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 UHN, 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 https://www.scie.org.uk/news/
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 https://www.nmc.org.uk/news/
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/
Meridian https://meridian.wmhsn.org/subdomain/meridian/end/home

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NHS 70

NHS Facts

NHS 70
The NHS turns 70 on the 5\textsuperscript{th} July, 2018. The NHS 70 website contains archive photos, personal stories, as well as facts and figures like the list below. If you visit the website you will also see details of events planned to celebrate.

Did you know?
• The NHS in England treats more than 1.4 million patients every 24 hours.
• The NHS is one of the largest employers in the world, along with the Chinese People’s Liberation Army, the Indian railways and the Wal-Mart supermarket chain.
• The NHS in England is expected to spend £126 billion in 2018/19
• There are more than 7,400 GP practices in England
• In March 2017, the NHS employed 106,430 doctors, 285,893 nurses and health visitors, 21,597 midwives, 132,673 scientific, therapeutic and technical staff (across England’s hospital and community healthcare services (full-time equivalent))
• There are more than 100 volunteering roles within health and social care
• There were 16 million total hospital admissions in England in 2015/16, 28 per cent more than a decade earlier
• The total annual attendances at England’s accident and emergency departments was 23 million in 2016/17, 23.5 per cent higher than a decade earlier
• In comparison with the healthcare systems of ten other countries (Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland and USA) the NHS was found to be the most impressive overall by the Commonwealth Fund in 2017.

If Wards Could Talk, A People’s History of The North Staffordshire Royal Infirmary & City General Hospital

UHNM
The old North Staffordshire Royal Infirmary and City General Hospitals hold a lot of history. This film tells the story through the words of those who have worked or been treated here over the last 70 years

Health Library says: “Happy Birthday to the NHS”, 70 Years Old!
On Thursday 5th July it will be 70 years since the beginning of the National Health Service and many NHS Trusts and departments will be celebrating with events and displays nationwide. The staff at the Health Library are celebrating the event with a display in the library rotunda. We have chosen a theme which looks at NHS reform over the 70 years and will include some original documents from the library collection. We are also looking out our own NHS memorabilia, so who knows what may turn up!!!
The NHS at 70: How good is the NHS?

King’s Fund

To mark the BBC’s coverage of the NHS’s 70th birthday in July 2018, researchers from the Health Foundation, the Institute for Fiscal Studies, The King’s Fund and the Nuffield Trust have joined forces for the first time, using combined expertise to shed light on some of the big questions on the NHS.

The four organisations have been asked by the BBC to look at five key topics, covering the relative strengths and weaknesses of the health service, the state of social care, NHS funding, the public’s expectations of the NHS and the potential of technology to change things in future. This project and the reports we have produced are intended to inform the national conversation about the past, present and future of the NHS.

This first, main report, How good is the NHS? uses OECD data and a range of other public sources to compare the NHS to health systems in 18 similar developed countries, including France, Germany, Italy, Japan and the USA. It looks at three aspects of what we might mean by a good health care system: the speed and accessibility of care, the efficiency of the system, and the outcomes delivered for patients. It also sets the scene by looking at what the health service has to work with, so that we can consider whether it is doing a good job given the circumstances.

The report finds that the NHS performs neither as well as its supporters sometimes claim nor as badly as its critics often allege. Compared with health systems in similar countries, it has some significant strengths but also some notable weaknesses.

Key strengths of the UK’s NHS include:

• It provides unusually good financial protection to the public from the consequences of ill health. For example, it has the lowest proportion of people who skipped medicine due to cost (2.3% in 2016 compared to an average of 7.2% across the comparator countries).
• It is relatively efficient: the UK has the largest share of generic prescribing of all comparator countries, at 84% in 2015 compared to an average of 50%.
• It performs well in managing patients with some long-term conditions like diabetes and kidney diseases: fewer than one in a thousand people are admitted to hospital for diabetes in a given year, compared to over two in a thousand admitted in Austria or Germany.

Key weaknesses include:

• The UK’s NHS performs worse than the average in the treatment of eight out of the 12 most common causes of death, including deaths within 30 days of having a heart attack and within five years of being diagnosed with breast cancer, rectal cancer, colon cancer, pancreatic cancer and lung cancer, despite narrowing the gap in recent years.
• It is the third-poorest performer compared to the 18 developed countries on the overall rate at which people die when successful medical care could have saved their lives (known as ‘amenable mortality’).
• It has consistently higher rates of death for babies at birth or just after (perinatal mortality), and in the month after birth (neonatal mortality): seven in 1,000 babies died at birth or in the week afterwards in the UK in 2016, compared to an average of 5.5 across the comparator countries.
Given limited or patchy data in certain areas and the inherent complexity of making comparisons internationally, this analysis does not provide us with the final word, but rather a set of issues to address as we look forward from the health service’s 70th birthday. The five reports we have produced look at some of the most important issues affecting its future. The NHS is a system set up to deliver the best care to everybody in the UK, and its staff believe deeply in this mission. The most fitting birthday present the service could receive would be a national discussion about how government, society and the public can work with it to realise this goal more successfully than ever.

**Innovative models of general practice**

**King’s Fund**

**Overview**

• General practice is in crisis. Previous work from The King’s Fund found general practitioners (GPs) dealing with a rising, more complex workload. Funding has not been growing at the same rate as demand, leading to a profession under enormous strain and facing a recruitment and retention crisis.

• New clinical delivery models are needed to meet demand, altering the way in which general practice operates and interacts with individuals, families and local communities.

• In this report, we look at innovative models of general practice from the UK and other countries and identify key design features we believe will be important in designing effective GP services in the future.

• We set out five attributes that underpin general practice: person-centred, holistic care; access; coordination; continuity and community focus. Models that focus on access at the expense of other attributes may not provide the most effective and comprehensive care for patients.

• Successful new models of general practice often focus on building relationship—between patients and professionals, between professionals within general practice and beyond, and between general practice and wider communities.

• Making radical changes to the model of general practice is complex and takes time, leadership and resources. General practice often has less access to the financial or human resources needed to undertake change than other NHS organisations. External support for improvement will be critical.

