Welcome to the latest issue of your NIHR CLAHRC West Midlands News Blog.

Welcome to the latest issue of our News Blog where we discuss the underestimated issue of contingency in study design and interpretation. We also have two guest blogs - one on a new Family Health and Lifestyles service; and the other on a group to engage pregnant women and new mothers in research. In addition we look at recent work on surgical complications and patient satisfaction; how best to provide enhanced diagnostic services; the effect training has on cognitive decline; the wonderful clarity of orthopaedic trials; the effectiveness of management consultants; and comparing warfarin and DOACs in preventing stroke.

Further we have the latest news and events; funding opportunities; this issue's quiz question; showcase some of our latest publications; and have selected replies and a letter from a reader.

We hope that you find these posts of interest, and we welcome any comments. You can find previous issues of our News Blog here.
Correction: In the previous News Blog we mistakenly omitted an author from the Guest Blog on Digital Communications with Patients - the authors should have been listed as follows:

Frances Griffiths, Professor of Medicine in Society and Penny Kechagioglou, the Oncologist.

Our apologies for this error.

Director's Blog

The Underestimated Issue of Contingency in Study Design and Interpretation

Introduction
The central dogma of evidence-based care is that parameter estimates from clinical studies should inform clinical decisions. In its archetypal form the parameter estimates are obtained from head-to-head comparisons in randomised controlled trials (RCTs). Consider first clinical treatments, such as drugs, devices and talking therapies. Here, a target clinical population is defined in whom the treatment is hypothesised to have a beneficial effect – for instance the hypothesis that a left ventricular device for patients in Grade III heart failure may reduce the death rate within two years from 50% to 40% - a ten percentage point improvement. Such a treatment effect can be achieved with a sample of only 1,036 patients (false positive [alpha error] 5%; false negative [beta error] 10%). The same type of simple calculation can be performed across treatment types and outcomes – improve depression scores in people already depressed; pedagogic methods and examination scores in children sitting a particular examination.

Contingent effects
Consider now a diagnostic/screening test (hereafter called a ‘test’). Here again a population of interest would be described, pregnant women, say, or febrile patients. However, in this case the purpose of the population eligible for the test is to identify a further (sub) population – those eligible for treatment for the condition for which the person has tested positive. Here we wish to compare outcomes among a population given a test, but where the benefit is contingent on the treatment effect among those who test positive. This means that the intervention effect is greatly ‘diluted’ by all the people screening negative. Moreover, the dilution effect is not linear; for every halving of absolute effect size, the sample size needs to quadruple – other factors being equal. To put all this another way, the proportion of true positives among all tested, sets an upper limit for the benefit of a test. Take, for example, a test for postnatal depression, which occurs with sufficient severity to warrant treatment in, say, 10% of women. Consider a population of 10,000 pregnant women – 1,000 can expect to get postnatal depression. Standard screening methods can identify 60% of these women – 600 in our ‘population’. A new genetic test comes along that might identify a further 20%. In that case 80% of
Affected patients will be identified vs. 60% without the test. This amounts to 200 additional women in the original 10,000. Treatment can ‘cure’ depression in half of depressed women, so the incidence of depression in the screened population would drop by one percentage-point. These crude, indicative, figures are laid out below.

<table>
<thead>
<tr>
<th>Population</th>
<th>10,000 control</th>
<th>10,000 intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed</td>
<td>1,000</td>
<td>1,000</td>
</tr>
<tr>
<td>Not identified</td>
<td>400</td>
<td>200</td>
</tr>
<tr>
<td>Identified</td>
<td>600</td>
<td>800</td>
</tr>
<tr>
<td>‘Cured’</td>
<td>300</td>
<td>400</td>
</tr>
</tbody>
</table>

Difference of 100, or 1% of original population

*Indicative (not real) figures to calculate realistic outcomes for a population screening test.*

A trial to detect a one percentage point difference in outcome would require 14,200 participants; whereas a trial to determine the effect of a potential new treatment for use in screen positive women that could ‘cure’ 70% vs. a 50% control rate would require a total of only about 248 participants, other things being equal (α = 0.05; β = 0.9 and no loss to follow-up).

