjects who rarely attended the practice were 2.3 times less likely to receive a diagnosis of depression, compared with those having a high frequency of visits (95% CI=1.2-4.6). Similarly, patients presenting with physical symptoms or with pain and those with a low frequency of visits were rarely treated with antidepressants. The combination of physical or pain presentation with low frequency of visits further increased the risk for nonrecognition, which was sixfold that of the reference category.Conclusions Some subgroups of depressed patients still run a high risk of having their depression unrecognized by the PCP. Screening for depression among patients presenting with pain might be useful in order to improve recognition and management

Mitchell,P. (2008). Mental health care roles of non-medical primary health and social care services. ***Health and Social Care in the Community*****. Epublication 11/8/2008**

http://dx.doi.org/10.1111/j.1365-2524.2008.00800.x

http://pmid.us/18700871

Changes in patterns of delivery of mental health care over several decades are putting pressure on primary health and social care services to increase their involvement. Mental health policy in countries like the UK, Australia and New Zealand recognises the need for these services to make a greater contribution and calls for increased intersectoral collaboration. In Australia, most investment to date has focused on the development and integration of specialist mental health services and primary medical care, and evaluation research suggests some progress. Substantial inadequacies remain, however, in the

comprehensiveness and continuity of care received by people affected by mental health problems, particularly in relation to social and psychosocial interventions. Very little research has examined the nature of the roles that non-medical primary health and social care services actually or potentially play in mental health care. Lack of information about these roles could have inhibited development of service improvement initiatives targeting these services. The present paper reports the results of an exploratory study that examined the mental health care roles of 41 diverse non-medical primary health and social care services in the state of Victoria, Australia. Data were collected in 2004 using a purposive sampling strategy. A novel method of surveying providers was employed whereby respondents within each agency worked as a group to complete a structured survey that collected quantitative and qualitative data simultaneously. This paper reports results of quantitative analyses including a tentative principal components analysis that examined the structure of roles. Non-medical primary health and social care services are currently performing a wide variety of mental health care roles and they aspire to increase their involvement in this work. However, these providers do not favour approaches involving selective targeting of clients with mental disorders

Oxman,T.E.,et al . (2008) Problem-solving treatment and coping styles in primary care for minor depression. ***Journal of Consulting and Clinical Psychology 76*****(6), 933-943.**

http://dx.doi.org/10.1037/a0012617

http://pmid.us/19045962

Research was undertaken to compare problem-solving treatment for primary care (PST-PC) with usual care for minor depression and to examine whether treatment effectiveness was moderated by coping style. PST-PC is a 6-session, manual-based, psychosocial skills intervention. A randomized controlled trial was conducted in 2 academic, primary care clinics. Those subjects who were eligible were randomized (N = 151), and 107 subjects completed treatment (57 PST-PC, 50 usual care) and a 35-week follow-up. Analysis with linear mixed modeling revealed significant effects of treatment and coping, such that those in PST-PC improved at a faster rate and those initially high in avoidant coping were significantly more likely to have sustained benefit from PST-PC.

Poutanen,O., Koivisto,A.M., & Salokangas,R.K.R. (2008). The Depression Scale (DEPS) as a case finder for depression in various subgroups of primary care patients. ***European Psychiatry*****,** ***23*****(8), 580-586.**

http://dx.doi.org/10.1016/j.eurpsy.2008.06.007

http://pmid.us/18778920

Purpose The quick and simple Depression Scale (DEPS) has been a popular self-rating depression scale in Finland for nearly 15 years. The purpose was to assess the validity of the DEPS in various subgroups of patients.Materials and methods Primary care patients, aged 18-64, completed a postal questionnaire including the DEPS. Of the 1643 patients all screen-positive subjects and every 10th screen-negative subject were invited for

interview (the Present State Examination, PSE). Complete DEPS scores were available for 410 patients. They were grouped by gender, age, marital status, perceived physical health, basic education and the Michigan Alcoholism Screening Test (MAST) score. Separately for each subgroup, receiver operating characteristic (ROC) curve analyses were done, sensitivity, specificity, area under the curve (AUC), predictive values and likelihood ratios were calculated, and Cronbach's [alpha] was estimated.Results The DEPS was valid in general, but best for patients with basic education longer than 9 years.Discussion The key statistical figures for the DEPS were comparable to the figures for other short self-rating scales.Conclusion The DEPS is a valid case finder for primary care patients in the age group 18-64 years, and especially suitable for more highly educated patients. Future studies comparing the DEPS with other simple depression rating scales are needed

Revicki,D.A., et al (2008). Health-related quality of life and utilities in primary-care patients with generalized anxiety disorder. ***Quality of Life Research*****. 23/10/2008**

http://dx.doi.org/10.1007/s11136-008-9406-6

http://pmid.us/18949580

Background: Generalized anxiety disorder (GAD) is prevalent and significantly impacts patient health-related quality of life (HRQL) and disability. Purpose: This study evaluated the effect of GAD and anxiety symptom severity on the HRQL of primary-care patients with GAD. Methods: Patients 18 years or older with GAD were recruited from an integrated health care delivery system. Clinical assessments included the Hamilton Anxiety Rating Scale (HAM-A), GAD Questionnaire-IV (GAD-Q-IV), and the Patient Health Questionnaire depression module (PHQ). HRQL was assessed by the Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form (Q-LES-Q-SF), Sheehan Disability Scale (SDS), SF-12 Health Survey (SF-6D), and the Health Utilities Index (HUI2, HUI3). Results: The sample included 297 patients, 72% women with mean +/- standard deviation (SD) age of 47.6 +/- 13.7 years. At baseline, the mean HAM-A score was 16.8 +/- 7.6 (suggesting the presence of moderate anxiety symptoms). Anxiety and depression symptoms were significantly correlated with mental component summary (MCS), Q-LES-Q-SF, SDS, SF-6D, HUI2, and HUI3 scores (all $P < 0.001$). The mean HRQL and all of the preference-based measures varied significantly by anxiety severity groups (all $P < 0.001$). Anxiety and depression symptoms significantly predicted HRQL and preference-based scores (R (2) values ranged from 0.22 to 0.57). Conclusions: Anxiety symptoms reported by GAD patients resulted in significant impairment to HRQL and functional outcomes

Subramanian, Deepak N., Hopayian, Kevork (2008) An audit of the first year of screening for depression in patients with diabetes and ischaemic heart disease under the Quality and Outcomes Framework ***Quality in Primary Care*** **16 (5) 341-344**

Background: Depression is more prevalent in those with chronic ill-health. Screening for depression in patients with diabetes and ischaemic heart disease was included in the

Quality and Outcomes Framework (QOF) in 2006. Aim: To investigate if screening in accordance with the QOF leads to improved detection and treatment of depression in the target groups. Method: We conducted an audit of records in a single semi-rural general practice. Records of patients in the target groups for the year ending 31 March 2007 were audited to calculate the proportions of patients who were screened, detected to have depression and received treatment. Results: Out of 435 eligible patients, 365 (84%) were screened. Of those not currently depressed or under treatment for depression, only three patients (1%) screened positive. None were subsequently diagnosed as having depression. Conclusion: Screening in our practice did not result in any new diagnoses of depression. It remains to be seen whether depression screening in other practices will result in substantial improvement in the identification and treatment of depression in high-risk groups.

Wittkampf ,K.A et al (2008). Patients' view on screening for depression in general practice. ***Family Practice*****,** ***25*****(6), 438-444.**

http://dx.doi.org/10.1093/fampra/cmn057

http://pmid.us/18836095

Background. In general practice, depression is often not recognized. As treatment of depression is effective, screening has been proposed as one solution to combat this hidden morbidity'. The results of screening programmes for depression, however, are inconsistent and most studies do not show a positive effect on patient outcomes. Patients do not always accept this diagnosis and hence do not receive proper treatment. Nothing is known about the tendency of those patients who screen positive for depression to accept treatment for their disclosed' disorder. Objective. In this study, we aimed to better understand the views of patients who screened positive in a screening programme for depression. Methods. We performed a qualitative study with semi-structured in-depth interviews with 17 patients. These adult patients (nine females), all suffering from major depressive disorder, were disclosed by a screening programme for depression performed within 11 Dutch general practices. The transcripts were independently analysed by two researchers using MAXqda2. Results. All patients appreciated the active way in which they were approached for screening. Fifteen of the 17 patients recognized the depressive symptoms but nine of them did not accept the diagnosis. The first explanation for resistance to the diagnosis of depression is fear of stigmatization and scepticism about the usefulness of labelling. Secondly, patients experienced their depressive symptoms as a normal and transitory reaction to adversity. Thirdly, patients had doubts about the necessity and effectiveness of treatment. Depressive symptoms, such as feelings of guilt, self-depreciation and fatigue, hamper help-seeking behaviour. Conclusions. We conclude that some patients with undisclosed depression, who took the trouble of going through a complete screening programme, felt aversion to being diagnosed as having depression. In the context of screening for depression, we recommend that the patients' view on depression be elicited before diagnosing and offering treatment

ORGANIZATIONS

Blake,H., & Lloyd,S. (2008). Influencing organisational change in the NHS: lessons learned from workplace wellness initiatives in practice. ***Quality in Primary Care*****,** ***16*****(6), 449-455.**

http://pmid.us/ 19094421

This article presents a discussion of the key issues in influencing organisational change in NHS settings, in the development of workplace wellness interventions to improve employee health and wellbeing. To tackle poor public health and associated rising healthcare costs, there must be a focus on the root cause of many preventable diseases - unhealthy lifestyle choices. Workplace wellness initiatives are now an important prevention strategy adopted by socially responsible organisations to target the health and wellbeing of working age adults. Lessons learned from initiatives in secondary care suggest that effective implementation requires change in organisational 'health culture', through a combination of education, behaviour change intervention, needs-based facilities, and services and strategies for developing supportive and health-promoting work environments. Most of all, employers must demonstrate a commitment to health and wellness that is fully integrated with their mission, values and long-term vision, paving the way for sustainable lifestyle changes. Evaluation systems must be in place to measure the impact and outcomes of wellness schemes

Wilkie, P, (2008) Sixty years of the NHS: general practice and the patient 1948-2008 ***Quality in Primary Care 16(5)*** **379-381**

This year much has been written in both the medical and the popular press about the changes in the National Health Service (NHS) since its launch 60 years ago. While the majority of articles are complimentary, praising the NHS and reminding us of how much the NHS is admired by the rest of the world, many authors do point to the challenges of rising costs, an ageing population and the changing public expectations that the NHS now faces. Some of these articles describe the changes in the organisation of the NHS over the last 60 years, but little has been said about the implications of these changes for patients. This paper looks at some of the implications for patients of the way that general practice is now organised.