**Influenza vaccine for chronic obstructive pulmonary disease (COPD)**

**Cochrane Review**

It appeared, from the limited number of RCTs we were able to include, all of which were more than a decade old, that inactivated vaccine reduced exacerbations in people with COPD. The size of effect was similar to that seen in large observational studies, and was due to a reduction in exacerbations occurring three or more weeks after vaccination, and due to influenza. There was a mild increase in transient local adverse effects with vaccination, but no evidence of an increase in early exacerbations. Addition of live attenuated virus to the inactivated vaccine was not shown to confer additional benefit.
**Botulinum toxins for the prevention of migraine in adults**  
*Cochrane Review*
In chronic migraine, botulinum toxin type A may reduce the number of migraine days per month by 2 days compared with placebo treatment. Non-serious adverse events were probably experienced by 60/100 participants in the treated group compared with 47/100 in the placebo group. For people with episodic migraine, we remain uncertain whether or not this treatment is effective because the quality of this limited evidence is very low. Better reporting of outcome measures in published trials would provide a more complete evidence base on which to draw conclusions.

**Donepezil for dementia due to Alzheimer’s disease**  
*Cochrane Review*
There is moderate-quality evidence that people with mild, moderate or severe dementia due to Alzheimer’s disease treated for periods of 12 or 24 weeks with donepezil experience small benefits in cognitive function, activities of daily living and clinician-rated global clinical state. There is some evidence that use of donepezil is neither more nor less expensive compared with placebo when assessing total healthcare resource costs. Benefits on 23 mg/day were no greater than on 10 mg/day, and benefits on the 10 mg/day dose were marginally larger than on the 5 mg/day dose, but the rates of withdrawal and of adverse events before end of treatment were higher the higher the dose.

**What works to increase attendance for diabetic retinopathy screening? An evidence synthesis and economic analysis**  
*NIHR*
**Background**
Diabetic retinopathy screening (DRS) is effective but uptake is suboptimal.

**Objectives**
To determine the effectiveness of quality improvement (QI) interventions for DRS attendance; describe the interventions in terms of QI components and behaviour change techniques (BCTs); identify theoretical determinants of attendance; investigate coherence between BCTs identified in interventions and determinants of attendance; and determine the cost-effectiveness of QI components and BCTs for improving DRS.

**Data sources and review methods**
Phase 1 – systematic review of randomised controlled trials (RCTs) evaluating interventions to increase DRS attendance (The Cochrane Library, MEDLINE, EMBASE and trials registers to February 2017) and coding intervention content to classify QI components and BCTs. Phase 2 – review of studies reporting factors influencing attendance, coded to theoretical domains (MEDLINE, EMBASE, PsycINFO and sources of grey literature to March 2016). Phase 3 – mapping BCTs (phase 1) to theoretical domains (phase 2) and an economic evaluation to determine the cost-effectiveness of BCTs or QI components.

**Results**
Phase 1 – 7277 studies were screened, of which 66 RCTs were included in the review. Interventions were multifaceted and targeted patients, health-care professionals (HCPs) or health-care systems. Overall, interventions increased DRS attendance by 12% [risk difference (RD) 0.12, 95% confidence interval (CI) 0.10 to 0.14] compared with usual care, with substantial heterogeneity in effect size. Both
DRS-targeted and general QI interventions were effective, particularly when baseline attendance levels were low. All commonly used QI components and BCTs were associated with significant improvements, particularly in those with poor attendance. Higher effect estimates were observed in subgroup analyses for the BCTs of ‘goal setting (outcome, i.e. consequences)’ (RD 0.26, 95% CI 0.16 to 0.36) and ‘feedback on outcomes (consequences) of behaviour’ (RD 0.22, 95% CI 0.15 to 0.29) in interventions targeting patients and of ‘restructuring the social environment’ (RD 0.19, 95% CI 0.12 to 0.26) and ‘credible source’ (RD 0.16, 95% CI 0.08 to 0.24) in interventions targeting HCPs. Phase 2 – 3457 studies were screened, of which 65 non-randomised studies were included in the review. The following theoretical domains were likely to influence attendance: ‘environmental context and resources’, ‘social influences’, ‘knowledge’, ‘memory, attention and decision processes’, ‘beliefs about consequences’ and ‘emotions’. Phase 3 – mapping identified that interventions included BCTs targeting important barriers to/enablers of DRS attendance. However, BCTs targeting emotional factors around DRS were under-represented. QI components were unlikely to be cost-effective whereas BCTs with a high probability (≥ 0.975) of being cost-effective at a societal willingness-to-pay threshold of £20,000 per QALY included ‘goal setting (outcome)’, ‘feedback on outcomes of behaviour’, ‘social support’ and ‘information about health consequences’. Cost-effectiveness increased when DRS attendance was lower and with longer screening intervals.

Limitations
Quality improvement/BCT coding was dependent on descriptions of intervention content in primary sources; methods for the identification of coherence of BCTs require improvement.

Conclusions
Randomised controlled trial evidence indicates that QI interventions incorporating specific BCT components are associated with meaningful improvements in DRS attendance compared with usual care. Interventions generally used appropriate BCTs that target important barriers to screening attendance, with a high probability of being cost-effective. Research is needed to optimise BCTs or BCT combinations that seek to improve DRS attendance at an acceptable cost. BCTs targeting emotional factors represent a missed opportunity to improve attendance and should be tested in future studies.

Digital change in health and social care
King’s Fund
Overview
• The use of digital technology in health and social care can improve quality, efficiency and patient experience as well as supporting more integrated care and improving the health of a population.
• Large-scale change involving digital technology, such as adopting electronic patient records (EPRs) and shared care records, is complex and necessitates attention to particular aspects of the change.
• This report shares practical learning from a series of case studies where significant largescale digital change is happening.
• Key barriers to successful digital change include the constraints care organisations face in their workforce, tight budgets, organisations’ attitudes towards risk and the relationships that exist between care providers and key stakeholders.
• Most of the barriers can be mitigated through time and effort and by treating digital projects as change projects, not IT projects. Effective and consistent staff engagement and resource allocation to the project are key factors in success.
The NHS at 70: What's the problem with social care, and why do we need to do better?

King’s Fund

The NHS is celebrating its 70th birthday, but the anniversary of an equally important service is not being marked in the same way: adult social care. Unlike the legislation that set up the NHS, the 1948 National Assistance Act did not nationalise social care services and create a familiar public institution, nor did it result in services being free at the point of use. Local authorities were obliged to provide accommodation for people who needed it on the grounds of age or disability, but could charge.

Across the UK, more people work in social care than in the NHS, with social care representing 6% of total UK employment, but the services and support delivered in social care are not well known. The public are increasingly aware of the pressures being faced by the NHS, but much less so about the challenges facing social care, and what that might mean if they or a family member develops social care needs.

This briefing sets out the demand and funding pressures facing social care across the UK. It then looks in detail at the impact of these pressures in England and the barriers to funding reform.