The same general principle applies to generic service delivery interventions that operate through a causal chain with contingent effects, such as this:

The mathematics of these cases have been worked out by our group elsewhere.[1-3]

In conclusion, it is important to model plausible effect sizes in advance to verify the plausibility of sample size calculations when the observed effect is contingent on upstream events in the causal chain. Causal thinking in clinical and service delivery research can help us identify realistic sample sizes for hypothesis tests.
Okay then, who was the father of neurosurgery?

Email CLAHRC WM your answer.

Answer to our previous quiz: The father of psychiatry is Dr Benjamin Rush (as well as being a Founding Father of the United States). Congratulations to Alan B Cohen and Marion Okoh who were first to answer correctly.

Guest Blog

Family Health and Lifestyles Service

Public Health departments up and down the UK have been rising to the challenge of redesigning services to place prevention at the heart of the health and social care system.

Here in Coventry, the opportunity to do things differently has been well and truly embraced. As a key example of this, a radical programme of redesign has led to the development of a new Family Health and Lifestyles service, bringing together seven services (health visiting, school nursing, family nurse partnership, infant feeding, a specialist BAME service, stop smoking in pregnancy, and a family weight management service) into one integrated service that supports families from the antenatal period through to the older childhood years, and extending to supporting families to achieve healthy lifestyles. We are being ambitious with our plans, moving to a life-course approach where the interconnectedness of opportunities to build resilient, physically, and mentally well families are viewed in their entirety rather than in isolation from each other.

The newly designed Family Health and Lifestyle service is designed to ensure that that key prevention aspects of the service are strengthened, supporting children, families and communities to be more resilient. We believe it’s simple – you cannot build a house on rocky foundations. Efforts to improve key public health priorities – such as healthy weight, active lifestyles, good child development, and children’s readiness for school –
will be hindered if children do not have good foundations to build upon. When we talk
about foundations we are talking about being resilient, having good emotional well-
being, children being raised by parents who are confident and competent in their
parenting skills, and families being well connected and supported by those in their wider
community. Our change in ethos and focus for our new Family Health and Lifestyles
service will ensure that the unique opportunities of universal and targeted service
interactions (with families and communities) are used to set in place these important
foundations that we know act as protective forces.

So what does this mean in practice? It means working to:

- Build a robust community offer, where staff act as community brokers, supporting
  parents to integrate and engage in their community.
- Deliver universal and proportionate parenting support, including specific support
  around positive attachment (i.e. bonds created between infant and primary care
giver, which are best developed when caring adults respond in warm, stimulating
  and consistent ways. This secure attachment with those close to them leads to the
development of empathy, trust and well-being) [Early Intervention: The Next
- Introduce new roles that offer support around transitions (acknowledging that life
  events, such as starting school, can be sources of anxiety for children and
  families, and, for some, dedicated time is needed to prepare for these transitions).
- Shift towards a strategic leadership offer to schools, rather than operational,
  working in partnership to understand the health needs of the school populations
  and to access evidenced based health and wellbeing programmes.
- Adopt assessment tools that explore the family, their strengths and needs, as a
  whole. So when the service interacts with families, for example, where a baby has
  recently been born, the lifestyle needs of the parents are also discussed, in
  addition to the traditional focus of childhood development.

Critical to the success of taking this newly designed service from a vision to a reality, is
the collaborative relationship that we will establish with the provider, building learning
and insight as we go. This includes measuring those things that are at the heart of the
service and taking a brave new step towards measuring less of the old and more of the
new. If the service is to have a greater focus on working with families to be part of a
supportive community, to build resilience, and so on, then the data collected needs to
support achievement of what we are calling ‘foundational outcomes’, particularly as
payments will eventually be linked to their achievement.