PATIENT AND PUBLIC INVOLVEMENT

Etz, R.S., et al . (2008). Bridging primary care practices and communities to promote healthy behaviors. ***American Journal of Preventive Medicine 35*****(5 Suppl), S390-S397.**

http://dx.doi.org/10.1016/j.amepre.2008.08.008

http://pmid.us/18929986

Background: Primary care practices able to create linkages with community resources may be more successful at helping patients to make and sustain health behavior changes. Methods: Health behavior-change interventions in eight practice-based research networks were examined. Data were collected July 2005-October 2007. A comparative analysis of the data was conducted to identify and understand strategies used for linking primary care practices with community resources. Results: Intervention practices developed three strategies to initiate and/or implement linkages with community resources: pre-identified resource options, referral guides, and people external to the practice who offered support and connection to resources. To initiate linkages, practices required the capacity to identify patients, make referrals, and know area resources. Linkage implementation could still be defeated if resources were not available, accessible, affordable, and perceived as valuable. Linkages were facilitated by boundary-spanning strategies that compensated for the lack of infrastructure between practices and resources, and by brokering strategies that identified interested community partners and aided mutually beneficial connections with them. Linkages were stronger when they incorporated practice or resource abilities to motivate the patient, such as brief counseling or postreferral outreach. Further, data suggested that sustaining linkages requires continuous attention and ongoing communication between practices and resources. Conclusions: Creating linkages between primary care practices and community resources has the potential to benefit both patients and clinicians and to lessen the burden on the U.S. healthcare system resulting from poor health behaviors. Infrastructure support and communication systems must be developed to foster sustainable linkages between practices and local resources

Martin,G.P. (2008). Representativeness, legitimacy and power in public involvement in health-service management. ***Social Science & Medicine*****,** ***67*****(11), 1757-1765.**

http://dx.doi.org/10.1016/j.socscimed.2008.09.024

http://pmid.us/18922611

Public participation in health-service management is an increasingly prominent policy internationally. Frequently, though, academic studies have found it marginalized by health professionals who, keen to retain control over decision-making, undermine the legitimacy of involved members of the public, in particular by questioning their representativeness. This paper examines this negotiation of representative legitimacy between staff and involved users by drawing on a qualitative study of service-user involvement in pilot cancer-genetics services recently introduced in England, using interviews, participant observation and documentary analysis. In contrast to the findings of much of the literature, health professionals identified some degree of representative legitimacy in the contributions made by users. However, the ways in which staff and users constructed representativeness diverged significantly. Where staff valued the

identities of users as biomedical and lay subjects, users themselves described the legitimacy of their contribution in more expansive terms of knowledge and citizenship. My analysis seeks to show how disputes over representativeness relate not just to a struggle for power according to contrasting group interests, but also to a substantive divergence in understanding of the nature of representativeness in the context of state-orchestrated efforts to increase public participation. This divergence might suggest problems with the enactment of such aspirations in practice; alternatively, however, contestation of representative legitimacy might be understood as reflecting ambiguities in policy-level objectives for participation, which secure implementation by accommodating the divergent constructions of those charged with putting initiatives into practice

Mason, A.R., et al (2008). Establishing the economics of engaging communities in health promotion: what is desirable, what is feasible? *Critical Public Health*, *18*(3), 285-297.

http://dx.doi.org/10.1080/09581590802277366

Over the last 30 years, there has been a growing recognition of the potential for community-based efforts to improve public health. However, the costs and ΓÇÿadded valueΓÇÖ of community engagement approaches remain unclear. This paper reports findings from a systematic review of the economic evidence relating to planning, design, delivery or governance of health promotion interventions. Key databases were searched, review bibliographies were checked and experts in the field of economics of public health were consulted. To be eligible for inclusion, studies needed to report community engagement or community development approaches for primary health promotion; to include a control or suitable comparator group; and to assess both health outcomes and costs. Data were extracted and studies were quality assessed. Of the 4405 references screened, 152 records (3%) were potentially relevant and eight studies met the inclusion criteria for the review. Seven studies reported positive findings, but no study was designed to evaluate the impact or cost-effectiveness of a specifically ΓÇÿcommunity-engagementΓÇÖ component. The review found tentative evidence that community engagement as part of a multifaceted approach to health promotion may have positive effects and could be cost-effective. To improve the evidence base for community engagement, future studies need to involve communities more closely at all stages of the research in order to fully capture the community's priorities and perspectives, and appropriately assess the value added and opportunity cost of engagement

Milewa,T., Buxton,M., & Hanney,S. (2008). Lay involvement in the public funding of medical research: expertise and counter-expertise in empirical and analytical perspective. *Critical Public Health*, *18*(3), 357-366

http://dx.doi.org/10.1080/09581590802084838

The relationship between social context, interaction, interpretation and the drawing of boundaries with regard to knowledge and competence deemed appropriate for informed decision-making is particularly pertinent with regard to the public funding of medical research. This article focuses on this issue by drawing on a study of an advisory group established to provide lay perspectives on the work of the UK's Medical Research Council, a publicly funded organisation that promotes and selectively funds basic and applied medical research. The impact of the advisory group on the Medical Research Council, particularly in terms of organisational culture, highlights the potential fluidity of boundaries that demarcate knowledge and competence among experts and lay actors. The potential for radical change in the role played by lay actors in the governance of science increases markedly once the ability to distinguish good science from bad is framed in terms that extend beyond methodological rigour and disciplinary innovation in the formulation of research proposals

Protheroe,J., et al (2008). Promoting patient engagement with self-management support information: a qualitative meta-synthesis of processes influencing uptake. ***Implementation Science 3*** **44.**

http://dx.doi.org/10.1186/1748-5908-3-44

http://www.implementationscience.com/content/3/1/44

http://pmid.us/18851743

Background: Patient information has been viewed as a key component of self-management. However, little attention has been given to methods of dissemination or implementation of effective information strategies. Previous problems identified with the use and implementation of patient information point to the need to explore the way in which patients engage with and use information to support self-management for chronic conditions. Methods: Four published qualitative studies from a programme of research about self-management were analysed as a group; these included studies of the management of inflammatory bowel disease (IBD); self-help in anxiety and depression (SHADE); menorrhagia, treatment, information, and preference (MENTIP) study; and self-help for irritable bowel syndrome (IBS). For the analysis, we used an adapted meta-ethnographic approach to the synthesis of qualitative data in order to develop an evidence base. Results: The ontological status and experience of the condition in everyday life was the most dominant theme to emerge from this synthesis. This, coupled with access to and experience of traditional health services responses, shaped the engagement with and use of information to support self-management. Five key elements were found which were likely to influence this: the perception and awareness of alternative self-management possibilities; the prior extent and nature of engagement with information; the extent of and ability to self-manage; opportunities for use of the information and the stage of the illness career; and congruence and synergy with the professional role. Conclusion: People with chronic conditions need support from providers in both supply and engagement with information, in a way which gives legitimacy to the person's own self-management strategies and possible alternatives. Thus, a link could usefully be made between information offered, as well as patients' past experiences of self-management and

engagement with services for their condition. The timeliness of the information should be considered, both in terms of the illness career and the type of condition (i.e., before depression gets too bad or time to reflect on existing knowledge about a condition and how it is to be managed) and in terms of the pre-existing relationship with services (i.e., options explored and tried).More considered use of information (how it is provided, by whom, and at what point it should be introduced) is key to facilitating patients' engagement with and therefore use of information to support self-management

PRIMARY/SECONDARY CARE INTERFACE

Ham, C., et al . (2008). Making the shift from hospital to the community: lessons from an evaluation of a pilot programme. *Primary Health Care Research & Development*, *9*(04), 299-309.

http://dx.doi.org/10.1017/S1463423608000856

Aim To analyse the experience of a pilot programme designed to shift care from hospital to the community. Background The white paper, Our Health, Our Care, Our Say, published in England in 2006, set out a vision for the future of primary care and community services. A key component of this vision is to provide care closer to home. The NHS Institute for Innovation and Improvement established a pilot programme in five field test sites to explore the scope for bringing about shifts in care from hospital to the community. This paper reports the results of the evaluation of the programme. Methods A comparative case study design was used including interviews with key stakeholders at different points during the pilot programme, participation in discussion groups, documentary analysis, and collation of activity and output statistics. By comparing evidence drawn from 14 projects in the five field test sites, the evaluation was able to identify the impact of different factors on the progress of the projects. Findings All of the projects made some progress in taking forward their plans to shift care, although there were wide variations in what had been achieved at the end of the test and learn phase. Key factors influencing progress were the existence of a receptive context for change, project focus, organisational leadership, project management, stakeholder analysis, clinical engagement and leadership, overcoming barriers to change, aligned incentives, training and support, measuring and monitoring progress, and the timescale for change. A critical requirement in programmes of this kind is through dogged attention to project and change management. Also important is ensuring that the evidence on change management and quality improvement is acted on by those leading change programmes