Key findings

• The social care system is also 70 years old this year but unlike the NHS, its anniversary will pass largely unnoticed. The fault line established 70 years ago between health care which is free at the point of use and social care which is means-tested, remains a fundamental source of inequity and unfairness today.
• New polling suggests that the majority of the public (56%) think that individuals having to use their housing assets to pay for care is at least somewhat unacceptable, compared to 25% who think it is at least somewhat acceptable.
• Adult social care spending in the UK has fallen by 9.9% between 2009/10 and 2016/2017.
• An ageing population and younger adults with disabilities living longer are pushing up the cost of caring for older and disabled people, placing the social care system under huge strain. Based on current spending, a UK funding gap of £18 billion will open up by 2030/31.

Impact of not enough funding for adult social care in England

• In England the financial thresholds to access social care are 12% lower (in real terms) in 2018/19 than they were in 2010/11, meaning fewer people are now eligible for publicly funded social care.
• About 400,000 fewer adults received social care services in 2013/14 than in 2009/10, as local authorities have had to prioritise funding for people with the most severe care needs.
• The care home market is unstable. According to the Competition and Markets Authority (CMA), care homes that have more than 75% of local authority funded residents are most at risk of failure and a quarter of UK-wide care homes fall into this category.
• There was a 6.6% vacancy rate for the adult social care sector in 2016/17 and particularly high turnover rates for care workers.
• Informal carers continue to absorb the bulk of the pressure – 75% said they had not received any support or service which allowed them to take a break of between one and 24 hours from caring in the last 12 months.
• Cuts in local authority social care spending have led to increased use of A&E services by people aged 65 and over.
Where next for social care?

Despite 12 green and white papers and five independent commissions over the last 20 years, successive governments have ducked the challenge of social care reform.

People in need of care will continue to fall through the cracks of a social care system riddled with holes. Attempts to shore up the NHS will be hindered without adequate funding for social care.

Tackling the challenge of social care reform will require decisive political action and an appropriate funding settlement. Unless this happens we will continue to have a system whose inadequacies undermine the NHS and leave many people without the care they need. Transformation is required to make the social care system fair and sustainable in the future.

**Hearing loss in adults: assessment and management**

NICE

This guideline covers some aspects of assessing and managing hearing loss in primary, community and secondary care. It aims to improve the quality of life for adults with hearing loss by advising healthcare staff on assessing hearing difficulties, managing earwax and referring people for audiological or specialist assessment and management.

The guideline covers adults aged over 18, including adults whose age of onset of hearing loss was under 18 but who present for the first time in adulthood.

This guideline includes recommendations on:

- assessment and referral
- removing earwax
- investigation using MRI
- treating idiopathic sudden sensorineural hearing loss
- assessment and management in audiology services
- hearing aids and assistive listening devices, including follow-up in audiology services
- information and support

**NHS RightCare Scenario: Sepsis**

NHS England

This NHS RightCare Scenario, produced with the NHS England-led Cross-system Sepsis Programme Board, will demonstrate the opportunities to reduce the unwarranted variation in sepsis care.

In this scenario using a fictional patient, Rob, we examine a case of sepsis, its identification and subsequent management, comparing a suboptimal, difficult scenario against an ideal pathway. At each stage we have modelled the costs of care to commissioners and describe the impact of suboptimal care and then of ideal care on the outcomes and experiences of Robert and his family.
This document is intended to help local health economies understand the implications on quality of life and costs – of shifting the sepsis pathway away from a suboptimal journey to one that consistently delivers timely evidence-based excellence.

Commissioners, clinicians and providers responsible for their population should consider:

- Planning care models to address speedy diagnosis of possible sepsis in all areas of the health economy (Primary, Community and Secondary care)
- Systematic and robust monitoring of patients for signs of acute deterioration using NEWS2 (the National Early Warning Score version 2) and assessing acutely ill patients for sepsis
- Providing tailored and speedy care to patients in line with guidance, which considers, for example, treatment burden and sharing information with other professions and services.
- Education for clinicians, patients, carers and family members through a variety of appropriate communication channels.

**SMARTCARE - The ‘Frailty Passport’ for advance care planning**

**Meridian**

Dr Amit Arora at University Hospital of North Midlands (UHN) has developed a Frailty Passport for frail elderly patients. The Frailty Passport is a patient held diary that holds the patient’s statement of preferences and wishes for the rest of their life.

This project aims to discuss advance care planning with frail elderly patients and as a by-product also reduces unplanned admissions and length of stay by communicating a personalised integrated care plan that is agreed by all parties involved- putting the patient right at the centre of care.

**Public Health and Lifestyle Services**

**Hiding in plain sight: Treating tobacco dependency in the NHS**

**Royal College of Physicians**

Hiding in plain sight: Treating tobacco dependency in the NHS addresses the harms and costs arising from smoking in the patients we see every day, and argues for a new approach to treating their addiction. We argue that responsibility for treating smokers lies with the clinician who sees them, and that our NHS should be delivering default, opt-out, systematic interventions for all smokers at the point of service contact.

**Childhood obesity: a plan for action**

**Chapter 2**

**DH**

The government’s much anticipated new action plan to tackle childhood obesity was released in June. Sugar reduction, calorie reduction, advertising and promotions are all key areas that the report addresses, as well as looking at how this might be implemented at a local level.
Influenza vaccine for chronic obstructive pulmonary disease (COPD)
Cochrane Review
It appeared, from the limited number of RCTs we were able to include, all of which were more than a decade old, that inactivated vaccine reduced exacerbations in people with COPD. The size of effect was similar to that seen in large observational studies, and was due to a reduction in exacerbations occurring three or more weeks after vaccination, and due to influenza. There was a mild increase in transient local adverse effects with vaccination, but no evidence of an increase in early exacerbations. Addition of live attenuated virus to the inactivated vaccine was not shown to confer additional benefit.

Protein supplementation of human milk for promoting growth in preterm infants
Cochrane Review
Low-quality evidence showed that protein supplementation of human milk, fed to preterm infants, increased short-term growth. However, the small sample sizes, low precision, and very low-quality evidence regarding duration of hospital stay, feeding intolerance, and necrotising enterocolitis precluded any conclusions about these outcomes. There were no data on outcomes after hospital discharge. Our findings may not be generalisable to low-resource settings, as none of the included studies were conducted in these settings.

Since protein supplementation of human milk is now usually done as a component of multi-nutrient fortifiers, future studies should compare different amounts of protein in multi-component fortifiers, and be designed to determine the effects on duration of hospital stay and safety, as well as on long-term growth, body composition, cardio-metabolic, and neurodevelopmental outcomes.