As outcomes that have not traditionally been measured or reported on, this is new
territory for both us as commissioners, and the provider. This is where CLAHRC WM
Theme 3 ‘Prevention and Detection of Diseases’ comes in. We are fortunate to be at the
beginning of an exciting programme of work with Kiya Hurley (Research Fellow at the
University of Birmingham) to identify a set of measures that can be used to measure
progress the following outcomes:

- Children and young people have good emotional wellbeing.
- Children have strong attachment to at least one adult.
- Children, young people and parents feel connected and included.
More families are resilient.

We hope at this stage that the picture is being built – here in public health we have a strong vision for the new Family Health and Lifestyles service. Despite our strength of vision we know these changes cannot happen in isolation. Integration, as a hot topic area in public sector transformation, offers the potential to join up the way we support families and maximise the resources available in a given locality. Families do not, and should not, see or experience the complexity of the systems we work in. It is our job to create the connections and create the environment that allows relationships and networks to be built between providers of care.

In Coventry we already have a long history of integrated working, having led Acting Early, a programme bringing together early years workers including midwives, children centre workers, and health visitors into locality based teams. Investment in leadership and integrated team development has gone a long way towards laying the foundations for integration of the public health workforce into the wider system. Because of this we are ahead of the game in this agenda. The next step for us is to lead the integration of the Family Health and Lifestyles service into the bigger jigsaw of which it is only one part. The jigsaw we are referring to is an early help jigsaw, where universal and early help services are bought together in a locality providing a ‘family hub’. Midwives, early help children’s services, family health, and lifestyle staff, schools, general practice, social care, police and the voluntary sector will eventually all connect through the Family Hubs in Coventry. To reflect our commitment to a learning culture we will be working with members of CLAHRC WM Theme 5, Implementation and Organisational Studies, Professor Graeme Currie and Dr Yaru Chen (Warwick Business School) to understand the potential successes and challenges that we, and other organisations, will face in working to design and develop a truly integrated approach to supporting individuals, families, and communities.

In this blog we have taken the opportunity to discuss the new way in which we are driving up ‘foundational outcomes’ through the new Family Health and Lifestyles service, and how we are pressing ahead with the integration agenda. We haven’t managed to touch on the innovative procurement approach we have adopted in securing the right organisation to deliver this service; nor the way in which we have completely overhauled how we use data (to see its value move far beyond measurement of contractual adherence). Also, we haven’t talked about the relentless focus we have built into the service on empowering staff to make continuous improvements to the service themselves and the drive to ensure parents, as leaders of their communities, can work hand in hand with staff on this agenda. However, what we have done is, hopefully, give you a taste of the approach we are taking to radically redesigning the way public health services support families in Coventry. With the work planned with CLAHRC WM the future looks exciting for us here in Coventry.

-- Sue Frossell, Consultant in Public Health, Coventry City Council
-- Christina Waling, Programme Manager in Public Health, Coventry City Council

Available at: http://mailchi.mp/32bcae324b68/clahrcwm-2018-02-23
“Bump, Talk ‘n’ Tone” –
New group to engage pregnant women and new mothers in research

Anyone who has had a baby, or supported someone during pregnancy, will know how much of a challenging time it is. In addition to coping with physical changes, women also have to prepare for the new arrival. The list of things an expectant mother has to do during the pregnancy is long and requires some skilful spinning of plates and juggling of balls: equipment to buy, nurseries to decorate, maternity leave to prepare for, hospital appointments to attend, baby showers to think about, etc. It probably comes as no surprise, therefore, that it’s hard to recruit pregnant women and new mothers-to-be for research projects. With so much going on in their lives, they often don’t have the time or mental space to engage with research and become involved in projects. But their views and experiences are important, and in CLAHRC West Midlands we recognise the value patient and public insights can bring to research projects.