Lega,F., & Mengoni,A. (2008). Why non-urgent patients choose emergency over primary care services? Empirical evidence and managerial implications. *Health Policy*, *88*(2-3), 326-338.

http://dx.doi.org/10.1016/j.healthpol.2008.04.005

http://pmid.us/18502533

Objective To investigate structural and psychological factors that lead non-urgent patients to choose the Accidents & Emergency Department (A&ED) rather than primary care services.Data sources Data were collected through interviews by means of a structured questionnaire. Data regarding the A&ED sample were also drawn from the database of the department.Study design Hypotheses were tested in a survey comparing A&ED non-urgent patients and patients using GP surgeries. Different perceptions of the characteristics of A&ED and primary care services were measured and a perceptual map was created using the linear discriminant analysis (LDA).Data collection Emergency services users were interviewed in the A&ED of the General Hospital of the Province of Macerata (Italy). Primary care users were interviewed in four GP surgeries. 527 patients were interviewed between December 2006 and February 2007.Principal findings A&ED and primary care patients look for different characteristics as diagnostic and therapeutic potentialities, empathy and competence, quick access or long-lasting relationship. Information asymmetry explains part of the behaviour.Conclusions Use of A&ED services for non-urgent care can be reduced. The understanding of reasons underlying the choice and a change in access, timing and contents of care/services provided by general practitioners (GPs) might provide incentives for shifting from A&ED to GPs surgeries

O'Malley,A.S., & Cunningham,P.J. (2008). Patient experiences with coordination of care: the benefit of continuity and primary care physician as referral source.
Journal of General Internal Medicine **19th December 2008**

http://dx.doi.org/10.1007/s11606-008-0885-5

http://pmid.us/19096897

Background: Coordination across a patient's health needs and providers is important to improving the quality of care. Objectives: (1) Describe the extent to which adults report that their care is coordinated between their primary care physician (PCP) and specialists and (2) determine whether visit continuity with one's PCP and the PCP as the referral source for specialist visits are associated with higher coordination ratings. Design: Cross-sectional study of the 2007 Health Tracking Household Survey. Participants: A total of 3,436 adults with a PCP and one or more visits to a specialist in the past 12 months. Measurements: Coordination measures were patient perceptions of (1) how informed and up to date the PCP was about specialist care received, (2) whether the PCP talked with the patient about what happened at the recent specialist visit and (3) how well different doctors caring for a patient's chronic condition work together to manage that care. RESULTS: Less than half of respondents (46%) reported that their PCP always seemed informed about specialist care received. Visit continuity with the PCP was associated with better coordination of specialist care. For example, 62% of patients who usually see the same PCP reported that their PCP discussed with them what happened at their recent specialist visit vs. 48% of those who do not usually see the same PCP (adjusted percentages, $p < 0.0001$). When a patient's recent specialist visit was based on PCP referral (vs. self-referral or some other source), 50% reported that the PCP was informed and up to date about specialist care received (vs. 35%, $p < 0.0001$), and 66% reported that their PCP discussed with them what happened at their recent specialist visit (vs. 47%, $p < 0.0001$). Conclusions: Facilitating visit continuity between the patient and PCP, and

encouraging the use of the PCP as the referral source would likely enhance care coordination

Regen,E., et al (2008). Challenges, benefits and weaknesses of intermediate care: results from five UK case study sites. ***Health and Social Care in the Community*****,** ***16*****(6), 629-637.**

http://dx.doi.org/10.1111/j.1365-2524.2008.00788.x

http://pmid.us/18484975

The authors explore the views of practitioners and managers on the implementation of intermediate care for elderly people across England, including their perceptions of the challenges involved in its implementation, and their assessment of the main benefits and weaknesses of provision. Qualitative data were collected in five case study sites (English primary care trusts) via semistructured interviews (n = 61) and focus group discussions (n = 21) during 2003 to 2004. Interviewees included senior managers, intermediate care service managers, clinicians and health and social care staff involved in the delivery of intermediate care. The data were analysed thematically using an approach based on the 'framework' method. Workforce and funding shortages, poor joint working between health and social care agencies and lack of support/involvement on the part of the medical profession were identified as the main challenges to developing intermediate care. The perceived benefits of intermediate care for service-users included flexibility, patient centredness and the promotion of independence. The 'home-like' environment in which services were delivered was contrasted favourably with hospitals. Multidisciplinary teamworking and opportunities for role flexibility were identified as key benefits by staff. Insufficient capacity, problems of access and awareness at the interface between intermediate care and 'mainstream' services combined with poor co-ordination between intermediate care services emerged as the main weaknesses in current provision. Despite reported benefits for service-users and staff, the study indicates that intermediate care does not appear to be achieving its full potential for alleviating pressure within health and social care systems. The strengthening of capacity and workforce, improvements to whole systems working and the promotion of intermediate care among doctors and other referrers were identified as key future priorities

Siminski, P.,et al (2008). Primary care presentations at emergency departments: rates and reasons by age and sex. ***Australian Health Review*****,** ***32*****(4), 700-709.**

http://pmid.us/18980566

Primary care presentations at emergency departments (EDs) have been the subject of much attention in recent years. This paper is a demographic analysis using administrative data from the Emergency Department Information System (EDIS) for 2005 of such presentations in New South Wales EDs and of self-reported reasons for presentation. Age and sex differences in the reasons given by patients for such presentations are analysed using data from a survey of patients conducted in a subset of EDs in 2004. The rate of

"potential primary care" presentations varies greatly with age and to a lesser extent with sex. Almost half (47%) of these presentations are made by people under 25 years of age. Children aged 0-4 years account for 14% of the total. The pattern is distinctly different to the corresponding rate of ED presentations that do not fit the "potential primary care" definition. Reasons given for "potential primary care" presentations are consistent across all age groups, reflecting self-assessed urgency, access to diagnostics and self-assessed complexity. Older "primary care" patients are particularly unlikely to give reasons associated with GP affordability or availability for their presentations. Young adults' responses are consistent with the overall population, and children under the age of five seem most susceptible to availability issues

QUALITY OF CARE

Agarwal,G., & Crooks,V.A. (2008). The nature of informational continuity of care in general practice. ***British Journal of General Practice 58*****(556), e17-e24.**

http://dx.doi.org/10.3399/bjgp08X342624

http://pmid.us/19000395

Background: The availability of patient information to practitioners forms the basis of informational continuity of care. Changes in family practice that now encourage multiphysician clinics have meant that informational continuity of care has become crucial because it is likely that a patient will not continuously see the same doctor. Therefore a review of the nature of informational continuity is useful. AIM: To answer the question 'How is informational continuity developed in general practice?'. Design of study: A rigorous systematic review of relevant electronic databases. Method: Databases were searched for articles answering the research question. Articles focused on family medicine and informational continuity of care were included. Data from reviewed articles were independently extracted and reviewed by two researchers. Conceptual and evidence-based articles were included. Results: initially, 193 articles were obtained from all five bibliographic databases; 57 were retained following title and abstract review. Of these, 34 articles were included in the final systematic review. Results show that informational continuity of care is developed using paper/electronic records and remembered information collectively, through a series of doctor-patient consultations over time. Obstacles to its development are practitioners not recording patient information and patients not disclosing important details. Conclusion: These findings have implications for newer styles of primary care that may have a negative impact in the successful management of chronic illnesses in particular

Baeza,J.I., Fitzgerald,L., & McGivern,G. (2008). Change capacity: the route to service improvement in primary care. ***Quality in Primary Care*****,** ***16*****(6), 401-407.**

http://pmid.us/19094415

Background: This paper draws on data from five English primary care trust (PCT) case studies which formed part of a larger research project that explored the roles and relationships of clinical managers and their colleagues in periods of change within different healthcare organisations. AIMS: This article uses empirical data to further our understanding of how primary care organisations can successfully implement service improvements. Method: Qualitative methods were used to compare across multiple cases. Three methods were utilised comprising semi-structured interviews, document analysis and observation at meetings. Through an iterative process of data coding using the NVivo data analysis software, final conclusions developed and became more explicit. Data were collected between mid-2002 and 2005. Results: Our analysis demonstrates the important influence of context on the change process. The case studies provide evidence of the nature of the relationships between context and progress in organisational change. We identified three interrelated dimensions of organisational context that played a crucial role in the progress or otherwise of service improvement. Conclusion: We conclude that primary care organisations need to have three key features in combination to successfully implement service improvements. These are (i) the presence of change leaders, at several levels throughout the organisation; (ii) a coherent change strategy; and (iii) a sound foundation of relationships between managers and clinical professional groups