Formula versus donor breast milk for feeding preterm or low birth weight infants
Cochrane Review
In preterm and LBW infants, feeding with formula compared with donor breast milk, either as a supplement to maternal expressed breast milk or as a sole diet, results in higher rates of weight gain, linear growth, and head growth and a higher risk of developing necrotising enterocolitis. The trial data do not show an effect on all-cause mortality, or on long-term growth or neurodevelopment.

A pedometer-based walking intervention in 45- to 75-year-olds, with and without practice nurse support: the PACE-UP three-arm cluster RCT
NIHR
Background
Guidelines recommend walking to increase moderate to vigorous physical activity (MVPA) for health benefits.

Objectives
To assess the effectiveness, cost-effectiveness and acceptability of a pedometer-based walking intervention in inactive adults, delivered postally or through dedicated practice nurse physical activity (PA) consultations.

Design
Parallel three-arm trial, cluster randomised by household.

Setting
Seven London-based general practices.

Participants
A total of 11,015 people without PA contraindications, aged 45–75 years, randomly selected from practices, were invited. A total of 6399 people were non-responders, and 548 people self-reporting achieving PA guidelines were excluded. A total of 1023 people from 922 households were randomised to usual care (n = 338), postal intervention (n = 339) or nurse support (n = 346). The recruitment rate was 10% (1023/10,467). A total of 956 participants (93%) provided outcome data.

Interventions
Intervention groups received pedometers, 12-week walking programmes advising participants to gradually add ‘3000 steps in 30 minutes’ most days weekly and PA diaries. The nurse group was offered three dedicated PA consultations.

Main outcome measures
The primary and main secondary outcomes were changes from baseline to 12 months in average daily step counts and time in MVPA (in ≥ 10-minute bouts), respectively, from 7-day accelerometry. Individual resource-use data informed the within-trial economic evaluation and the Markov model for simulating long-term cost-effectiveness. Qualitative evaluations assessed nurse and participant views. A 3-year follow-up was conducted.

Results
Baseline average daily step count was 7479 [standard deviation (SD) 2671], average minutes per week in MVPA bouts was 94 minutes (SD 102 minutes) for those randomised. PA increased significantly at 12 months in both intervention groups compared with the control group, with no difference between interventions; additional steps per day were 642 steps [95% confidence interval (CI) 329 to 955 steps] for the postal group and 677 steps (95% CI 365 to 989 steps) for nurse support, and additional MVPA in bouts (minutes per week) was 33 minutes per week (95% CI 17 to 49 minutes per week) for the postal group and 35 minutes per week (95% CI 19 to 51 minutes per week) for nurse support. Intervention groups showed no increase in adverse events. Incremental cost per step was 19p and £3.61 per minute in a ≥ 10-minute MVPA bout for nurse support, whereas the postal group took more steps and cost less than the control group. The postal group had a 50% chance of being cost-effective at a £20,000 per quality-adjusted life-year (QALY) threshold within 1 year and had both lower costs [−£11M (95% CI −£12M to −£10M) per 100,000 population] and more QALYs [759 QALYs gained (95% CI 400 to 1247 QALYs)] than the nurse support and control groups in the long term. Participants and nurses found the interventions acceptable and enjoyable. Three-year follow-up data showed persistent intervention effects (nurse support plus postal vs. control) on steps per day [648 steps (95% CI 272 to 1024 steps)] and MVPA bouts [26 minutes per week (95% CI 8 to 44 minutes per week)].

Limitations
The 10% recruitment level, with lower levels in Asian and socioeconomically deprived participants, limits the generalisability of the findings. Assessors were unmasked to the group.

Conclusions
A primary care pedometer-based walking intervention in 45- to 75-year-olds increased 12-month step counts by around one-tenth, and time in MVPA bouts by around one-third, with similar effects for the nurse support and postal groups, and persistent 3-year effects. The postal intervention provides cost-effective, long-term quality-of-life benefits. A primary care pedometer intervention delivered by post could help address the public health physical inactivity challenge.

What works to increase attendance for diabetic retinopathy screening? An evidence synthesis and economic analysis

NIHR

Background

Diabetic retinopathy screening (DRS) is effective but uptake is suboptimal.

Objectives

To determine the effectiveness of quality improvement (QI) interventions for DRS attendance; describe the interventions in terms of QI components and behaviour change techniques (BCTs); identify theoretical determinants of attendance; investigate coherence between BCTs identified in interventions and determinants of attendance; and determine the cost-effectiveness of QI components and BCTs for improving DRS.

Data sources and review methods

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General Practice

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King’s Fund
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General Practice Forward View snapshot infographic
NHS England
This infographic illustrates some of the key areas of progress, two years into the implementation of the General Practice Forward View programme.

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NHS England
This NHS RightCare Scenario, produced with the NHS England-led Cross-system Sepsis Programme Board, will demonstrate the opportunities to reduce the unwarranted variation in sepsis care.

In this scenario using a fictional patient, Rob, we examine a case of sepsis, its identification and subsequent management, comparing a suboptimal, difficult scenario against an ideal pathway. At each stage we have modelled the costs of care to commissioners and describe the impact of suboptimal care and then of ideal care on the outcomes and experiences of Robert and his family.

This document is intended to help local health economies understand the implications on quality of life and costs – of shifting the sepsis pathway away from a suboptimal journey to one that consistently delivers timely evidence-based excellence.

Commissioners, clinicians and providers responsible for their population should consider:
• Planning care models to address speedy diagnosis of possible sepsis in all areas of the health economy (Primary, Community and Secondary care)
• Systematic and robust monitoring of patients for signs of acute deterioration using NEWS2 (the National Early Warning Score version 2) and assessing acutely ill patients for sepsis
• Providing tailored and speedy care to patients in line with guidance, which considers, for example, treatment burden and sharing information with other professions and services.
• Education for clinicians, patients, carers and family members through a variety of appropriate communication channels.

GPs urged to make most of cancer screening dashboard
NHS Digital
GPs and health organisations are being urged to help to improve rates of potentially lifesaving cervical screening by making the most of an innovative online data tool.

