Issue No: 132 June 2018

The Clinical Effectiveness Bulletin aims to highlight some key pieces of evidence, published in the previous month.

Where possible, links to the full text documents are included. If you are employed by UHNIM, NSCHT, Stoke on Trent Public Health, or you are CCG or practice staff in North Staffordshire, get in touch to find out more about your NHS library service.
Current Sources:

Cochrane Library  http://www.thecochranelibrary.com/
Health Technology Assessment (HTA) Database  http://www.journalslibrary.nihr.ac.uk/hta
https://discover.dc.nihr.ac.uk/portal/home
Department of Health http://www.gov.uk/dh
King’s Fund http://www.kingsfund.org.uk/
Nice Guidance  https://www.nice.org.uk/guidance/published
Social Care Institute for Excellence http://www.scie.org.uk/
SIGN http://www.sign.ac.uk/our-guidelines.html
Primary Care Commissioning www.pcc-cic.org.uk
Chartered Society of Physiotherapy www.csp.org.uk
Queen’s Nursing Institute: http://www.qni.org.uk/
NMC www.nmc.org.uk
RCN https://www.rcn.org.uk/professional-development/publications
Campbell Collaboration  http://www.campbellcollaboration.org/
Local patient and public information groups
https://bmcmusculoskeletdisord.biomedcentral.com/
https://archivesphysiotherapy.biomedcentral.com/

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Commissioning

NHS Community Services: Taking Centre Stage

Welcome to the third edition in our series of reports that examine the state of the NHS provider sector. Our latest assessment sets out to provide a valuable commentary on how the community services provider sector is performing, the challenges that community service providers are facing, and the solutions that will enable success as we head towards a longer term funding settlement.

This is a crucial area of care for the NHS as it covers a diverse range of services delivered in the community that help keep people well throughout their lifetime. As they work closely with primary, social and acute care, community services can be considered as the glue that holds the wider health and care system together.

Community services need to be at the heart of local health and care provision in all systems, but for too long they have been marginalised and not given enough priority at national and local level. That needs to change and our report makes the case for why community services need to be centre stage as we move towards more integrated health and care systems.

Despite the fact that the NHS has long been committed to expanding and strengthening community services, and the birth of sustainability and transformation partnerships should have provided an ideal opportunity for this, this expansion and strengthening has not happened. Our research has identified seven key barriers that need national attention to make the rhetoric of strengthening and expanding community services a reality.

The report provides a unique combination of our own policy analysis and commentary, published data, and, most importantly, the views of the chairs and chief executives who run community, hospital, mental health, and ambulance services in England. We also interviewed several leaders of community interest companies to ensure their contribution to and perspective on the health and care system is taken into account.

We are grateful to the trust chairs and chief executives, and community interest company leaders, who took the time to complete the survey and participate in interviews. The report would not be possible without these contributions, and we hope our report does justice to them.

Using data in the NHS: the implications of the opt-out and GDPR

King’s Fund

Key messages

- Patient data is not only vital for managing an individual’s care, it also plays an important role in other ways: planning health services, improving diagnosis and treatment and evaluating the effectiveness of policy. These ‘secondary uses’ of data offer significant opportunities to improve care, especially if advances in technology and data analysis can be harnessed.
- Public confidence in data-sharing has been tested by several high-profile breaches of data security and confidentiality, while the NHS is still recovering from the controversy associated with the care.data programme. Nevertheless, the public trust NHS organisations to manage
patient data, and there is strong support for data being shared to improve care and for further research.

- Safeguards governing the secondary use of patient data have been strengthened in recent years and will be bolstered by the implementation of a new national data opt-out alongside the introduction of the General Data Protection Regulation (GDPR) on 25 May 2018.
- These changes will not have any impact on depersonalised datasets, so most secondary analysis and research will be unaffected. However, analysis that relies on using confidential patient information – including some of the national patient surveys and specific efforts to evaluate NHS services and conduct research – may be affected.
- The consequences will depend on opt-out rates. If large numbers of people opt out of allowing confidential patient information to be used for research, this could affect the quality and validity of the data on which this research depends, potentially undermining important work to improve services and treatments.
- National policy has to keep a balance between responding to legitimate public concern about the security and confidentiality of data and enabling data to be shared and used by NHS organisations and third parties. It is also essential that NHS national bodies are transparent with the public about how patient data is used.
- NHS England and NHS Digital must ensure that opt-out levels are kept under review and put in place a long-term plan to promote the benefits of NHS organisations and third parties being able to access and use patient data. At the same time, NHS organisations must ensure they are beyond reproach in the way they use patient data.