Bowie,P., et al (2008). Judging the quality of clinical audit by general practitioners: a pilot study comparing the assessments of medical peers and NHS audit specialists. ***Journal of Evaluation in Clinical Practice 14*****(6), 1038-1043.**

http://dx.doi.org/10.1111/j.1365-2753.2008.00941.x

http://pmid.us/19019097

Rationale, aims and objectives: Clinical audit informs general practitioner (GP) appraisal and will provide evidence of performance for revalidation in the UK. However, objective evidence is now required. An established peer assessment system may offer an educational solution for making objective judgements on clinical audit quality. National Health Service (NHS) clinical audit specialists could potentially support this system if their audit assessments were comparable with established medical peer assessors. The study aimed to quantify differences between clinical audit specialists and medical peer assessors in their assessments of clinical audit projects. MethodS: A comparison study of the assessment outcomes of clinical audit reports by two groups using appropriate assessment instruments was conducted. Mean scores were compared and 95% confidence intervals (CIs) and limits of agreement calculated. A two-point mean difference would be relevant. Results: Twelve significant event analysis (SEA) reports and 12 criterion audit projects were assessed by 11 experienced GP assessors and 10 NHS audit specialist novice assessors. For SEA, the mean score difference between groups was <1.0. The 95% CI for bias was -0.1 to 0.5 (P = 0.14). Limits of agreement ranged from -0.7 to 1.2. For criterion audit, a mean score difference of <or=1.0 was calculated for seven projects and scores between 1.1 and 1.9 for four. The 95% CI for bias was 0.8 to 1.5 (P < 0.001). Limits of agreement ranged from -2.5 to -0.0. Conclusions: The study findings suggest

that a sample of NHS clinical audit specialists can give numerically accurate feedback scores to GPs on the quality of their clinical audit activity compared with established peer assessors as part of the model outlined

Campbell, S.M., et al (2008). Quality indicators for the prevention and management of cardiovascular disease in primary care in nine European countries. ***European Journal of Cardiovascular Prevention and Rehabilitation*, *15*(5), 509-515.**

http://dx.doi.org/10.1097/HJR.0b013e328302f44d

http://pmid.us/18695594

Background: With free movement of labour in Europe, European guidelines on cardiovascular care and the enlargement of the European Union to include countries with disparate health care systems, it is important to develop common quality standards for cardiovascular prevention and risk management across Europe. Methods: Panels from nine European countries (Austria, Belgium, Finland, France, Germany, Netherlands, Slovenia, United Kingdom and Switzerland) developed quality indicators for the prevention and management of cardiovascular disease in primary care. A two-stage modified Delphi process was used to identify indicators that were judged valid for necessary care. Results: Forty-four out of 202 indicators (22%) were rated as valid. These focused predominantly on secondary prevention and management of established cardiovascular disease and diabetes. Less agreement on indicators of preventive care or on indicators for the management of hypertension and hypercholesterolaemia in patients without established disease was observed. Although 85% of the 202 potential indicators assessed were rated valid by at least one panel, lack of consensus among panels meant that the set that could be agreed upon among all panels was much smaller. Conclusion: Indicators for the management of established cardiovascular disease have been developed, which can be used to measure the quality of cardiovascular care across a wide range of countries. Less agreement on how the quality of preventive care should be assessed was observed, probably caused by differences in health systems, culture and attitudes to prevention

Corriol,C., et al (2008). How to limit the burden of data collection for Quality Indicators based on medical records? The COMPAQH experience. ***BMC Health Services Research* , *8*(1), 215.**

http://dx.doi.org/10.1186/1472-6963-8-215

http://www.biomedcentral.com/1472-6963/8/215

http://pmid.us/18940005

Background: Our objective was to limit the burden of data collection for Quality Indicators (QIs) based on medical records. Methods:The study was supervised by the COMPAQH project. Four QIs based on medical records were tested: medical record

conformity; traceability of pain assessment screening for nutritional disorders; time elapsed before sending copy of discharge letter to the general practitioner. Data were collected by 6 Clinical Research Assistants (CRAs) in a panel of 36 volunteer hospitals and analyzed by COMPAQH. To limit the burden of data collection, we used the same sample of medical records for all 4 QIs, limited sample size to 80 medical records, and built a composite score of only 10 items to assess medical record completeness. We assessed QI feasibility by completing a grid of 19 potential problems and evaluating time spent. We assessed reliability (Kappa coefficient) as well as internal consistency (Cronbach alpha coefficient) in an inter-observer study, and discriminatory power by analysing QI variability among hospitals .Results: Overall, 23 115 data items were collected for the 4 QIs and analyzed. The average time spent on data collection was 8.5 days per hospital. The most common feasibility problem was misunderstanding of the item by hospital staff. QI reliability was good (Kappa coefficient: 0.59-0.97 according to QI). The hospitals differed widely in their ability to meet the quality criteria (mean value: 19-85%). Conclusions: These 4 QIs based on medical records can be used to compare the quality of record keeping among hospitals while limiting the burden of data collection, and can therefore be used for benchmarking purposes. The French National Health Directorate has included them in the new 2009 version of the accreditation procedure for healthcare organizations

Grandes,G., et al (2008). Is integration of healthy lifestyle promotion into primary care feasible? Discussion and consensus sessions between clinicians and researchers. ***BMC Health Services Research*****,** ***8*****(1), 213.**

http://dx.doi.org/10.1186/1472-6963-8-213

http://www.biomedcentral.com/1472-6963/8/213/abstract

http://pmid.us/18854033

Background: The adoption of a healthy lifestyle, including physical activity, a healthy diet, moderate alcohol consumption and abstinence from smoking, is associated with a major decrease in the incidence of chronic diseases and mortality. Primary health-care (PHC) services therefore attempt, with rather limited success, to promote such lifestyles in their patients. The objective of the present study is to ascertain the perceptions of clinicians and researchers within the Basque Health System of the factors that hinder or facilitate the integration of healthy lifestyle promotion in routine PHC setting. Methods: Formative research based on five consensus meetings held by an expert panel of 12 PHC professionals with clinical and research experience in health promotion, supplied with selected bibliographic material. These meetings were recorded, summarized and the provisional findings were returned to participants in order to improve their validity. Results: The Health Belief Model, the Theory of Planned Action, the Social Learning Theory, "stages of change" models and integrative models were considered the most useful by the expert panel. Effective intervention strategies, such as the "5 A's" strategy (assess, advise, agree, assist and arrange) are also available. However, none of these can be directly implemented or continuously maintained under current PHC conditions. These strategies should therefore be redesigned by adjusting the intervention objectives

and contents to the operation of primary care centres and, in turn, altering the organisation of the centres where they are to be implemented. Conclusion: It is recommended to address optimisation of health promotion in PHC from a research perspective in which PHC professionals, researchers and managers of these services cooperate in designing and evaluating innovative programs. Future strategies should adopt a socio-ecological approach in which the health system plays an essential role but which nevertheless complements other individual, cultural and social factors that condition health. These initiatives require an adequate theoretical and methodological framework for designing and evaluating complex interventions

Holden, J. (2008). The work and research of a single non-academic family physician. ***Family Practice*** **25/11/2008 Epub ahead of print**

http://dx.doi.org/10.1093/fampra/cmn090

http://pmid.us/19033547

This review of my own work over 30 years aims to help others decide whether they should and could pursue an interest in research in primary care. Lessons from failure are considered as well as how to be opportunistic in research. I suggest audit is a good place to start research as it requires several of the same disciplines. The difficult issue of working successfully with others is addressed along with a publication strategy. I illustrate some of the advantages and disadvantages of undertaking research from general practice. Finally, I discuss how personal research can lead to a higher degree

Kostopoulou,O., Delaney,B.C., & Munro,C.W. (2008). Diagnostic difficulty and error in primary care--a systematic review. ***Family Practice 25*****(6), 400-413.**

http://dx.doi.org/10.1093/fampra/cmn071

http://pmid.us/18842618

Background: Diagnostic error in primary care can have serious implications for the patient, the clinician and the health-care system, possibly more so than other types of error. Objective: To identify common characteristics of diseases that GPs may misdiagnose. Methods: Systematic search of the MEDLINE and EMBASE databases for primary research on diagnostic error/delay in primary care. Papers on system errors, patient delay, case reports, reviews, opinion pieces, studies not based on actual cases and studies not using a systematic sample were excluded from the review. Twenty-one papers were included. All papers were assessed for quality using the GRADE system. Common features were identified across diseases and presentations that made diagnosis difficult and led to error/delay. Results: Most studies were retrospective cohorts of patients recruited in hospital and collected data from patient interviews and/or hospital records, resulting in incomplete and potentially biased information. It was usually not possible to determine preventability of the delay. Some conditions were extremely rare, suggesting a specialist research interest rather than an increased rate of misdiagnosis. Conditions investigated were malignancies, myocardial infarction, meningitis, dementia, iron deficiency anaemia, asthma, tremor in the elderly and HIV. Common features of

difficulty were atypical presentations, non-specific presentations, very low prevalence, the presence of co-morbidity and perceptual features and could be missed. Conclusions: Misdiagnosis in primary care covers a wide range of conditions that may be related in the manner in which they present. The challenge is to identify ways of supporting the diagnostic process in potentially difficult presentations

Krohne K, & Brage S (2008). How GPs in Norway conceptualise functional ability: a focus group study . British Journal of General Practice Advance Online Publications November 2008

http://dx.doi.org/10.3399/bjgp08X376131

Background Loss of functional ability has been introduced as a criterion for social benefits in several European countries. This criterion may direct attention towards work ability and individual resources, and thus reduce the number of persons claiming social benefits. However, little is known about how functional ability is conceptualised by GPs. Aim To explore how GPs conceptualise functioning and functional ability in relation to their sickness certification practice. Design of study Qualitative study using focus group nterviews. Setting General practices in Eastern Norway. Method Four focus groups with a total of 23 GPs were recruited via the Norwegian Medical Association. Data were analysed according to Malterud' s systematic text condensation method and supported by a historical framework. Results Functioning was conceptualised by the GPs as physical, mental, and social ability. Of these domains, physical ability received special emphasis in the conceptualisation of overall functioning. The assessment of physical functioning was generally considered straightforward, aside from instances in which the underlying pathology proved difficult to locate. Mental ability was reportedly more difficult to assess, and the GPs used a wide array of rating scales to support assessments. Social ability was described in terms of social problems and their impact on patients' general functional ability. Relating functional ability to patients' work situation was a two-step process requiring knowledge beyond the scope of the clinician. Conclusion The concept of functioning is understood within a biopsychosocial paradigm, but implementing it into clinical practice and in accordance with insurance legislation proves difficult.