Laura Goodwin, researcher in CLAHRC WM’s Maternity Theme, and Magdalena Skrybant, PPIE Lead, have tried to overcome this issue. They have secured funding from the Wellcome Trust to engage expectant mothers in the latest research that is relevant to them. To encourage women to attend sessions, they will receive a free pregnancy yoga session, followed by an opportunity to chat with other women and a midwife about pregnancy-related issues. A guest speaker will then lead an informal discussion about current local maternity research, providing women with an opportunity to get involved in projects that interest them. Many women already choose to take part in an exercise-based activity during pregnancy so it is hoped that we will be able to attract women to attend. The funding will cover the cost of the yoga instructor, refreshments and even spare yoga mats, so it is hoped that there will be minimal barriers for women to attend the sessions. We will also be running these informal research engagement sessions in Children’s Centres (without the yoga session), to try and determine which model of engagement is most successful and sustainable. CLAHRC West Midlands will be evaluating both engagement groups and measuring whether they help increase involvement in research from this under-represented group.

The implementation team are hosting some events in March to help us refine the details of the engagement sessions. At these events we will be working with women to decide when and where the sessions should take place, how we can best promote the activities to pregnant and early postnatal women, and how the sessions should be structured. We are very much looking forward to engaging this group in research, and we hope that this will lead to greater and more diverse involvement in future research.

For further information please contact Laura Goodwin L.Goodwin@bham.ac.uk or Magdalena Skrybant m.t.skrybant@bham.ac.uk.

-- Magdalena Skrybant & Laura Goodwin
Director's Choice - From the Journals

A Study Shows a Correlation Between Complications of Surgery and Patient Satisfaction: But That's Not the Point

Prabhu, et al. report on the above correlation in a small, single centre study.[1] But that's hardly the point – complications are not a sensitive or specific sign of poor care.[2] [3] That patients with complications are less satisfied is not news. The article cannot unravel the causal pathway, and is compatible with:

1. Poor care causes complications and independently causes less satisfaction (A causes B).
2. Complications cause less satisfaction, irrespective of how they arise (B causes A).
3. Certain patients are at risk, a priori, of being less satisfied and experiencing more complications (C causes A and B). Of course, controls for some co-variants, such as the Association of Anaesthetists risk classification, were included, but these were limited and I do not see any tests for interactions so the model assumes that confounders have the same effects across sub-groups.

More important are the clear findings reported elsewhere, that patient satisfaction is not a good monitor for the technical quality of clinical care.[4] [5] If this were not so, then market failure / information asymmetry would not be the problem it is in health care.

-- Richard Lilford, CLAHRC WM Director

Leave a comment

References

Limited Evidence on How to Go About Providing Enhanced Diagnostic Services in the Community

Chambers and colleagues have recently conducted a mapping review of the literature on provision of diagnostic services in the community.[1] There is a massive literature on the performance of various community based diagnostic testing strategies. That is to say, measuring the sensitivity, specificity and predictive value of testing. However, there is a much less well-developed literature on how to go about implementing such a service. The above review provides a good summary of the state of the science. The authors describe a framework covering skills, training, equipment, user perspectives, and the primary to secondary care interface. Diagnostic testing services varied widely from those that were relatively simple, such as pulse oximetry, to more complex services such as endoscopy and ultrasound. They found that there were many serious barriers to these more complex services. Most of these involved training and quality control, as well as availability of staff. There were also widespread perceptions that quality might suffer. Complex community-based diagnostic services may be another example of deployment
of technology that turns out to be much more complex than originally thought.[2] Advice to service managers: "do not plunge in, but look before you leap". CLAHRC WM works closely with local managers to identify barriers and facilitators to putative improved services.

-- Richard Lilford, CLAHRC WM Director

References

Does Physical or Cognitive Training Slow Cognitive Decline with Age and Delay Onset of Dementia?

Two careful reviews in Annals of Medicine review current trial evidence. This is a hard topic to study because interventions are heterogeneous, outcomes are multiple, they vary between studies, and long-term follow-up is required. As far as exercise is concerned, the evidence is simply insufficient. Cognitive training reduces cognitive decline in the particular cognitive task targeted by the training,[1] but does not seem to produce a global benefit.[2] These studies are based on people with normal functioning at baseline. I am nihilistic about the treatment of Alzheimer’s (so many null results). Hopefully preventive trials will produce some consistently positive findings. Unfortunately this study is not encouraging.