### Hypothecated funding for health and social care: how might it work?

**King’s Fund**

Hypothecation – the earmarking of a tax to be spent on a specific area of public expenditure – is back on the political agenda. All the major parties seem agreed that a longer-term and sustainable settlement for NHS expenditure – and quite possibly one for social care as well – is now desirable. Hypothecation is being debated, across the political parties and by other think tanks, as one of the routes by which the money for that could be found.

There are strong advocates and equally strong opponents of hypothecation. This short paper examines both sides of the argument. It seeks to set out the problems hypothecation is meant to solve, and the conditions under which it might do so, and provides a brief history of hypothecation in the UK.

### A fork in the road: next steps for social care funding reform

**King’s Fund**

The costs of social care funding options, public attitudes to them – and the implications for policy reform

This paper pulls together new financial modelling, public perceptions work and policy analysis to identify the problems with adult social care in England and outline options for its reform. It does not aim to make firm proposals or recommendations but rather to identify and make explicit the advantages and disadvantages, impact and consequences of adopting one option over another. It concludes that reforming the current system will be expensive, but that if reform is chosen, England is
now at a clear ‘fork in the road’ between a better means-tested system and one that is more like the NHS; free at the point of use for those who need it.

'The world's biggest quango' the first five years of NHS England

King’s Fund
In this study, commissioned jointly by the Institute for Government and The King's Fund, Nicholas Timmins explores the fate of one of the central provisions of the Health and Social Care Act, NHS England, established as a statutorily independent board with the aim of distancing politicians from the day-to-day running of the NHS.

'The world’s biggest quango' draws on extensive, often exclusive, interviews, with some of those most intimately involved in the first five years of NHS England.

It doesn’t attempt to analyse the whole of the effect of the Act. It has a much narrower focus – to ask whether the objectives of establishing a statutorily independent board were fulfilled or disappointed. And, given that much of what has happened has turned out to be distinctly different from the original intentions of the legislation, what might be learnt from the first five years' existence of "the world’s biggest quango"?

Spending on and availability of health care resources: how does the UK compare to other countries?

King’s Fund
The recent announcement by the Prime Minister to bring forward a new long-term funding settlement for the NHS means it is timely to look at how health spending in the UK compares to other countries and how the NHS measures up on some of the key resources this spending pays for.

Although it can be difficult to find data on health care resources on a comparable basis across countries, international comparisons can still provide useful context for the debate about how much funding the NHS might need in future. There is also precedent for this approach – for example, when Tony Blair famously pledged on the ‘Breakfast with Frost’ programme in 2000 to get health spending up to the European Union average.

Various organisations undertake analysis to compare different health systems around the world. For example, the US-based think tank the Commonwealth Fund compares the performance of health systems in a number of developed countries using a wide range of indicators, finding that the UK scores very highly on measures of administrative efficiency and delivering equitable and timely access to care but performs poorly on health outcomes.

In this briefing, we focus specifically on a small number of key resources – staff, beds, equipment and medicines – using data from the Organisation for Economic Co-operation and Development (OECD). We also update our analysis of how much the UK spends on health care under the new System of Health Accounts 2011 methodology, which has led to substantial changes in what is classed as ‘health care spending’.
Homeshare Partnership Programme Evaluation

SCIE
Research published in May 2018 by Lloyds Bank Foundation for England and Wales and the Big Lottery Fund, revealed how intergenerational homesharing can help reduce loneliness and isolation, improve wellbeing and address the lack of affordable housing options. The homeshare model is based on trust and friendship, allowing people to ‘live well’ within their chosen communities.

The evaluation, commissioned by SCIE and conducted by Traverse, looked at what works to develop a sustainable homeshare scheme, through:

- Identifying which approaches and activities work best as well as barriers
- Assessing the cost and benefits of the schemes
- Identifying what would encourage a wider take up of homeshare, through the development of a framework of factors to be used by commissioners to assess bids for homeshare schemes.

The evaluation found that the homeshare model:

- reduces loneliness and improves wellbeing by offering companionship and facilitating intergenerational relationships
- provides affordable housing for younger people who are often priced out.

The evaluation was funded by Lloyds Bank Foundation for England and Wales (LBF) and the Big Lottery Fund (BLF), who have collectively invested £2m in the Homeshare Partnership programme. The programme included supporting the set up of homeshare schemes at eight sites in England and Scotland, to test and develop the model. Further details about these sites are provided in the report.

Heatwave Plan for England

Public Health England, Department of Health and Social Care, and NHS England

The Heatwave Plan for England is intended to protect the population from heat-related harm to health.

NHS England announces new £10 million fund to help retain GPs

NHS England

Some £7 million will be made available through regional-based schemes to help GPs to stay in the workforce, by promoting new ways of working and by offering additional support through a new Local GP Retention Fund.