The interactive data dashboard provides in-depth information on screening levels and shows where they could be improved. It was launched a year ago by NHS Digital, Public Health England (PHE) and Jo’s Cervical Cancer Trust

Influenza vaccine for chronic obstructive pulmonary disease (COPD)
Cochrane Review
It appeared, from the limited number of RCTs we were able to include, all of which were more than a decade old, that inactivated vaccine reduced exacerbations in people with COPD. The size of effect
was similar to that seen in large observational studies, and was due to a reduction in exacerbations occurring three or more weeks after vaccination, and due to influenza. There was a mild increase in transient local adverse effects with vaccination, but no evidence of an increase in early exacerbations. Addition of live attenuated virus to the inactivated vaccine was not shown to confer additional benefit.

**Antibiotics for exacerbations of asthma**

*Cochrane Review*

We found limited evidence that antibiotics given at the time of an asthma exacerbation may improve symptoms and PEFR at follow-up compared with standard care or placebo. However, findings were inconsistent across the six heterogeneous studies included, two of the studies were conducted over 30 years ago and most of the participants included in this review were recruited from emergency departments, limiting the applicability of findings to this population. Therefore we have limited confidence in the results. We found insufficient evidence about several patient-important outcomes (e.g. hospital admission) to form conclusions. We were unable to rule out a difference between groups in terms of all adverse events, but serious adverse events were rare.

**Donepezil for dementia due to Alzheimer's disease**

*Cochrane Review*

There is moderate-quality evidence that people with mild, moderate or severe dementia due to Alzheimer's disease treated for periods of 12 or 24 weeks with donepezil experience small benefits in cognitive function, activities of daily living and clinician-rated global clinical state. There is some evidence that use of donepezil is neither more nor less expensive compared with placebo when assessing total healthcare resource costs. Benefits on 23 mg/day were no greater than on 10 mg/day, and benefits on the 10 mg/day dose were marginally larger than on the 5 mg/day dose, but the rates of withdrawal and of adverse events before end of treatment were higher the higher the dose.

**Chronic obstructive pulmonary disease: fluticasone furoate, umeclidinium and vilanterol (Trelegy)**

*NICE*

This updated evidence summary describes Fluticasone furoate/umeclidinium/vilanterol (Trelegy, GlaxoSmithKline UK) which is a received a triple-therapy inhaler containing an inhaled corticosteroid (ICS), long-acting beta-2 agonist (LABA) and long-acting muscarinic antagonist (LAMA). It is licensed for maintenance treatment of adults with moderate-to-severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an ICS and a LABA.

**Intranasal phototherapy for allergic rhinitis**

*NICE*

Evidence-based recommendations on intranasal phototherapy for allergic rhinitis in adults. This involves using light to reduce inflammation inside the nose.

**Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease**

*NICE*

Evidence-based recommendations on donepezil (Aricept), galantamine (Reminyl), rivastigmine (Exelon) and memantine (Ebixa) for treating Alzheimer's disease in adults.
This guidance has been partially updated by NICE’s guideline on dementia (NG97) and replaces NICE technology appraisal guidance on donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease (TA111).

**SMARTCARE - The ‘Frailty Passport’ for advance care planning**

**Meridian**

Dr Amit Arora at University Hospital of North Midlands (UHNM) has developed a Frailty Passport for frail elderly patients. The Frailty Passport is a patient held diary that holds the patient’s statement of preferences and wishes for the rest of their life.

This project aims to discuss advance care planning with frail elderly patients and as a by-product also reduces unplanned admissions and length of stay by communicating a personalised integrated care plan that is agreed by all parties involved—putting the patient right at the centre of care.

**National Deconditioning Awareness and Prevention Campaign: ‘Sit Up Get Dressed Keep Moving’**

**Meridian**

Dr Amit Arora is a consultant geriatrician at the University Hospital of North Midlands and has served as Chairman of England Council of the British Geriatrics Society. He and his team developed the “National Deconditioning Awareness and Prevention Campaign” that encouraged elderly patients to “Sit up, Get Dressed, Keep Moving”. The campaign aims to stop older patients becoming deconditioned whilst in hospital or care homes. The campaign was initially used locally and then launched nationally on Older People’s Day, 1st October 2016.

**Rehabilitation and Occupational Health**

**Early, specialist vocational rehabilitation to facilitate return to work after traumatic brain injury: the FRESH feasibility RCT**

**NIHR**

**Background**

Up to 160,000 people incur traumatic brain injury (TBI) each year in the UK. TBI can have profound effects on many areas of human functioning, including participation in work. There is limited evidence of the clinical effectiveness and cost-effectiveness of vocational rehabilitation (VR) after injury to promote early return to work (RTW) following TBI.

**Objective**

To assess the feasibility of a definitive, multicentre, randomised controlled trial (RCT) of the clinical effectiveness and cost-effectiveness of early, specialist VR plus usual care (UC) compared with UC alone on work retention 12 months post TBI.

**Design**

A multicentre, feasibility, parallel-group RCT with a feasibility economic evaluation and an embedded mixed-methods process evaluation. Randomisation was by remote computer-generated allocation.
Setting
Three NHS major trauma centres (MTCs) in England.

Participants
Adults with TBI admitted for > 48 hours and working or studying prior to injury.

Interventions
Early specialist TBI VR delivered by occupational therapists (OTs) in the community using a case co-ordination model.

Main outcome measures
Self-reported RTW 12 months post randomisation, mood, functional ability, participation, work self-efficacy, quality of life and work ability. Feasibility outcomes included recruitment and retention rates. Follow-up was by postal questionnaires in two centres and face to face in one centre. Those collecting data were blind to treatment allocation.

Results
Out of 102 target participants, 78 were recruited (39 randomised to each arm), representing 39% of those eligible and 5% of those screened. Approximately 2.2 patients were recruited per site per month. Of those, 56% had mild injuries, 18% had moderate injuries and 26% had severe injuries. A total of 32 out of 45 nominated carers were recruited. A total of 52 out of 78 (67%) TBI participants responded at 12 months (UC, n = 23; intervention, n = 29), completing 90% of the work questions; 21 out of 23 (91%) UC respondents and 20 out of 29 (69%) intervention participants returned to work at 12 months. Two participants disengaged from the intervention. Face-to-face follow-up was no more effective than postal follow-up. RTW was most strongly related to social participation and work self-efficacy. It is feasible to assess the cost-effectiveness of VR. Intervention was delivered as intended and valued by participants. Factors likely to affect a definitive trial include deploying experienced OTs, no clear TBI definition or TBI registers, and repatriation of more severe TBI from MTCs, affecting recruitment of those most likely to benefit/least likely to drop out.

Limitations
Target recruitment was not reached, but mechanisms to achieve this in future studies were identified. Retention was lower than expected, particularly in UC, potentially biasing estimates of the 12-month RTW rate.