-- Richard Lilford, CLAHRC WM Director

References

Why the CLAHRC WM Director Loves Orthopaedic Trials

I love them because:

1. The outcomes are measured on a continuous functional scale, so that one-third of a standard deviation can be detected with a trial of about 500 patients, rather than the 5,000 needed for many mortality trials.
2. Outcomes are usually short-term; we do not need to wait for recurrence or death, for example.
3. It is possible to rapidly determine the effect of trial results on clinical practice through hospital databases, and confirm through orthopaedic registries.

CLAHRC WM is collaborating with CLAHRC East Midlands in evaluating all outputs from the NIHR HTA programme, and orthopaedic trials are proving particularly informative. We give three examples in the table below:

| Clark, et al. | Outpatient versus inpatient | Outpatient polyp treatment is effective, |

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how effective are management consultants?

CLAHRC WM collaborator Ian Kirkpatrick (University of Warwick) reports an interesting article on the effectiveness of management consultants in the NHS hospitals in England. [1] Across all such hospitals the mean yearly spend is £1.2m. I know of only one RCT of use of management consultants. [2] This was a study of garment manufacturing companies in India where the use of management consultants was associated with an upturn in productivity. The retrospective study of Kirkpatrick, et al. reaches the opposite conclusion. Their explanatory variable is deployment of a management consultant, and their outcome variable is a change in efficiency before and after the intervention. They also make use of the fact that different hospitals have deployed management consultants at different times, which strongly mitigates against a temporal trend in the intervention effectiveness. As I understand it each hospital acts as its own control, and these differences are then amalgamated across all hospitals. This mitigates (but does not eliminate) selection bias. [3] The authors are careful to allow for autocorrelation, that is lack of independence between the outcome variable within hospitals, and they adjust for all the expected covariates, such as hospital size and teaching status. The efficiency measure was derived from a publically available database comparing the average unit cost for providing diagnosis and treatment of the trust to the national average.

This is a unique and extremely provocative study. However, we need to be very careful in jumping to a cause and effect conclusion. Firstly, large regression-based studies should be interpreted cautiously, since important confounding variables may be omitted, and it is impossible to take into account all interactions (and first and higher orders).

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Second, we also need to consider reverse causality; it is possible that deployment of management consultants was prompted by managers’ pre-emptive response to challenges. All of that being said, I have not always been persuaded by the value of management consultants during the various director and non-executive director roles I have occupied. The management consultant model is rather different to the CLAHRC model. CLAHRCs make sure all relevant literature is taken into account, we explicate the causal pathways that may lead to both good and bad outcomes (pre-implementation testing / prospective evaluation), and we conduct proof of principle studies as a prelude to evaluation of larger interventions. In short, our approach is more sceptical.

-- Richard Lilford, CLAHRC WM Director

References

Preventing Strokes

Strokes affect over 100,000 people each year in the UK,[1] with atrial fibrillation (AF) being a contributing factor in around 20% of these cases.[2] In total there are around 1.2m people in the UK living with AF,[3] though estimates suggest another 500,000 remain undiagnosed,[4] and they have a five-fold risk of a stroke.[5] Most of these people are prescribed long-term anticoagulants as a preventive method, predominantly warfarin. However, use of warfarin requires regular monitoring to avoid complications, such as clot formation or uncontrolled bleeding. Therefore there is a need to improve the clinical utility of using anticoagulants as a preventive method – either by using direct-acting oral anticoagulants (DOACs) instead, or improving the use of warfarin.