A further £3 million will also be made available to establish seven intensive support sites across the country in areas that have struggled most to retain GPs. Details on these sites and plans for retention efforts there will be announced next month.

The fund will support local health services focussing on supporting newly qualified GPs or those within their first five years of practice, who are seriously considering leaving general practice or who are no longer clinically practising in the NHS in England but remain on the National Performers List (Medical).
End of life care in England: A briefing paper
Institute for Public Policy Research
Death is an inevitable part of life. We will all die and almost all of us will experience the death of someone close to them. Dying is an incredibly important life stage, but for too many people the end of life can often be an unnecessarily difficult experience.

Every year in England and Wales over 500,000 people die. For three-quarters of these people, death does not come suddenly. Instead, dying is a process that may take days, weeks or even years, involving a progressive decline in functioning and frequent interactions with health professionals. During this time, many receive some form of end of life care, designed to ease any pain or distress caused by their symptoms, and to maximise their quality of life until the moment of their death.

The value of this care cannot be understated, not just for those people who are reaching the end of their lives but also for their families and carers.

Public Health and Lifestyle Services

Scientific expert reaction to new Cochrane Review on HPV vaccine for cervical cancer prevention in girls and women
Cochrane Collaboration
New evidence published today in the Cochrane Library shows that human papilloma virus (HPV) vaccines protect against cervical lesions in young women, particularly in those who are vaccinated between the ages of 15 and 26. It also summarizes findings on harms that have been assessed in randomized controlled trials.

Prophylactic vaccination against human papillomaviruses to prevent cervical cancer and its precursors
Cochrane Library
There is high-certainty evidence that HPV vaccines protect against cervical precancer in adolescent girls and young women aged 15 to 26. The effect is higher for lesions associated with HPV16/18 than for lesions irrespective of HPV type. The effect is greater in those who are negative for hrHPV or HPV16/18 DNA at enrolment than those unselected for HPV DNA status. There is moderate-certainty evidence that HPV vaccines reduce CIN2+ in older women who are HPV16/18 negative, but not when they are unselected by HPV DNA status.

We did not find an increased risk of serious adverse effects. Although the number of deaths is low overall, there were more deaths among women older than 25 years who received the vaccine. The deaths reported in the studies have been judged not to be related to the vaccine. Increased risk of adverse pregnancy outcomes after HPV vaccination cannot be excluded, although the risk of miscarriage and termination are similar between trial arms. Long-term of follow-up is needed to monitor the impact on cervical cancer, occurrence of rare harms and pregnancy outcomes.
Sugar Reduction Programme, Progress made by industry in the first year

PHE
The sugar reduction programme challenges the food industry – retailers, manufacturers, restaurants, cafés, takeaways, pubs, entertainment chains and delivery services – to reduce sugar in their most popular products commonly consumed by children.

The challenge we’ve set is to reduce sugar in these products by 20% by 2020, with 5% in the first year of the programme (August 2016 to August 2017).

These products cover ten categories: breakfast cereals, chocolate confectionary, sweet confectionary, yogurts and fromage frais, ice cream, lollies and sorbets, sweet spreads and sauces, cakes, biscuits, puddings, and morning goods such as croissants and buns.

To help industry achieve this, PHE produced guidelines for the amount of sugar per 100g and calories in products consumed on one occasion.

If this action is successful, 200,000 tonnes of sugar could be removed from the UK market per year by 2020.

Air pollution: a tool to estimate healthcare costs

PHE
A tool to help local authorities estimate the burden of air pollution on the health care system.

Face-to-face interventions for informing or educating parents about early childhood vaccination

Cochrane Library
There is low- to moderate-certainty evidence suggesting that face-to-face information or education may improve or slightly improve children's vaccination status, parents' knowledge, and parents' intention to vaccinate.

Face-to-face interventions may be more effective in populations where lack of awareness or understanding of vaccination is identified as a barrier (e.g. where people are unaware of new or optional vaccines). The effect of the intervention in a population where concerns about vaccines or vaccine hesitancy is the primary barrier is less clear. Reliable and validated scales for measuring more complex outcomes, such as attitudes or beliefs, are necessary in order to improve comparisons of the effects across studies.

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The Heatwave Plan for England is intended to protect the population from heat-related harm to health.
**Health economics: a guide for public health teams**

**Public Health England**

Resources to help local commissioners achieve value for money by estimating the return on investment (ROI) and cost-effectiveness of public health programmes.