Middleton,H. (2008). Quality improvement in primary care mental health practice. A case for political intervention? *Quality In Primary Care*, *16*(6), 419-424.

http://pmid.us/19094417

Improving the quality and consistency of detecting and providing for so-called common mental health problems in primary care settings is a contemporary issue. Such conditions are common and they are now recognised as a significant burden upon the economy. Though energetically pursued for much of the last half century, a medical approach based upon syndromal diagnosis and treatment has not provided a clear, evidence-based approach to their management that can form the basis of an educational intervention. Where that has been attempted and evaluated, it has been found wanting. A more politically driven imperative has stimulated 'top-down' and firmly managed processes of

change, encouraged by fresh investment. Improving Access to Psychological Therapies will not be the first programme to influence mental health services in this way. Experience of other programmes of deliberately managed change suggests that this approach can be effective and productive, particularly in a context which mental health exemplifies, where there are relatively few clinical certainties and a multitude of opinions

O'Riordan,M., Skelton,J., & de la Croix,A. (2008). Heartlift patients? An interview-based study of GP trainers and the impact of 'patients they like'. *Family Practice*, *25*(5), 349-354.

http://dx.doi.org/10.1093/fampra/cmn043

http://pmid.us/18718887

Background. The concept of the heartsink patient' is well known and much used when talking about general practice. The opposite of this type of patient, however, has been little explored. Objective. To identify patient characteristics valued by GPs. Methods. Structured interview to collect narratives from GPs of individual patients, analysed qualitatively through thematic analysis and word frequency. Setting. Primary Care in Ireland. Participants. GP trainers. Main outcome measures. Emergent themes from four lead questions: Tell me about a patient you like, Tell me about the patient's personality, What have you learned about yourself as a GP?, What is different about being a GP as opposed to any other kind of doctor? In addition, a corpus linguistic analysis of word frequencies disclosed further themes, not identifiable on the surface of discourse. Results. Ten themes were identified: GPs valued patients who were likeable, a challenge, involved them in negotiation of the doctor-patient relationship, were interesting or virtuous and had a positive effect. GPs valued their profession in that they were facilitators, gave and elicited loyalty, formed personal attachments and had a different perspective. Conclusions. Heartlift patients' may be a robust concept, to counterbalance heartsink patients. Data collected are suitable for training, and could help GPs enhance a sense of vocation

Pollak,K.I., et al (2008). Estimated time spent on preventive services by primary care physicians. *BMC Health Services Research* *8*(1), 245.

http://dx.doi.org/10.1186/1472-6963-8-245

http://www.biomedcentral.com/1472-6963/8/245

http://pmid.us/19046443

Background: Delivery of preventive health services in primary care is lacking. One of the main barriers is lack of time. We estimated the amount of time primary care physicians spend on important preventive health services. Methods: We analyzed a large dataset of

primary care (family and internal medicine) visits using the National Ambulatory Medical Care Survey (2001-4); analyses were conducted 2007-8. Multiple linear regression was used to estimate the amount of time spent delivering each preventive service, controlling for demographic covariates. Results: Preventive visits were longer than chronic care visits (M = 22.4, SD = 11.8, M = 18.9, SD = 9.2, respectively). New patients required more time from physicians. Services on which physicians spent relatively more time were prostate specific antigen (PSA), cholesterol, Papanicolaou (Pap) smear, mammography, exercise counseling, and blood pressure. Physicians spent less time than recommended on two "A" rated ("good evidence") services, tobacco cessation and Pap smear (in preventive visits), and one "B" rated ("at least fair evidence") service, nutrition counseling. Physicians spent substantial time on two services that have an "I" rating ("inconclusive evidence of effectiveness"), PSA and exercise counseling. Conclusions: Even with limited time, physicians address many of the "A" rated services adequately. However, they may be spending less time than recommended for important services, especially smoking cessation, Pap smear, and nutrition counseling. Future research is needed to understand how physicians decide how to allocate their time to address preventive health

Sahota N, & et al (2008) Developing performance indicators for primary care: Walsall' s experience. ***British Journal of General Practice*** **Advance Online Publication November 2008**

http://dx.doi.org/10.3399/bjgp08X376096

Background There has been increasing interest in the development of performance indicators in primary care, especially since the introduction of the Quality and Outcomes Framework (QOF). Public health and primary care trusts collect a range of data from routine or non-routine sources that may be useful for this purpose. Aim To assess whether performance against the QOF is a robust measure of practice performance when compared with health-inequality indicators and to contribute to the development of a tool to monitor and improve primary care services. Design of study A retrospective cross-sectional study. Setting Sixty-three GP practices contracted with Walsall Teaching Primary Care Trust. Method Correlation analysis and scatter plots were used to identify possible significant relationships between QOF scores and health-inequality data. The study also utilised confidence limit theory and control chart methodology as tools to identify possible performance outliers. Results Little correlation was found between overall QOF score and deprivation score. Uptake of flu immunisation ($r^2 = 0.22$) and cervical screening ($r^2 = 0.11$) both showed a slight increase with increased QOF score. Benzodiazepine ($r^2 = 0.06$) and antibiotic prescribing levels ($r^2 = 0.02$) decreased slightly with increased QOF scores, although not significantly. An increase in practice-population deprivation score was correlated with a reduction in cervical screening uptake ($r^2 = 0.27$) and an increase in benzodiazepine prescribing ($r^2 = 0.25$). Statistically significant relationships were found between the patient: GP ratio and flu immunisation uptake ($r^2 = 0.1$) and antibiotic prescribing ($r^2 = 0.1$). The majority of GPs found it acceptable to use performance indicator data as part of their annual appraisal. Conclusion QOF and health-inequality data can be used together to measure practice performance

and to develop tools to help identify areas for performance development and the sharing of best practice.

Scott,J.G., et al (2008). Understanding healing relationships in primary care. ***Annals of Family Medicine* *6*(4), 315-322.**

http://dx.doi.org/10.1370/afm.860

http://pmid.us/18626031

Purpose: Clinicians often have an intuitive understanding of how their relationships with patients foster healing. Yet we know little empirically about the experience of healing and how it occurs between clinicians and patients. Our purpose was to create a model that identifies how healing relationships are developed and maintained. Methods: Primary care clinicians were purposefully selected as exemplar healers. Patients were selected by these clinicians as having experienced healing relationships. In-depth interviews, designed to elicit stories of healing relationships, were conducted with patients and clinicians separately. A multidisciplinary team analyzed the interviews using an iterative process, leading to the development of case studies for each clinician-patient dyad. A comparative analysis across dyads was conducted to identify common components of healing relationships Results: Three key processes emerged as fostering healing relationships: (1) valuing/creating a nonjudgmental emotional bond; (2) appreciating power/consciously managing clinician power in ways that would most benefit the patient; and (3) abiding/displaying a commitment to caring for patients over time. Three relational outcomes result from these processes: trust, hope, and a sense of being known. Clinician competencies that facilitate these processes are self-confidence, emotional self-management, mindfulness, and knowledge. Conclusions: Healing relationships have an underlying structure and lead to important patient-centered outcomes. This conceptual model of clinician-patient healing relationships may be generalizable to other kinds of healing relationships

Stevenson,K., Grayling,I., & Lakhani,M. (2008). Learning how to make things happen: a report of an educational intervention designed to support clinical governance leads in primary care. ***Quality in Primary Care*, *16*(6), 441-448.**

http://pmid.us/ 19094420

Making Things Happen (MaTH) was devised as a six-module educational programme to support clinical governance leads (CGLs) in primary health care. The aim of the programme was to help develop practice CGLs' awareness, understanding and ability to initiate and manage change. The objectives of the training programme were: * to promote an increased and sophisticated understanding of clinical governance by building on knowledge gained already * to develop skills in delivering and sustaining improvements * to improve personal effectiveness in bringing about change. A pilot training programme was planned and delivered twice in 2003/2004 to two separate cohorts of clinical governance leads (n = 30 and n = 15) from two pilot primary care trusts (PCTs). The six training modules were delivered to the two groups by the same staff but at different times

and in two separate locations. The effectiveness of the programme was evaluated in both PCTs at three levels. First the content of the programme was evaluated by the CGLs that attended the programme. Secondly, the value of the programme to the PCT was considered by the PCT co-ordinators. Thirdly, the effectiveness of the programme was considered by the presenting team. All three groups felt that the objectives were met, that the principles of MaTH training were sound and that it would be a valuable resource to offer nationally. It was also noted that training for PCT local co-ordinators in how to support clinical governance would be a useful training co-opportunity