A number of RCTs have been conducted, which showed that DOACs were the better option in terms of key indicators, having a wider therapeutic range, and as their use did not require regular monitoring. As such, NICE updated their guidance in 2014, advising that both DOACs and warfarin should be given equal weight at consultations. From this there has been an increase in the use of DOACs in clinical practice, and a corresponding increase in expenditure – more than £100 million in the NHS in 2015/16, and £400 million in 2016/17.[6] An article by Sir John Burn and Munir Pirmohamed published in Open Heart takes a look at the evidence for DOACs vs. warfarin,[6] and argues there are a number of major concerns with the use of DOACs:

- RCTs generally have a younger study population, with fewer comorbidities, and thus fewer adverse events. Further, there is not enough evidence on the impact of drug-drug interactions with DOACs.
- Analysis of prescription issuance shows that patients are less likely to adhere to regimes of DOACs, perhaps due to the lack of routine monitoring and that some of the drugs need to be taken twice a day.
- Evidence suggests a possible link between DOACs and myocardial infarction.

Instead, the authors argue that it is possible to improve the effectiveness of warfarin using a simple genotype guidance that identifies patients more suited to warfarin
treatment, and by increased adoption of home monitoring technology. This would also 
reduce the rising expenditure facing the NHS.

-- Peter Chilton, Research Fellow

Leave a comment

References

News & Events

CLAHRC WM Job Opportunity

CLAHRC West Midlands are seeking an administrator based at the University of 
Warwick on a fixed-term contract until 30 September 2019. The deadline for applications 
is 27 February 2018. For more information, please click here.

Flow Design Practical Skills Workshop

A one day Flow Design Practical Skills Workshop will be held on 14 or 15 March 2018 
in Sutton Coldfield, Birmingham. The workshop aims to demonstrate the principles of 
Improvement Science and how to ‘Diagnose and Treat’ the root causes of chronic 
queues, delays and chaos. Attendees will also be able to learn:

1. Map processes and systems.
2. Measure process and system behaviour.
3. Model the current state and diagnose the root causes of the chronic queues.
4. Create the charts that make the diagnosis and treatment visible and explainable.
5. Treat the commonest causes of queues: the process design.

The course is designed for service managers, practice managers, service development 
managers, programme management teams, transformation teams, clinicians, clinical 
scientists, AHPs, team leaders and trainees.

For more information please download this flyer, or visit: saasoft.co.uk/workshops.

West Midlands Training Conference

The NIHR Clinical Research Network are holding a training conference in Birmingham on Tuesday 27 March that will focus on success with research grants and fellowships. 
The event will showcase NIHR funding schemes, fellowship schemes, and how to 
access support from Patient and Public Involvement, the Research Design Service and registered Clinical Trial Units. For more information, please visit: goo.gl/CWp4tq. To confirm your place, please email Debbie.Peplow@nihr.ac.uk.

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Funding

PhD Opportunities

The Healthcare Improvement Studies (THIS) Institute has opened applications for PhD fellowships. These Fellowships may be held at any UK university, and offer talented researchers the opportunity to undertake high-quality studies that will advance the field of healthcare improvement research. Awards range from £137,500 to £276,000, and are intended to draw out fresh ideas about healthcare, from people with clinical or non-clinical backgrounds and from diverse fields including, for example, health services research, epidemiology, social science, law, business studies, philosophy or engineering.

Any UK university may apply to the scheme, with a maximum of two doctoral fellowship applications per university per funding round.

Applications close 19 March 2018. For more information, please visit: thisinstitute.cam.ac.uk/fellowships.

PhD Opportunity, University of Birmingham

A PhD opportunity is available at the University of Birmingham for a project on developing structured clinical handover tools for non-communicable diseases in India. For more information, please view this poster, or visit Find a PhD. The deadline for application is Friday 23 March 2018.

NIHR Funding Opportunities

The NIHR Health Services and Delivery Research Programme have the following opportunities available:

- 18/09 Health services and interventions for children and young people who have experienced online-facilitated abuse, including on-line grooming.
- 18/10 Research on interventions to improve the patient and family experience of complaints management and the decision to litigate against the NHS.
- 18/11 Improving the participation and conduct of health services research in nursing and care homes at scale.
- 18/12 Predicting failure of quality of care in NHS healthcare service provider organisations, and evidence for the interventions that lead to sustained improvement.