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**General Practice**

**NHS England announces new £10 million fund to help retain GPs**

**NHS England**

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**Continuous low-dose antibiotic prophylaxis to prevent urinary tract infection in adults who perform clean intermittent self-catheterisation: the AnTIC RCT**

**NIHR**

**Background**

People carrying out clean intermittent self-catheterisation (CISC) to empty their bladder often suffer repeated urinary tract infections (UTIs). Continuous once-daily, low-dose antibiotic treatment (antibiotic prophylaxis) is commonly advised but knowledge of its effectiveness is lacking.

Objective: To assess the benefit, harms and cost-effectiveness of antibiotic prophylaxis to prevent UTIs in people who perform CISC.
Design: Parallel-group, open-label, patient-randomised 12-month trial of allocated intervention with 3-monthly follow-up. Outcome assessors were blind to allocation.

Setting: UK NHS, with recruitment of patients from 51 sites.

Participants: Four hundred and four adults performing CISC and predicted to continue for ≥ 12 months who had suffered at least two UTIs in the previous year or had been hospitalised for a UTI in the previous year.

Interventions: A central randomisation system using random block allocation set by an independent statistician allocated participants to the experimental group [once-daily oral antibiotic prophylaxis using either 50 mg of nitrofurantoin, 100 mg of trimethoprim (Kent Pharmaceuticals, Ashford, UK) or 250 mg of cefalexin (Sandoz Ltd, Holzkirchen, Germany); n = 203] or the control group of no prophylaxis (n = 201), both for 12 months.

Main outcome measures: The primary clinical outcome was relative frequency of symptomatic, antibiotic-treated UTI. Cost-effectiveness was assessed by cost per UTI avoided. The secondary measures were microbiologically proven UTI, antimicrobial resistance, health status and participants’ attitudes to antibiotic use.

Results: The frequency of symptomatic antibiotic-treated UTI was reduced by 48% using prophylaxis [incidence rate ratio (IRR) 0.52, 95% confidence interval (CI) 0.44 to 0.61; n = 361]. Reduction in microbiologically proven UTI was similar (IRR 0.49, 95% CI 0.39 to 0.60; n = 361). Absolute reduction in UTI episodes over 12 months was from a median (interquartile range) of 2 (1–4) in the no-prophylaxis group (n = 180) to 1 (0–2) in the prophylaxis group (n = 181). The results were unchanged by adjustment for days at risk of UTI and the presence of factors giving higher risk of UTI. Development of antimicrobial resistance was seen more frequently in pathogens isolated from urine and Escherichia coli from perianal swabs in participants allocated to antibiotic prophylaxis. The use of prophylaxis incurred an extra cost of £99 to prevent one UTI (not including costs related to increased antimicrobial resistance). The emotional and practical burden of CISC and UTI influenced well-being, but health status measured over 12 months was similar between groups and did not deteriorate significantly during UTI. Participants were generally unconcerned about using antibiotics, including the possible development of antimicrobial resistance.

Limitations: Lack of blinding may have led participants in each group to use different thresholds to trigger reporting and treatment-seeking for UTI.

Conclusions: The results of this large randomised trial, conducted in accordance with best practice, demonstrate clear benefit for antibiotic prophylaxis in terms of reducing the frequency of UTI for people carrying out CISC. Antibiotic prophylaxis use appears safe for individuals over 12 months, but the emergence of resistant urinary pathogens may prejudice longer-term management of recurrent UTI and is a public health concern. Future work includes longer-term studies of antimicrobial resistance and studies of non-antibiotic preventative strategies.
**Chronic obstructive pulmonary disease: beclometasone, formoterol and glycopyrronium (Trimbow)**

**NICE Evidence Summary**

This evidence summary discusses 3 randomised controlled trials (TRILOGY, TRINITY and TRIBUTE) looking at the safety and efficacy of beclometasone/formoterol/glycopyrronium in people with COPD with severe or very severe airflow limitation, symptoms despite treatment and a history of exacerbations.

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**Point-of-care diagnostic testing in primary care for strep A infection in sore throat**

**NICE Medtech innovation briefing**

- The 11 technologies described in this briefing are point-of-care tests for diagnosing group A beta-haemolytic streptococcus (strep A) throat infection.
- The innovative aspects are the fast turnaround time compared with laboratory culture of throat swabs, allowing potential use in primary care.
- The intended use would be in addition to clinical scoring systems, to increase diagnostic confidence of a suspected strep A infection and guide antibiotic prescribing for people presenting with sore throat in primary care and community pharmacies.
- The main points from the evidence summarised in this briefing are from 4 prospective studies, 1 pilot study and 1 systematic review, including 102,694 patients, of whom 3,552 were tested with the technologies described in this briefing. The evidence, which covers 5 of 11 tests included in the briefing, suggests that point-of-care tests are more helpful for diagnosing strep A infection than clinical scoring systems alone in people with acute sore throat.
- Key uncertainties around the technology are the lack of an established NHS care pathway for using strep A tests. There are also differences in diagnostic accuracy depending on the patient population tested.
- The cost of point-of-care strep A tests varies depending on the technology, from £0.80 per test with no additional costs to £50 per test with an additional reader cost of £17,339.27 (excluding VAT).
- The resource impact would initially be greater than standard care because of the additional test costs. This could be offset if their use led to better antimicrobial stewardship and helped to reduce antimicrobial resistance and improved patient education and satisfaction.