Conclusions
This study met most feasibility objectives. The intervention was delivered with high fidelity. When objectives were not met, strategies to ensure feasibility of a full trial were identified. Future work should test two-stage recruitment and include resources to recruit from ‘spokes’. A broader measure covering work ability, self-efficacy and participation may be a more sensitive outcome.

Enabling Self-management and Coping with Arthritic Pain using Exercise - a group rehabilitation programme
Meridian
ESCAPE-pain is an evidence-based, NICE-recommended group rehabilitation programme appropriate for people with chronic joint pain/osteoarthritis in their knee and/or hip.
Challenge identified and actions taken:
The probability of having hip replacement is 2.87 times higher in people with usual care compared to those who have participated in individually tailored exercise programmes such as ESCAPE-pain. People with chronic joint pain/osteoarthritis in their knee and/or hip participate and learn together through 2 sessions per week for 6 weeks. Each session involves education and exercise components which are individualised for each patient. The Programme is both clinically and cost effective, producing measurable improvements in physical and mental health. It delivers the core NICE recommendations for the management of osteoarthritis in adults. Research papers show it has wide health benefits and reduces healthcare utilisation. It is cited as a case study in the NHS /Rightcare QIPPseries. Delivering ESCAPE-pain typically involves scheduling changes coupled with a commitment from the CCG and Provider organisation to ‘invest to save,’ using the ‘evidence-base’ of ESCAPE-pain to ensure that a minimum of 10 (and ideally 12 sessions) are offered to participants, for longer-term benefit.

**Physiotherapy**

**Strong bones after 50: Fracture liaison services explained**
Fracture Liaison Service Database, Royal College of Physicians
Strong bones after 50 is a guide that provides jargon-free information to patients and carers for supporting older people who have broken a bone following a fall.

**Advanced practice physiotherapy-led triage in Irish orthopaedic and rheumatology services: national data audit**
BMC Musculoskeletal Disorders
Background
Many people with musculoskeletal (MSK) disorders wait several months or years for Consultant Doctor appointments, despite often not requiring medical or surgical interventions. To allow earlier patient access to orthopaedic and rheumatology services in Ireland, Advanced Practice Physiotherapists (APPs) were introduced at 16 major acute hospitals. This study performed the first national evaluation of APP triage services.

Method
Throughout 2014, APPs (n = 22) entered clinical data on a national database. Analysis of these data using descriptive statistics determined patient wait times, Consultant Doctor involvement in clinical decisions, and patient clinical outcomes. Chi square tests were used to compare patient clinical outcomes across orthopaedic and rheumatology clinics. A pilot study at one site identified re-referral rates to orthopaedic/rheumatology services of patients managed by the APPs.

Results
In one year, 13,981 new patients accessed specialist orthopaedic and rheumatology consultations via the APP. Median wait time for an appointment was 5.6 months. Patients most commonly presented with knee (23%), lower back (22%) and shoulder (15%) disorders. APPs made autonomous clinical decisions regarding patient management at 77% of appointments, and managed patient care pathways without onward referral to Consultant Doctors in more than 80% of cases. Other onward
clinical pathways recommended by APPs were: physiotherapy referrals (42%); clinical investigations (29%); injections administered (4%); and surgical listing (2%). Of those managed by the APP, the pilot study identified that only 6.5% of patients were re-refferred within one year.

Conclusion
This national evaluation of APP services demonstrated that the majority of patients assessed by an APP did not require onward referral for a Consultant Doctor appointment. Therefore, patients gained earlier access to orthopaedic and rheumatology consultations in secondary care, with most patients conservatively managed.

Update on the risks of complications after knee arthroscopy
BMC Musculoskeletal Disorders
Background
Knee arthroscopy is one of the most common surgical procedures worldwide and the number of arthroscopies has substantially increased in the last 30 years. Thus, our aim was to provide updated estimates on the risk of complications and compare it with the background risk in the general population.

Methods
We identified patients aged 15–84 years with knee arthroscopy in the years 2005–2016 in southern Sweden. We calculated the risk of pyogenic arthritis, venous thromboembolism, and other typical complications within 30 days. As a reference cohort we included the regional population in the corresponding age interval. We estimated the relative and absolute risks of complications compared to the reference cohort using logistic regression adjusted for age, sex, and level of education. We also estimated the proportion of complications in the population explained by knee arthroscopy (population attributable fraction).

Results
We identified 18,735 knee arthroscopy patients (mean age 39 years) and 1,171,084 reference subjects (mean age 46 years). The absolute risk of one or more complications was 1.1% after knee arthroscopy and 0.16% in references. The odds ratio of any complication after knee arthroscopy vs. the reference cohort was 9.4 (95% confidence interval [CI] 8.1, 10.9) with an absolute risk difference of 1.4% (1.1, 1.6%). The relative risk (95% CI) for pyogenic arthritis was 115 (75, 174), venous thromboembolism 6.8 (5.1, 9.1), and other complications 7.7 (6.3, 9.5). The population attributable fraction for pyogenic arthritis was 5%.

Conclusions
The absolute risks of complications associated with knee arthroscopy remain small at about 1%. Still, 5% of all pyogenic knee arthritis cases in adults are attributable to knee arthroscopy, thus risks with knee arthroscopy should be carefully considered in the choice of treatment.
Impact of a tailored activity counselling intervention during inpatient rehabilitation after knee and hip arthroplasty – an explorative RCT
BMC Musculoskeletal Disorders

Background
The aim of the study was to improve physical activity (PA), well-being and clinical outcome after total knee and hip arthroplasty through tailored activity counselling during inpatient rehabilitation.

Methods
65 patients (aged 70.4 ± 7.3 years, BMI 28.5 ± 4.3) starting inpatient rehabilitation after primary knee or hip arthroplasty due to osteoarthritis were recruited and pseudo-randomized into an intervention (IG) and a control group (CG). Twice a week, the IG was encouraged to increase their daily step count by 5%. PA, e.g. number of steps, step frequency, or active minutes, was measured by step activity monitoring. Well-being and clinical outcome were assessed using the SF-36, Oxford Knee/Hip Score and Global rating of Change. Procedures were conducted at the onset of inpatient rehabilitation, and repeated one and 6 months after inpatient rehabilitation.

Results
Data sets were obtained from 49 patients (IG: n = 23, CG: n = 26). Both groups significantly increased their number of daily steps from the 1 month to the 6 months follow up after rehabilitation: CG: 9019 (95%CI: 7812, 10,226), IG: 9280 (7972, 10,588) and CG: 10921 (9571, 12,271), IG: 11326 (9862, 12,791) respectively. Additionally, well-being and clinical outcome improved significantly in both groups. No significant differences in physical activity, clinical outcome and well-being were found between the groups.