RESEARCH AND DEVELOPMENT

Belanger,E., & Rodriguez,C. (2008). More than the sum of its parts? A qualitative research synthesis on multi-disciplinary primary care teams. ***Journal of Interprofessional Care*, *22*(6), 587-597.**

http://dx.doi.org/10.1080/13561820802380035

http://pmid.us/19012139

This qualitative research synthesis reviews interpretive scholarly papers on multi-disciplinary primary care teams. A bibliographic search was conducted in electronic databases: Medline, Embase, and the Web of Science Citation Index, and in the references of retrieved papers. The research consists of a taxonomic analysis of 19 qualitative studies about primary care teams published in peer-reviewed journals between 2001 and July 2008 in English and French. Nineteen qualitative studies were synthesized. Two major concerns emerged: (1) strategies for organizational change toward effective co-operative practice, and (2) dimensions of team interactions and work relations. The authors conclude that qualitative results suggest common strategies to improve the development of primary care teams, while identifying dimensions of team interactions that remain problematic. A fundamental aspect of team formation appears to be overlooked, i.e., the construction of a collective identity, which would involve the whole team in a shared ideal of co-operative practice. The adoption of discourse analysis is suggested as a more sophisticated qualitative methodology to explore this issue

Dormandy,E., (2008). Maximising recruitment and retention of general practices in clinical trials: a case study. ***British Journal of General Practice* *58*(556), 759-7ii.**

http://dx.doi.org/10.3399/bjgp08X319666

http://pmid.us/19000399

Background: There is limited evidence regarding the factors that facilitate recruitment and retention of general practices in clinical trials. It is therefore pertinent to consider the factors that facilitate research in primary care. AIM: To formulate hypotheses about

effective ways of recruiting and retaining practices to clinical trials, based on a case study. Design of study: Case study of practice recruitment and retention to a trial of delivering antenatal sickle cell and thalassaemia screening. Setting: Two UK primary care trusts with 123 practices, with a high incidence of sickle cell and thalassaemia, and high levels of social deprivation. METHOD: Practices were invited to take part in the trial using a research information sheet for practices. Invitations were sent to all practice managers, GPs, practice nurses, and nurse practitioners. Expenses of approximately pound 3000 per practice were available. Practices and the research team signed research activity agreements, detailing a payment schedule based on deliverables. Semi-structured interviews were completed with 20 GPs who participated in the trial. Outcome measures were the number of practices recruited to, and completing, the trial. Results: Four practices did not agree to randomisation and were excluded. Of 119 eligible practices, 29 expressed an interest in participation. Two practices withdrew from the trial and 27 participated (two hosted pilot studies and 25 completed the trial), giving a retention rate of 93% (27/29). The 27 participating practices did not differ from non-participating practices in list size, number of GPs, social deprivation, or minority ethnic group composition of the practice population. Conclusion: Three factors appeared important in recruiting practices: research topic, invitation method, and interest in research. Three factors appeared important in retaining practices: good communication, easy data-collection methods, and payment upon meeting pre-agreed targets. The effectiveness of these factors at facilitating recruitment and retention requires assessment in experimental studies

Edwards,S.J., & Omar,R. (2008). Ethics review of research: in pursuit of proportionality. ***Journal of Medical Ethics*****,** ***34*****(7), 568-572.**

http://dx.doi.org/10.1136/jme.2007.022491

http://pmid.us/18591296

The ethics review system of research is now well-established, at least in the developed world, although there are many differences in how countries view it and go about managing it. The UK specifically is now seeking to revise its system by speeding up the process of ethics approval but only for some studies. It is proposed that only those studies which pose "no material ethical issues" should be "fast-tracked". However, it is unclear what this means, who should decide and what should be included in this category. In this paper, we go some way towards answering these questions. While we are certain that the debate is only just beginning, we are equally certain that it will continue to run long after the system has been reformed. To stimulate this conversation and to inform a pilot project of the new system directly, we review two candidates to help give some substance to the notion of "material" ethical issues. Firstly, material could mean a certain type or degree of risk. Second, material could mean how physically invasive the research is. We conclude that there is still much work to be done on making the system of governing health and social care consistent and practicable

Francis,J.J. et al (2008). Explaining the effects of an intervention designed to promote evidence-based diabetes care: a theory-based process evaluation of a pragmatic cluster randomised controlled trial. ***Implementation Science 3*****(1), 50.**

http://dx.doi.org/10.1186/1748-5908-3-50

http://www.implementationscience.com/content/3/1/50

http://pmid.us/19019242

Background: The results of randomised controlled trials can be usefully illuminated by studies of the processes by which they achieve their effects. The Theory of Planned Behaviour (TPB) offers a framework for conducting such studies. This study used TPB to explore the observed effects in a pragmatic cluster randomised controlled trial of a structured recall and prompting intervention to increase evidence-based diabetes care that was conducted in three Primary Care Trusts in England. Methods: All general practitioners and nurses in practices involved in the trial were sent a postal questionnaire at the end of the intervention period, based on the TPB (predictor variables: attitude; subjective norm; perceived behavioural control, or PBC). It focussed on three clinical behaviours recommended in diabetes care: measuring blood pressure; inspecting feet; and prescribing statins. Multivariate analyses of variance and multiple regression analyses were used to explore changes in cognitions and thereby better understand trial effects. Results: Fifty-nine general medical practitioners and 53 practice nurses (intervention: n = 55, 41.98% of trial participants; control: n = 57, 38.26% of trial participants) completed the questionnaire. There were no differences between groups in mean scores for attitudes, subjective norms, PBC or intentions. Control group clinicians had 'normatively-driven' intentions (i.e., related to subjective norm scores), whereas intervention group clinicians had 'attitudinally-driven' intentions (i.e., related to attitude scores) for foot inspection and statin prescription. After controlling for effects of the three predictor variables, this group difference was significant for foot inspection behaviour (trial group x attitude interaction, beta = 0.72, p<0.05; trial group x subjective norm interaction, beta = -0.65, p<0.05). Conclusions: Attitudinally-driven intentions are proposed to be more consistently translated into action than normatively-driven intentions. This proposition was supported by the findings, thus offering an interpretation of the trial effects. This analytic approach demonstrates the potential of the TPB to explain trial effects in terms of different relationships between variables rather than differences in mean scores. This study illustrates the use of theory-based process evaluation to uncover processes underlying change in implementation trials.

Graffy,J., et al (2008). UK research staff perspectives on improving recruitment and retention to primary care research; nominal group exercise. ***Family Practice*****.Epub 14/11/2008**

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

http://pmid.us/19011173

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

Hogg, W.,et al (2008). Framework for primary care organizations: the importance of a structural domain. ***International Journal for Quality in Health Care*****,** ***20*****(5), 308-313.**

http://dx.doi.org/10.1093/intqhc/mzm054

Purpose Conceptual frameworks for primary care have evolved over the last 40 years, yet little attention has been paid to the environmental, structural and organizational factors that facilitate or moderate service delivery. Since primary care is now of more interest to policy makers, it is important that they have a comprehensive and balanced conceptual framework to facilitate their understanding and appreciation. We present a conceptual framework for primary care originally developed to guide the measurement of the performance of primary care organizations within the context of a large mixed-method evaluation of four types of models of primary care in Ontario, Canada. MethodsThe framework was developed following an iterative process that combined expert consultation and group meetings with a narrative review of existing frameworks, as well as trends in health management and organizational theory. Results Our conceptual framework for primary care has two domains: structural and performance. The structural domain describes the health care system, practice context and organization of the practice in which any primary care organization operates. The performance domain includes features of health care service delivery and technical quality of clinical care. Conclusion As primary care evolves through demonstration projects and reformed delivery models, it is important to evaluate its structural and organizational features as these are likely to have a significant impact on performance

Rosser,W. (2008). Bringing important research evidence into practice: Canadian developments. ***Family Practice*** **12/11/2008 Epub ahead of print.**

http://dx.doi.org/10.1093/fampra/cmn080

http://pmid.us/19005227

Background: The transfer of evidence from research into clinical practice is made almost impossible by enormous volume of literature on any topic. Consolidated evidence into guidelines is not very helpful as there are usually 50 guidelines existing on common clinical topics. Clinicians need assistance in identifying the best available evidence. This paper describes two strategies to transfer research evidence into clinical practice. Methods: The Guideline Advisory Committee (GAC) in Ontario has assessed all available guidelines on 70 clinical topics using a validated and transparent process involving community-based physicians as assessors. A single best guideline is selected and a summary of its evidence-based recommendations are produced for easy use by practitioners (http://www.gacguidelines.ca). The Critically Appraised Practice Reflection Exercise (CAPRE) programme takes the best available evidence on 40 common practice problems, presents a summary for clinician and patient, has a strategy for physician and patient to find common ground in applying the evidence and has the practitioner to carry out a reflection exercise to gain continuing education credits (http://www.capre.ca). Distribution of these strategies in practice-based research networks is a further step in making research more relevant to practice. Results: The GAC website has more than 100 000 'hits' per month and 4500 identified regular users from Canada and the world. The numbers are steadily increasing. The CAPRE programme has not been formally evaluated but over 150 clinicians have used the programme with patients. With a national launch, the programme there between 60 000 and 80 000 hits per week with 100 physicians completing the programme for continuing medical education (CME) credits in the first month. Physicians report that their patients are very pleased with their physician using the latest evidence to address their problem. This is true even if the patient does not agree to follow the evidence-based recommendations. Using these programmes in practice-based research, networks should further promote making research more relevant to practice. Conclusions: Transferring research-based evidence into clinical practice has many challenges. Two programmes developed to address these challenges are described. Although not fully evaluated, there is some evidence of success

Sarre,G., & Cooke,J. (2008). Developing indicators for measuring Research Capacity Development in primary care organizations: a consensus approach using a nominal group technique. ***Health and Social Care in the Community*****. Epub ahead of publication 19/11/2008**