This briefing describes technologies that fulfil a similar purpose. During development, every effort was made to identify and include relevant technologies but others may not have been identified, or may have been excluded when important information was unavailable.

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**Heatwave Plan for England**

**Public Health England, Department of Health and Social Care, and NHS England**

The Heatwave Plan for England is intended to protect the population from heat-related harm to health.
Patients with Chronic Fatigue Syndrome needed for new study  
Primary Care and Health Sciences, Keele University

Researchers at Keele University are looking for people with Chronic Fatigue Syndrome (CFS) or Myalgic Encephalomyelitis (ME) to discuss a study which aims to give a better understanding of the support needs of people suffering with the condition. A meeting will be taking place at Keele University on Thursday 21st June 2018, 10am – midday. If you would like to take part, or need further information, then please get in touch with Laura Campbell l.campbell@keele.ac.uk / 01782 734727.

Risk classification of patients referred to secondary care for low back pain  
BMC Musculoskeletal Disorders

Background
Nonspecific low back pain is characterized by a wide range of possible triggering and conserving factors, and initial screening needs to scope widely with multilevel addressment of possible factors contributing to the pain experience. Screening tools for classification of patients have been developed to support clinicians. The primary aim of this study was to assess the criterion validity of STarT Back Screening Tool (STarT Back) against the more comprehensive Örebro Musculoskeletal Pain Questionnaire (ÖMPSQ), in a Norwegian sample of patients referred to secondary care for low back pain. Secondary aims were to assess risk classification of the patients, as indicated by both instruments, and to compare pain and work characteristics between patients in the different STarT Back risk categories.

Methods
An observational, cross-sectional survey among patients with low back pain referred to outpatient secondary care assessment at Trondheim University Hospital, Norway. Cohen’s Kappa coefficient, Pearson’s r and a Bland-Altman plot were used to assess criterion validity of STarT Back against ÖMPSQ. Furthermore, linear regression was used to estimate mean differences with 95% CI in pain and work related variables between the risk groups defined by the STarT Back tool.

Results
A total of 182 persons participated in the study. The Pearsons correlation coefficient for correspondence between scores on ÖMPSQ and STarT Back was 0.76. The Kappa value for classification agreement between the instruments was 0.35. Risk group classification according to STarT Back allocated 34.1% of the patients in the low risk group, 42.3% in the medium risk, and 23.6% in the high risk group. According to ÖMPSQ, 24.7% of the participants were allocated in the low risk group, 28.6% in the medium risk, and 46.7% in the high risk group. Patients classified with high risk according to Start Back showed a higher score on pain and work related characteristics as measured by ÖMPSQ.

Conclusion
The correlation between score on the screening tools was good, while the classification agreement between the screening instruments was low. Screening for work factors may be important in patients referred to multidisciplinary management in secondary care.

**Cartilage calcification of the ankle joint is associated with osteoarthritis in the general population**

*BMC Musculoskeletal Disorders*

**Background**
Cartilage calcification (CC) is associated with osteoarthritis (OA) in weight-bearing joints, such as the hip and the knee. However, little is known about the impact of CC and degeneration on other weight-bearing joints, especially as it relates to the occurrence of OA in the ankles. The goal of this study is to analyse the prevalence of ankle joint cartilage calcification (AJ CC) and to determine its correlation with factors such as histological OA grade, age and BMI in the general population.

**Methods**
CC of the distal tibia and talus in 160 ankle joints obtained from 80 donors (mean age 62.4 years, 34 females, 46 males) was qualitatively and quantitatively analysed using high-resolution digital contact radiography (DCR). Correlations with factors, such as the joint’s histological OA grade (OARSI score), donor’s age and BMI, were investigated.

**Results**
The prevalence of AJ CC was 51.3% (95% CI [0.40, 0.63]), independent of gender (p = 0.18) and/or the joint’s side (p = 0.82). CC of the distal tibia was detected in 35.0% (28/80) (95% CI [0.25, 0.47]) and talar CC in 47.5% (38/80) (95% CI [0.36, 0.59]) of all cases. Significant correlations were noted between the mean amount of tibial and talar CC (r = 0.59, p = 0.002), as well as between the mean amount of CC observed in one ankle joint with that of the contralateral side (r = 0.52, p = 0.02). Furthermore, although the amount of AJ CC observed in the distal tibia and talus correlated with the histological OA-grade of the joint (r = 0.70, p < 0.001 and r = 0.72, p < 0.001, respectively), no such correlation was seen in the general population with relation to age (p = 0.32 and p = 0.49) or BMI (p = 0.51 and p = 0.87).