Conclusions
PA counselling during inpatient rehabilitation does not improve PA, well-being and clinical outcome in patients with primary knee or hip arthroplasty in addition to the rehabilitation program. PA interventions may be more effective after the completion of the inpatient rehabilitation phase.

Weight bearing versus non-weight bearing ankle dorsiflexion measurement in people with diabetes: a cross sectional study
BMC Musculoskeletal Disorders

Background
Accurate measurement of ankle dorsiflexion is important in both research and clinical practice as restricted motion has been associated with many foot pathologies and increased risk of ulcer in people with diabetes. This study aimed to determine the level of association between non-weight bearing versus weight bearing ankle dorsiflexion in adults with and without diabetes, and to evaluate the reliability of the measurement tools.

Methods
One hundred and thirty-six adults with diabetes and 30 adults without diabetes underwent ankle dorsiflexion measurement non-weight bearing, using a modified Lidcombe template, and weight bearing, using a Lunge test. Pearson product-moment correlation coefficients, intraclass correlation coefficients (ICCs) with 95% confidence intervals, standard error of measurement and minimal detectable change were determined.
Results
There was a moderate correlation (r = 0.62–0.67) between weight and non-weight bearing tests in the non-diabetes group, and a negligible correlation in the diabetes group (r = 0.004–0.007). Intratester reliability was excellent in both groups for the modified Lidcombe template (ICC = 0.89–0.94) and a Lunge test (ICC = 0.83–0.89). Intertester reliability was also excellent in both groups for the Lidcombe template (ICC = 0.91) and a Lunge test (ICC = 0.88–0.93).

Conclusions
We found the modified Lidcombe template and a Lunge test to be reliable tests to measure non-weight bearing and weight bearing ankle dorsiflexion in adults with and without diabetes. While both methods are reliable, further definition of weight bearing ankle dorsiflexion normative ranges may be more relevant for clinical practice.

Health Visiting and Nursing

Protein supplementation of human milk for promoting growth in preterm infants
Cochrane Review

Low-quality evidence showed that protein supplementation of human milk, fed to preterm infants, increased short-term growth. However, the small sample sizes, low precision, and very low-quality evidence regarding duration of hospital stay, feeding intolerance, and necrotising enterocolitis precluded any conclusions about these outcomes. There were no data on outcomes after hospital discharge. Our findings may not be generalisable to low-resource settings, as none of the included studies were conducted in these settings.

Since protein supplementation of human milk is now usually done as a component of multi-nutrient fortifiers, future studies should compare different amounts of protein in multi-component fortifiers, and be designed to determine the effects on duration of hospital stay and safety, as well as on long-term growth, body composition, cardio-metabolic, and neurodevelopmental outcomes.

Formula versus donor breast milk for feeding preterm or low birth weight infants
Cochrane Review

In preterm and LBW infants, feeding with formula compared with donor breast milk, either as a supplement to maternal expressed breast milk or as a sole diet, results in higher rates of weight gain, linear growth, and head growth and a higher risk of developing necrotising enterocolitis. The trial data do not show an effect on all-cause mortality, or on long-term growth or neurodevelopment.
Carers action plan 2018 to 2020
DH
The plan sets out the cross-government programme of work to support carers over the next 2 years. It is structured around the following themes:
• services and systems that work for carers
• employment and financial wellbeing
• supporting young carers
• recognising and supporting carers in the wider community and society
• building research and evidence to improve outcomes for carers

The plan draws on responses to the 2016 Carers strategy: call for evidence.

The NHS at 70: What’s the problem with social care, and why do we need to do better?
King’s Fund
The NHS is celebrating its 70th birthday, but the anniversary of an equally important service is not being marked in the same way: adult social care. Unlike the legislation that set up the NHS, the 1948 National Assistance Act did not nationalise social care services and create a familiar public institution, nor did it result in services being free at the point of use. Local authorities were obliged to provide accommodation for people who needed it on the grounds of age or disability, but could charge.

Across the UK, more people work in social care than in the NHS, with social care representing 6% of total UK employment, but the services and support delivered in social care are not well known. The public are increasingly aware of the pressures being faced by the NHS, but much less so about the challenges facing social care, and what that might mean if they or a family member develops social care needs.

This briefing sets out the demand and funding pressures facing social care across the UK. It then looks in detail at the impact of these pressures in England and the barriers to funding reform.

Key findings
• The social care system is also 70 years old this year but unlike the NHS, its anniversary will pass largely unnoticed. The fault line established 70 years ago between health care which is free at the point of use and social care which is means-tested, remains a fundamental source of inequity and unfairness today.
• New polling suggests that the majority of the public (56%) think that individuals having to use their housing assets to pay for care is at least somewhat unacceptable, compared to 25% who think it is at least somewhat acceptable.
• Adult social care spending in the UK has fallen by 9.9% between 2009/10 and 2016/2017.
• An ageing population and younger adults with disabilities living longer are pushing up the cost of caring for older and disabled people, placing the social care system under huge strain. Based on current spending, a UK funding gap of £18 billion will open up by 2030/31.

Impact of not enough funding for adult social care in England
• In England the financial thresholds to access social care are 12% lower (in real terms) in 2018/19 than they were in 2010/11, meaning fewer people are now eligible for publicly funded social care.
• About 400,000 fewer adults received social care services in 2013/14 than in 2009/10, as local authorities have had to prioritise funding for people with the most severe care needs.
• The care home market is unstable. According to the Competition and Markets Authority (CMA), care homes that have more than 75% of local authority funded residents are most at risk of failure and a quarter of UK-wide care homes fall into this category.
• There was a 6.6% vacancy rate for the adult social care sector in 2016/17 and particularly high turnover rates for care workers.
• Informal carers continue to absorb the bulk of the pressure – 75% said they had not received any support or service which allowed them to take a break of between one and 24 hours from caring in the last 12 months.
• Cuts in local authority social care spending have led to increased use of A&E services by people aged 65 and over.

Where next for social care?

Despite 12 green and white papers and five independent commissions over the last 20 years, successive governments have ducked the challenge of social care reform.

People in need of care will continue to fall through the cracks of a social care system riddled with holes. Attempts to shore up the NHS will be hindered without adequate funding for social care.