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

http://pmid.us/19040697

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

Wilson,S., Draper,H., & Ives,J. (2008). Ethical issues regarding recruitment to research studies within the primary care consultation. *Family Practice*. Epublication 26/10/2008

http://dx.doi.org/10.1093/fampra/cmn076

http://pmid.us/18953068

Recruitment to primary care-based studies may occur within the consultation or in dedicated research clinics. For practical and logistic reasons, some patients are recruited to research studies by their family doctor during the consultation. However, this may preclude patients from discussing participation with others and some patients may not feel empowered to refuse participation. This may be a particular problem when patients have their own family doctor, whom they generally see, and the patient feels dependent on their practitioner's goodwill for ongoing care. Recruitment within the practice, therefore, raises ethical issues that warrant further exploration. This discussion article argues that there are reasons to suppose there may be problems associated with family

doctors recruiting their own patients into research. Nevertheless, assumptions that patients feel undue pressure or obligation to participate in primary care research may not be justified. It is important that potential research participants have time to consider the implications of participation. However, the risks to patients of consenting to participate in research are, in many instances, less than the risks inherent in their routine treatment. We conclude that it is important that those responsible for the implementation of research ethics approvals and governance procedures are careful to avoid imposing inflexible rules that prevent patients from acting according to their own wishes

Zwarenstein,M., et al (2008). Improving the reporting of pragmatic trials: an extension of the CONSORT statement. ***British Medical Journal*** **,** ***337*** **a2390.**

http://dx.doi.org/10.1136/bmj.a2390.

http://pmid.us/19001484

Background: The CONSORT statement is intended to improve reporting of randomised controlled trials and focuses on minimising the risk of bias (internal validity). The applicability of a trial's results (generalisability or external validity) is also important, particularly for pragmatic trials. A pragmatic trial (a term first used in 1967 by Schwartz and Lellouch) can be broadly defined as a randomised controlled trial whose purpose is to inform decisions about practice. This extension of the CONSORT statement is intended to improve the reporting of such trials and focuses on applicability. Methods At two, two-day meetings held in Toronto in 2005 and 2008, we reviewed the CONSORT statement and its extensions, the literature on pragmatic trials and applicability, and our experiences in conducting pragmatic trials. Recommendations We recommend extending eight CONSORT checklist items for reporting of pragmatic trials: the background, participants, interventions, outcomes, sample size, blinding, participant flow, and generalisability of the findings. These extensions are presented, along with illustrative examples of reporting, and an explanation of each extension. Adherence to these reporting criteria will make it easier for decision makers to judge how applicable the results of randomised controlled trials are to their own conditions. Empirical studies are needed to ascertain the usefulness and comprehensiveness of these CONSORT checklist item extensions. In the meantime we recommend that those who support, conduct, and report pragmatic trials should use this extension of the CONSORT statement to facilitate the use of trial results in decisions about health care

SELF MANAGEMENT

Ettner,S.L., (2008). Investing time in health: do socioeconomically disadvantaged patients spend more or less extra time on diabetes self-care? *Health Economics*. Epub 15/8/2008

http://dx.doi.org/10.1002/hec.1394

http://pmid.us/18709636

Background: Research on self-care for chronic disease has not examined time requirements. Translating Research into Action for Diabetes (TRIAD), a multi-site study of managed care patients with diabetes, is among the first to assess self-care time. Objective: To examine associations between socioeconomic position and extra time patients spend on foot care, shopping/cooking, and exercise due to diabetes. Data: Eleven thousand nine hundred and twenty-seven patient surveys from 2000 to 2001.Methods: Bayesian two-part models were used to estimate associations of self-reported extra time spent on self-care with race/ethnicity, education, and income, controlling for demographic and clinical characteristics. Results: Proportions of patients spending no extra time on foot care, shopping/cooking, and exercise were, respectively, 37, 52, and 31%. Extra time spent on foot care and shopping/cooking was greater among racial/ethnic minorities, less-educated and lower-income patients. For example, African-Americans were about 10 percentage points more likely to report spending extra time on foot care than whites and extra time spent was about 3 min more per day. Discussion: Extra time spent on self-care was greater for socioeconomically disadvantaged patients than for advantaged patients, perhaps because their perceived opportunity cost of time is lower or they cannot afford substitutes. Our findings suggest that poorly controlled diabetes risk factors among disadvantaged populations may not be attributable to self-care practices.

Farrand, P., et al (2008). Guided self-help supported by paraprofessional mental health workers: an uncontrolled before-after cohort study. *Healthand Social Care in the Community*. Epublication 17/6/2008

http://dx.doi.org/10.1111/j.1365-2524.2008.00792.x

http://pmid.us/18564197

There has been considerable development of guided self-help clinics within primary care. This uncontrolled before-after cohort study examines efficiency and effectiveness of these clinics when supported by paraprofessional mental health workers having little mental health training and experience. Data were collected by seven Graduate Mental Health Workers (GMHW) located in South-west England. Alongside an analysis of clinic attendance and dropout, efficiency was measured with respect to the number and length of sessions to support patients with the effectiveness of the interventions examined with respect to problem severity. Over a 15-month period, 1162 patients were referred to the GMHW clinics with 658 adopting guided self-help. Patients using guided self-help received an average input per patient, excluding assessment, of four sessions of 40 minutes. Dropout rate was comparable to other primary-care-based mental health clinics

supported by experienced mental health professionals with 458 patients completing all support sessions. However, only 233 patients went on to attend the 3 months of follow-up session. Effectiveness of guided self-help clinics supported by paraprofessional mental health workers was comparable to that supported by an experienced mental health nurse. Improvements in problem severity were statistically significant, with 55% and 58% (final support session) and 63% and 62% (3 months of follow-up) of patients experiencing clinically significant and reliable change for anxiety and depression, respectively. However, concerns exist over the efficiency of the GMHW clinic especially with respect to the use of longer support sessions and high dropout rate at the 3 months of follow-up session. The paper concludes by highlighting the effectiveness of guided self-help when supported by paraprofessional mental health workers, but questions the utility of the two-plus-one model of service delivery proposing a collaborative care approach as an alternative

Furler, J., et al . (2008). The emotional context of self-management in chronic illness: A qualitative study of the role of health professional support in the self-management of type 2 diabetes. ***BMC Health Services Research*****,** ***8*****(1), 214.**

http://dx.doi.org/10.1186/1472-6963-8-214

http://www.biomedcentral.com/1472-6963/8/214

http://pmid.us/18928555

Background: Support for patient self-management is an accepted role for health professionals. Little evidence exists on the appropriate basis for the role of health professionals in achieving optimum self-management outcomes. This study explores the perceptions of people with type 2 diabetes about their self-management strategies and how relationships with health professionals may support this. Methods: Four focus groups were conducted with people with type 2 diabetes: two with English-speaking and one each with Turkish and Arabic-speaking. Transcripts from the groups were analysed drawing on grounded hermeneutics and interpretive description. Results: We describe three conceptually linked categories of text from the focus groups based on emotional context of self management, dominant approaches to self management and support form health professionals for self management. All groups described important emotional contexts to living with and self-managing diabetes and these linked closely with how they approached their diabetes management and what they looked for from health professionals. Culture seemed an important influence in shaping these linkages. Conclusion: Our findings suggest people construct their own individual self-management and self-care program, springing from an important emotional base. This is shaped in part by culture and in turn determines the aims each person has in pursuing self-management strategies and the role they make available to health professionals to support them. While health professionals' support for self-care strategies will be more congruent with patients' expectations if they explore each person's social, emotional and cultural circumstances, pursuit of improved health outcomes may involve a careful balance between supporting as well as helping shift the emotional constructs surrounding a patient life with diabetes

Greener,I. (2008). Expert patients and human agency: long-term conditions and Giddens' Structuration theory. ***Social Theory and Health*** **6 (4) 273-290.**

http://dx.doi.org/10.1057/sth.2008.11

This paper critically examines the UK government's approach to long-term sickness, the 'Expert Patient', examining its relationship to the 'Third Way' project, its social theoretical underpinnings, the motivations for wishing to introduce it and the dangers of assuming that the pilot studies that have been carried out in the US and UK for the scheme are generalisable across the population of those with long-term conditions. Instead, it considers the nature of the dependent relationship between the long-term ill and the state, and asks why governments have come to be so averse to it, and asks who should be responsible for care decisions in healthcare.

Handley,M.A., Shumway,M., & Schillinger,D. (2008). Cost-Effectiveness of Automated Telephone Self-Management Support With Nurse Care Management Among Patients With Diabetes. ***Annals of Family Medicine*****,** ***6*****(6), 512-518.**

http://dx.doi.org/10.1370/afm.889

http://pmid.us/19001303

Purpose This study evaluated the cost-effectiveness of an automated telephone self-management support with nurse care management (ATSM) intervention for patients with type 2 diabetes, which was tested among patients receiving primary care in publicly funded (safety net) clinics, focusing on non-English speakers. Methods We performed cost analyses in the context of a randomized trial among primary care patients comparing the effects of ATSM (n = 112) and usual care (n = 114) on diabetes-related outcomes in 4 San Francisco safety net clinics. ATSM uses interactive phone technology to provide surveillance, patient education, and one-on-one counseling, and was implemented in 3 languages for a 9-month period. Cost utility was examined using quality-adjusted life-years (QALYs) derived from changes in scores on the 12-Item Short Form Health Survey. We also examined cost-effectiveness for costs associated with a 10% increase in the proportion of patients meeting diabetes-specific public health goals for increasing exercise, as recommended by Healthy People 2010 and the American Diabetes Association. Results The annual cost of the ATSM intervention per QALY gained, relative to usual care, was $65,167 for start-up and ongoing implementation costs combined, and $32,333 for ongoing implementation costs alone. In sensitivity analyses, costs per QALY ranged from $29,402 to $72,407. The per-patient cost to achieve a 10% increase in the proportion of intervention patients meeting American Diabetes Association exercise guidelines was estimated to be $558 when all costs were considered and $277 when only ongoing costs were considered. Conclusions The ATSM intervention for diverse patients with diabetes had a cost utility for functional outcomes

similar to that of many other accepted interventions targeted at diabetes prevention and treatment, and achieved public health physical activity objectives at modest costs. Because a considerable proportion of costs were fixed, cost-utility and cost-effectiveness estimates would likely be substantially improved in a scaled-up ATSM program