**Conclusion**
The prevalence of AJ CC in the general population is much higher than expected. The relationship between the amount of AJ CC and OA, independent of the donors’ age and BMI, indicates that CC may play a causative role in the development of OA in ankles.

**Psychosocial predictors for outcome after total joint arthroplasty: a prospective comparison of hip and knee arthroplasty**

*BMC Musculoskeletal Disorders*

**Background**
As findings regarding predictors for good outcome after total joint arthroplasty are highly inconsistent, aim of this study was to investigate the influence of the psychosocial variables sense of coherence and social support as well as mental distress on physical outcome after surgery. It should be investigated if different predictors are important in patients after total hip arthroplasty (THA) compared to patients after total knee arthroplasty (TKA).
Methods
In a prospective design, 44 patients undergoing THA and 61 patients undergoing TKA were examined presurgery and 6 and 12 weeks after surgery using WOMAC (disease-specific outcome), SF-36 (health-related quality of life), BSI (psychological distress), SOC-13 (sense of coherence), and F-SozU (social support). Changes over time were calculated by analyses of variance with repeated measures. Stepwise multiple linear regression analyses were computed for each group to predict scores of WOMAC total and all WOMAC subscales 12 weeks postoperatively.

Results
THA as well as TKA patients experienced improvements in all parameters (effect sizes for WOMAC scores between $\eta^2 = .387$ and $\eta^2 = .631$) with THA patients showing even better results than TKA patients. WOMAC scores 12 weeks after surgery were predicted predominantly by WOMAC baseline scores in TKA with an amount of explained variance between 9.6 and 19.5%. In THA, 12-weeks WOMAC scores were predicted by baseline measures of psychosocial aspects (anxiety, sense of coherence, social support). In this group, predictors accounted for 17.1 to 31.6% of the variance.

Conclusions
Different predictors for outcome after total joint arthroplasty were obtained for THA and TKA patients. Although psychosocial aspects seemed to be less important in TKA patients, preoperatively, distressed patients of both groups should be offered interventions to reduce psychological distress to obtain better outcomes after surgery.

A controlled before-after study to evaluate the effect of a clinician led policy to reduce knee arthroscopy in NSW
BMC Musculoskeletal Disorders
Background
Clinical evidence shows knee arthroscopy has little benefit for degenerative conditions and considerable variation in the incidence of knee arthroscopy in Australia has been identified. This study aimed to evaluate a clinician-led evidence-based policy which was implemented in one local health district in New South Wales (NSW) in 2012 to reduce the use of knee arthroscopy for patients aged 50 years or over.

Methods
Trends in rates and volume of knee arthroscopy for patients 50 years or over in NSW between 2004 and 2015 by district were examined. Changes at four hospitals that adopted the policy were assessed by a quasi-experimental before and after study design with control groups, using the generalised estimating equations (GEE) Poisson model. Each case hospital was matched with four control hospitals in terms of the volume of knee arthroscopy surgeries performed in the five years prior to the intervention.

Results
Between 2004 and 2015, the number of knee arthroscopies in NSW initially increased and then decreased after 2011, with considerable variation across districts. While an overall reducing trend in NSW was observed between 2011 and 2015 (39%), a 58% reduction (95% CI: 55–62%) was found in the intervention district, including the private sector, being the greatest reduction found in all districts. The GEE Poisson results show that, compared with control hospitals, the number of knee
arthroscopy was significantly reduced by 56% (95% CI: 11%–79%) at four hospitals that adopted the policy during the follow-up period (p = 0.02).

Conclusions
Clinicians in one local health district initiated a policy to restrict knee arthroscopy for patients aged 50 years or over, which may explain the greater reduction seen in that district compared to all others, despite an overall decrease noted in the state. A significant reduction found at intervened hospitals proved the effect of the policy, suggesting that the implementation of a simple clinical governance process may help reduce inappropriate surgery.