Tackling the challenge of social care reform will require decisive political action and an appropriate funding settlement. Unless this happens we will continue to have a system whose inadequacies undermine the NHS and leave many people without the care they need. Transformation is required to make the social care system fair and sustainable in the future.

Dementia: assessment, management and support for people living with dementia and their carers

NICE
This guideline covers diagnosing and managing dementia (including Alzheimer’s disease). It aims to improve care by making recommendations on training staff and helping carers to support people living with dementia.

Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer’s disease

NICE
Evidence-based recommendations on donepezil (Aricept), galantamine (Reminyl), rivastigmine (Exelon) and memantine (Ebixa) for treating Alzheimer’s disease in adults.
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The 100-year life: the role of housing, planning and design
SCIE
Future of care – No 7, June 2018
One in three children born in the UK today can expect to live to 100 – presenting challenges and opportunities to innovate. Co-producing housing, planning and design solutions with older people can support us to live independently in our own homes for longer – and generate new markets. This report – written in conjunction with Design Council and the Centre for Ageing Better – sets out recommendations for central and local government, builders, planners, designers and lenders.

Preventative support for adult carers in Wales: rapid review
SCIE
This overview of good and emerging practice in the development of preventative support for adult carers in Wales is one strand of a broader package of work by SCIE, commissioned by Social Care Wales in 2017. It is intended to support Social Care Wales in realising its ambition to improve well-being by promoting evidence-based policy, practice and service models that have a focus on prevention and early intervention. In its strategic plan for 2017 to 2022, Social Care Wales acknowledges that more can be done to support unpaid carers and families. It is estimated unpaid carers and families provide 96 per cent of the care in Wales, enabling vulnerable, sick and disabled people to maintain their independence and continue living at home (Social Care Wales, 2017). The expectation is that this review will help inform the development of Social Care Wales’s service improvement planning over the next five years, and the organisation’s response to the recent announcement by the Welsh Government of new national priorities for carer support.

National Deconditioning Awareness and Prevention Campaign: ‘Sit Up Get Dressed Keep Moving’
Meridian
Dr Amit Arora is a consultant geriatrician at the University Hospital of North Midlands and has served as Chairman of England Council of the British Geriatrics Society. He and his team developed the “National Deconditioning Awareness and Prevention Campaign” that encouraged elderly patients to “Sit up, Get Dressed, Keep Moving”. The campaign aims to stop older patients becoming deconditioned whilst in hospital or care homes. The campaign was initially used locally and then launched nationally on Older People’s Day, 1st October 2016

Mental Health
Enhanced psychological care in cardiac rehabilitation services for patients with new-onset depression: the CADENCE feasibility study and pilot RCT
NIHR
Background
Around 19% of people screened by UK cardiac rehabilitation programmes report having moderate or severe symptoms of depression. These individuals are at an increased risk of cardiac mortality and morbidity, reduced quality of life and increased use of health resources compared with their non-depressed counterparts. Maximising psychological health is a goal of cardiac rehabilitation, but psychological care is patchy.
Objective(s)
To examine the feasibility and acceptability of embedding enhanced psychological care (EPC) within cardiac rehabilitation, we tested the feasibility of developing/implementing EPC and documented the key uncertainties associated with undertaking a definitive evaluation.

Design
A two-stage multimethods study; a feasibility study and a qualitative evaluation, followed by an external pilot cluster randomised controlled trial (RCT) with a nested qualitative study.

Setting
UK comprehensive cardiac rehabilitation teams.

Participants
Adults eligible for cardiac rehabilitation following an acute coronary syndrome with new-onset depressive symptoms on initial nurse assessment. Patients who had received treatment for depression in the preceding 6 months were excluded.

Interventions
The EPC intervention comprised nurse-led mental health-care co-ordination and behavioural activation within cardiac rehabilitation. The comparator was usual cardiac rehabilitation care.

Main outcome measures
Measures at baseline, and at the 5- (feasibility and pilot) and 8-month follow-ups (pilot only). Process measures related to cardiac team and patient recruitment, and participant retention. Outcomes included depressive symptoms, cardiac mortality and morbidity, anxiety, health-related quality of life and service resource use. Interviews explored participant and nurses’ views and experiences.

Results
Between September 2014 and May 2015, five nurses from four teams recruited participants into the feasibility study. Of the 203 patients screened, 30 were eligible and nine took part (the target was 20 participants). At interview, participants and nurses gave valuable insights into the EPC intervention design and delivery. Although acceptable, the EPC delivery was challenging for nurses (e.g. the ability to allocate sufficient time within existing workloads) and the intervention was modified accordingly. Between December 2014 and February 2015, 8 out of 20 teams approached agreed to participate in the pilot RCT [five were randomised to the EPC arm and three were randomised to the usual-care (UC) arm]. Of the 614 patients screened, 55 were eligible and 29 took part (the target was 43 participants). At baseline, the trial arms were well matched for sex and ethnicity, although the EPC arm participants were younger, from more deprived areas and had higher depression scores than the UC participants. A total of 27 out of 29 participants were followed up at 5 months. Interviews with 18 participants (12 in the EPC arm and six in the UC arm) and seven nurses who delivered EPC identified that both groups acknowledged the importance of receiving psychological support embedded within routine cardiac rehabilitation. For those experiencing/delivering EPC, the intervention was broadly acceptable, albeit challenging to deliver within existing care.

Limitations
Both the feasibility and the pilot studies encountered significant challenges in recruiting patients, which limited the power of the pilot study analyses.

Conclusions
Cardiac rehabilitation nurses can be trained to deliver EPC. Although valued by both patients and nurses, organisational and workload constraints were significant barriers to implementation in participating teams, suggesting that future research may require a modified approach to intervention delivery within current service arrangements. We obtained important data informing definitive research regarding participant recruitment and retention, and optimal methods of data collection.

Future research
Consideration should be given to the delivery of EPC by dedicated mental health practitioners, working closely with cardiac rehabilitation services.

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Older Adults

Strong bones after 50: Fracture liaison services explained
Fracture Liaison Service Database, Royal College of Physicians
Strong bones after 50 is a guide that provides jargon-free information to patients and carers for supporting older people who have broken a bone following a fall.

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**Allied Health Professional**

**Allied Health Professions hold key role in future NHS**

NHS England

The Allied Health Professions (AHPs) have a significant role to play in the future delivery of integrated urgent care within the NHS.

And the quality of leadership of the AHPs will be vital in determining their impact and the quality of care that patients receive.

These are two of the key findings of a study ‘Leadership of Allied Health Professions in Trusts: what exists and what matters’ commissioned by NHS Improvement and compiled by Kingston University.