Selected Replies

Available at: http://mailchi.mp/32bcae324b68/clahrcwm-2018-02-23
Dear Richard,

You article questioning the dominant focus and greater preference for developing community (primary) care over hospital care in system-wide efforts to improve the health of the population is a fresh reminder for us not to just “follow the crowd”. I agree with your argument that in the urban slum setting, hospital can play a vital role in providing essential care to the population (in addition to their ‘usual role’ of providing specialist care). I wish to elaborate your idea and show that it does not necessarily contradict what was said in the Alma-Ata Declaration and Bamako Initiative. The apparent conflict in ideas arises from a more generic issue of non-standardised terminology in health services research.

For example the term ‘community’ is generally used in the Alma-Ata Declaration to signify bounded areas and people who live within them, which constitute the population the health care system aims to serve. However when we talk about community care vs hospital care, the term is used merely to indicate the location (outside of hospital) where the care takes place. Similarly, while we may naturally interpret ‘primary care’ as care taking place outside hospitals, the ‘primary health care’ advocated in the Alma-Ata Declaration was not defined as such. Rather, the essence of primary health care as defined in the Declaration lies with being the first port of contact with the health system, which should be universally accessible when needed (equity), and is responsive to the social value of the population which it serves (solidarity and participation) (Kruk, et al. 2015). Based on this interpretation, hospitals can indeed be very well positioned to offer primary health care (in the form of outpatient clinics) for urban communities – including slums – provided there is no barrier to access them. Here financial barriers is likely to be more important than the physical barrier of distance, which is crucial in rural settings.

Coming from a densely populated country, I know such a (non-slum) example of hospital-driven provision of primary health care well: in many cities in Taiwan, you won’t need to travel far to reach a high-standard, teaching hospital. These hospitals don’t just look after seriously ill patients. They have outpatient clinics which cover all medical specialities (including family medicine) and serve thousands of patients with chronic diseases and minor illnesses (who are free to choose hospitals and doctors without needing referral) each day. A large proportion of health care needs for people in the ‘community’ is thus met by hospitals. The system has worked well with universal coverage through national health insurance and received consistently high satisfaction from service users (Cheng 2015). An important challenge for such a service model, however, is coordination of care where patients require input from multiple specialities. This, along with the essential preventive care that you already mentioned, may be the areas where specialist-driven, disease-centred, hospital-based primary health care are particularly vulnerable and where generalist-led, person-centred ‘primary care’ (as generally understood in the UK) might have an edge over hospitals.

-- Yen-Fu Chen

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Re: The WISDAM Of Rupert Fawdry

Further to the article about Rupert Fawdrey’s system of hand held notes, it is has been my view for quite a few years, based on my own experience and that of others, that in all parts of the NHS and possibly social care we need to have patient-held records, unless there is a specific risk-based reason. This would mean clinicians trusting patients and carers who are generally quite capable to have, for example, their blood test results. This would cut down current issues where primary care and a neighbouring acute trust where the patient is being treated have computer systems that do not connect with each other, meaning the same blood tests are repeated in both. If the patient was allowed to hold the results they could pass them on to the relevant health professional, thus saving repeat blood tests and being cost-saving to the NHS, and time and cost-saving to the patients and those around them.

The other reason is a safety issue when emergency services are called to patients. Without a summary record held by the patient, the paramedics are potentially taking a history of someone with complex health issues from either the patient or their family and friends. Not being medically trained, they may mistakenly leave out an important medical detail in the stress of the situation, causing risk to the patient, and guilt and further burden to the family and friends, which can then impact their well-being and add to system cost. It is therefore important to an overburdened system, and for the well-being of the patients and their family and friends, that patient held records be implemented.

-- Debs Smith

Recent Publications


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