Health Visiting and Nursing

**Educational interventions for improving primary caregiver complementary feeding practices for children aged 24 months and under**

**Cochrane Library**
Education reduced the number of caregivers that introduced semi-solid foods to their infants before six months of age by up to 12% (moderate-quality evidence). Hygiene practices of caregivers who received education also showed some improvement compared to those that did not (moderate-quality evidence). In studies conducted in the community, education increased the duration of exclusive breastfeeding, but not in studies conducted in health facilities. There was no convincing evidence of an effect of education on the growth of children (low to very low-quality evidence). We could not combine the results from different studies for diarrhoea, knowledge of caregivers and adequacy of complementary food. However, from the individual reports of the study authors, education led to a reduction in diarrhoea and an improvement in the knowledge of caregivers. It also led to improvement in the quality and quantity of complementary foods fed to infants. Overall, we found evidence that education improves complementary feeding practices.

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Background
People carrying out clean intermittent self-catheterisation (CISC) to empty their bladder often suffer repeated urinary tract infections (UTIs). Continuous once-daily, low-dose antibiotic treatment (antibiotic prophylaxis) is commonly advised but knowledge of its effectiveness is lacking.

Objective: To assess the benefit, harms and cost-effectiveness of antibiotic prophylaxis to prevent UTIs in people who perform CISC.

Design: Parallel-group, open-label, patient-randomised 12-month trial of allocated intervention with 3-monthly follow-up. Outcome assessors were blind to allocation.

Setting: UK NHS, with recruitment of patients from 51 sites.

Participants: Four hundred and four adults performing CISC and predicted to continue for ≥ 12 months who had suffered at least two UTIs in the previous year or had been hospitalised for a UTI in the previous year.

Interventions: A central randomisation system using random block allocation set by an independent statistician allocated participants to the experimental group [once-daily oral antibiotic prophylaxis using either 50 mg of nitrofurantoin, 100 mg of trimethoprim (Kent Pharmaceuticals, Ashford, UK) or 250 mg of cefalexin (Sandoz Ltd, Holzkirchen, Germany); n = 203] or the control group of no prophylaxis (n = 201), both for 12 months.

Main outcome measures: The primary clinical outcome was relative frequency of symptomatic, antibiotic-treated UTI. Cost-effectiveness was assessed by cost per UTI avoided. The secondary measures were microbiologically proven UTI, antimicrobial resistance, health status and participants’ attitudes to antibiotic use.

Results: The frequency of symptomatic antibiotic-treated UTI was reduced by 48% using prophylaxis [incidence rate ratio (IRR) 0.52, 95% confidence interval (CI) 0.44 to 0.61; n = 361]. Reduction in microbiologically proven UTI was similar (IRR 0.49, 95% CI 0.39 to 0.60; n = 361). Absolute reduction in UTI episodes over 12 months was from a median (interquartile range) of 2 (1–4) in the no-prophylaxis group (n = 180) to 1 (0–2) in the prophylaxis group (n = 181). The results were unchanged by adjustment for days at risk of UTI and the presence of factors giving higher risk of UTI. Development of antimicrobial resistance was seen more frequently in pathogens isolated from urine and Escherichia coli from perianal swabs in participants allocated to antibiotic prophylaxis. The use of prophylaxis incurred an extra cost of £99 to prevent one UTI (not including costs related to increased antimicrobial resistance). The emotional and practical burden of CISC and UTI influenced well-being, but health status measured over 12 months was similar between groups and did not deteriorate significantly during UTI. Participants were generally unconcerned about using antibiotics, including the possible development of antimicrobial resistance.

Limitations: Lack of blinding may have led participants in each group to use different thresholds to trigger reporting and treatment-seeking for UTI.

Conclusions: The results of this large randomised trial, conducted in accordance with best practice, demonstrate clear benefit for antibiotic prophylaxis in terms of reducing the frequency of UTI for people carrying out CISC. Antibiotic prophylaxis use appears safe for individuals over 12 months, but
the emergence of resistant urinary pathogens may prejudice longer-term management of recurrent UTI and is a public health concern. Future work includes longer-term studies of antimicrobial resistance and studies of non-antibiotic preventative strategies.

**Heatwave Plan for England**
Public Health England, Department of Health and Social Care, and NHS England
The Heatwave Plan for England is intended to protect the population from heat-related harm to health.

**Ambitious new education standards will shape the future of nursing for next generation**
NMC
The first nurses can begin training against the new standards as early as January 2019
Last week we launched ambitious new standards that set out the skills and knowledge the next generation of nurses need. We also introduced a more modern and innovative approach to the way universities and their practise partners train nurses and midwives. The changes will allow greater independence of assessment, and greater innovation by placement providers.
The new standards represent two years’ work and have been developed alongside nurses - as well as students, educators, healthcare professionals, charities and patient groups from across the UK.

**The Best Start: The Future of Children’s Health – One Year on. Valuing school nurses and health visitors in England**
Royal College of Nursing
In May 2017 the RCN reported on the significant decline in school nurses and an emerging trend of reductions in the health visiting workforce and included a number of recommendations addressed to the Government, local authorities and Health Education England. This short paper is focused on the position in England and therefore aims to update and build upon the issues covered in last year’s report.