Pratt,R., Halliday,E., & Maxwell,M. (2008). Professional and service-user perceptions of self-help in primary care mental health services. *Health and Social Care in the Community*. Epub ahead of print 19/11/2008

http://dx.doi.org/10.1111/j.1365-2524.2008.00819.x

http://pmid.us/19040698

Self-help is becoming an increasingly accessible option for addressing mental health problems. Despite this, self-help is subject to a variety of interpretations, little is known about how professionals and service-users conceptualise self-help, or how service-users engage in self-help activities. This study aimed to explore the views of self-help by service-users and health professionals in one area of Scotland, including the perceptions of what constitutes self-help and how it might be used to address mental health problems in primary care. The research involved semistructured interviews with 31 primary care mental health professionals, and in-depth interviews with 34 service-users. We found that professionals and service-users describe self-help in different ways, which has great implications for referral to and implementation of self-help in primary care settings. It also emerged that self-help was not necessarily perceived to be able to address the causes of mental distress, which could leave some professionals defaulting to offering no interventions despite the fairly positive attitude service-users show to self-help strategies. Finally, professionals need to be convinced that interventions are useful, effective and accessible as there are significant barriers in professionals using self-help; if they are not convinced, such approaches will support their therapeutic approach. The research supports the need to develop methods of delivery that offer self-help as part of a broad package of care that also considers social causes of distress

Siminerio, L.M.,et al . Delivering diabetes self-management education (DSME) in primary care: the Pittsburgh Regional Initiative For Diabetes Education (PRIDE). *Disease Management & Health Outcomes 2008; 16(4):267-272*, *16*(4), 267-272.

Background: Diabetes self-management education (DSME) is a critical component of the clinical management of diabetes mellitus. Although DSME is recognized as important, the number of patients with diabetes who receive education is disproportionately small. Several barriers to receiving diabetes education exist, including access and DSME delivery approaches., Objective: The purpose of this project was to explore opportunities to meet the Healthy People 2010 goal of increasing the proportion of people with diabetes mellitus who receive diabetes education from 40% (as it was in 1998) to 60% (in 2010). Our objectives were to examine the provision of DSME in primary care, to determine if DSME delivery in primary care increases the number of people who receive DSME, and to evaluate the effect of DSME on glycosylated hemoglobin (HbA1c) and low-density lipoprotein-cholesterol (LDL-C) levels. DSME was delivered in primary care practices as

part of the Pittsburgh Regional Initiative for Diabetes Education (PRIDE)., Research design and methods: A nurse who was a certified diabetes educator (CDE) was deployed to provide Point-Of-Service diabetes Education (POSE) to four University of Pittsburgh Medical Center (UPMC) Community Medicine Practices (CMI) primary care practices. The group of patients who received POSE was compared with patients from the same practices who were identified as having diabetes and who received usual care. The number of patients was computed and a percentage calculated for comparison against Healthy People 2010 goals. The HbA1c values of patients were tracked from January 2003 through December 2006, during the timeframe that POSE was provided., Results: Of the 5344 diabetes patients in the four practices, 784 received POSE. Mean HbA1c values were higher at baseline in those patients who received POSE than those who received usual care. There was a significant decrease in HbA1c and LDL-C levels in both groups. Although there was not a significant between-group difference in HbA1c, those who received POSE had significant improvement in LDL-C levels compared with the usual care group., Conclusions: Providing DSME in primary care is feasible and offers the opportunity to reach patients who may not be receiving DSME services. However, further research is needed to evaluate other methodologies to increase access to DSME and other factors that may influence improvement in clinical outcomes.,

SERVICE ORGANISATION AND DELIVERY

Jackson,C.L., et al (2008). The primary care amplification model: taking the best of primary care forward. *BMC Health Services Research* *8*(1), 268.

http://dx.doi.org/10.1186/1472-6963-8-268

http://www.biomedcentral.com/1472-6963/8/268

http://pmid.us/19099606

Background: Primary care internationally is approaching a new paradigm. The change agenda implicit in this threatens to de-stabilise and challenge established general practice and primary care. Discussion: The Primary Care Amplification Model offers a means to harness the change agenda by 'amplifying' the strengths of established general practices around a 'beacon' practice. Conclusion: Such 'beacon' practices can provide a mustering point for an expanded scope of practice for primary care, integrated primary / secondary service delivery, interprofessional learning, relevant local clinical research, and a focus on local service innovation, enhancing rather than fragmenting the collective capacity of existing primary care

WORKFORCE

Lee,S. (2008). Is there a need for professional regulation for primary care mental health workers? ***Quality in Primary Care*****,** ***16*****(4), 263-267.**

http://pmid.us/18718163

Primary care mental health (PCMH) workers need not have a professional qualification. The development of the role of these workers highlights the influence of a number of factors that provide a framework that offers assurance of the protection of the public and the promotion of quality of care. Factors such as legislation, codes of practice, stringent recruitment procedures, clinical supervision, employing evidence-based practice, and training all play an equal part in determining safe and good practice. Together, these factors formulate standards of practice which limit the need for professional regulation. The training of PCMH workers is guided by a national curriculum and other requirements. Practice of these workers is governed by various legislative frameworks and guidance. The requirement for clinical supervision for PCMH workers is a crucial element in promoting safe and effective care. In addition, stringent recruitment procedures ensure unsuitable candidates are not selected for the positions. This paper argues that professional regulation is not needed as there are other systems with similar significance that promote quality of care and can offer protection to the public

O'Neill,M., & Cowman,S. (2008). Partners in care: investigating community nurses' understanding of an interdisciplinary team-based approach to primary care. ***Journal of Clinical Nursing*****,** ***17*** **(22), 3004-3011.**

http://dx.doi.org/10.1111/j.1365-2702.2008.02068.x

http://pmid.us/19012769

Aim. This study investigated community nurses understanding of teamwork in primary care. Background. Internationally trends indicate a movement towards the development of primary care as a key element in health service delivery. This will have implications for the organisation of community nursing services by creating the need for more coherent integrated structures for service delivery. In this context, teamwork is associated with a range of positive outcomes including higher levels of quality care and job satisfaction. Design. A research study was undertaken to investigate community nurses' understanding of an interdisciplinary team-based approach to primary care using a qualitative research design. Focus groups were held with community nurses working in the areas of public health nursing, general nursing and practice nursing. Methods. Three focus groups were established. Twenty seven participants were recruited to form three groups comprising public health nurses (n = 10), general nurses (n = 10) and practice nurses (n = 7). A sequenced-questioning framework guided the systematic process of data collection. Data analysis engaged a thematic content analysis framework. Results. The analysis of the data revealed the following themes: teamwork, promoting community services, promoting health, professional roles and skills and knowledge for primary care. Conclusion. Nurses can contribute significantly to the re-orientation and development of primary care services. There must be greater efforts to encourage interdisciplinary

approaches. The outcomes of this study can inform strategies for effective team working in primary care. Collective team efforts enhance patient care and effective teamwork requires a greater understanding of group processes and team development. Relevance to clinical practice. Nurses clearly articulated their contribution to primary care, but recognised that there are many challenges to overcome. An enhanced primary care team has the potential to allow the public access to both the individual and collective skills and knowledge of team members

Ro,K.E., et al (2008). Counselling for burnout in Norwegian doctors: one year cohort study. ***British Medical Journal 337*** **a2004.**

http://dx.doi.org/10.1136/bmj.a2004.

http://pmid.us/19001492

Objective: To investigate levels and predictors of change in dimensions of burnout after an intervention for stressed doctors. Design: Cohort study followed by self reported assessment at one year. Setting: Norwegian resource centre. Participants: 227 doctors participating in counselling intervention, 2003-5. Interventions: Counselling (lasting one day (individual) or one week (group based)) aimed at motivating reflection on and acknowledgement of the doctors' situation and personal needs. Main outcome measures: Levels of burnout (Maslach burnout inventory) and predictors of reduction in emotional exhaustion investigated by linear regression. Results: 185 doctors (81%, 88 men, 97 women) completed one year follow-up. The mean level of emotional exhaustion (scale 1-5) was significantly reduced from 3.00 (SD 0.94) to 2.53 (SD 0.76) (t=6.76, P<0.001), similar to the level found in a representative sample of 390 Norwegian doctors. Participants had reduced their working hours by 1.6 hours/week (SD 11.4). There was a considerable reduction in the proportion of doctors on full time sick leave, from 35% (63/182) at baseline to 6% (10/182) at follow-up and a parallel increase in the proportion who had undergone psychotherapy, from 20% (36/182) to 53% (97/182). In the whole cohort, reduction in emotional exhaustion was independently associated with reduced number of work hours/week (beta=0.17, P=0.03), adjusted for sex, age, and personality dimensions. Among men "satisfaction with the intervention" (beta=0.25, P=0.04) independently predicted reduction in emotional exhaustion. Conclusions: A short term counselling intervention could contribute to reduction in emotional exhaustion in doctors. This was associated with reduced working hours for the whole cohort and, in men, was predicted by satisfaction with the intervention