**Supporting children's nurses working outside of a designated ward/department**
Royal College of Nursing
Updated 2018 guidance, designed as a checklist that can be used when considering the support, guidance, management and education framework required for children's nurses working outside of a designated ward/department.

**Staffing for Safe and Effective Care**
Royal College of Nursing
At Congress 2017, the membership of the RCN raised the alarm on the growing nursing workforce shortages across the UK, and their concern at the implications on patient safety. We have undertaken extensive engagement with members, RCN Boards, and nursing workforce experts, which we set out in this report. The outcome of this engagement is a set of RCN principles which provide high-level objectives which most meaningfully represent what we need to achieve on staffing for safe and
effective care, though legislation, statutory instruments and guidance, and sufficient funding, in every country in the UK.

**RCN position statement: The role of school nurses in providing emergency contraception services in education settings**
Royal College of Nursing
This position statement, which updates the RCN position statement published in 2006, and updated in 2012, aims to clarify the responsibilities of school nurses when they are providing emergency hormonal contraception (EC) to students in education settings (schools, colleges, pupil referral units or any educational institution where there are young people).

**Mouth care at the end of life**
Royal College of Nursing
A quick reference handy guide outlining mouth care at the end of life. In collaboration with Hospice UK.

**Social Care**

**A fork in the road: next steps for social care funding reform**
King’s Fund
The costs of social care funding options, public attitudes to them – and the implications for policy reform

This paper pulls together new financial modelling, public perceptions work and policy analysis to identify the problems with adult social care in England and outline options for its reform. It does not aim to make firm proposals or recommendations but rather to identify and make explicit the advantages and disadvantages, impact and consequences of adopting one option over another. It concludes that reforming the current system will be expensive, but that if reform is chosen, England is now at a clear 'fork in the road' between a better means-tested system and one that is more like the NHS; free at the point of use for those who need it.

**Homeshare Partnership Programme Evaluation**
SCIE
Research published in May 2018 by Lloyds Bank Foundation for England and Wales and the Big Lottery Fund, revealed how intergenerational homesharing can help reduce loneliness and isolation, improve wellbeing and address the lack of affordable housing options. The homeshare model is based on trust and friendship, allowing people to ‘live well’ within their chosen communities.

The evaluation, commissioned by SCIE and conducted by Traverse, looked at what works to develop a sustainable homeshare scheme, through:

- Identifying which approaches and activities work best as well as barriers
- Assessing the cost and benefits of the schemes
Identifying what would encourage a wider take up of homeshare, through the development of a framework of factors to be used by commissioners to assess bids for homeshare schemes. The evaluation found that the homeshare model:

- reduces loneliness and improves wellbeing by offering companionship and facilitating inter-generational relationships
- provides affordable housing for younger people who are often priced out.

The evaluation was funded by Lloyds Bank Foundation for England and Wales (LBF) and the Big Lottery Fund (BLF), who have collectively invested £2m in the Homeshare Partnership programme. The programme included supporting the set up of homeshare schemes at eight sites in England and Scotland, to test and develop the model. Further details about these sites are provided in the report.

**Learning Disability**

**Methylphenidate for attention deficit hyperactivity disorder (ADHD) in children and adolescents – assessment of adverse events in non-randomised studies**

*Cochrane Library*

Our findings suggest that methylphenidate may be associated with a number of serious adverse events as well as a large number of non-serious adverse events in children and adolescents, which often lead to withdrawal of methylphenidate. Our certainty in the evidence is very low, and accordingly, it is not possible to accurately estimate the actual risk of adverse events. It might be higher than reported here.

Given the possible association between methylphenidate and the adverse events identified, it may be important to identify people who are most susceptible to adverse events. To do this we must undertake large-scale, high-quality RCTs, along with studies aimed at identifying responders and non-responders.

**Sexual Health Services**

**Sexual and Reproductive Health. RCN report on the impact of funding and service changes in England**

*Royal College of Nursing*

This report brings together the results of a RCN survey with nurses working in sexual and reproductive health. It provides clarification and evidence following increasing concerns reported from those working in England on the impact of service provision following the changes to commissioning after the Health and Social Care Act (2012).

**RCN position statement: The role of school nurses in providing emergency contraception services in education settings**

*Royal College of Nursing*

This position statement, which updates the RCN position statement published in 2006, and updated in 2012, aims to clarify the responsibilities of school nurses when they are providing emergency
hormonal contraception (EC) to students in education settings (schools, colleges, pupil referral units or any educational institution where there are young people).