Evidence Summary

Introduction to Improving Quality

February 2016
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1. About this Evidence Summary

About this Evidence Summary

Evidence reviews are critical for advancing healthcare quality and improvement. In order to align our improvement activity with the latest developments, evidence and thinking, it is necessary to conduct good literature searches and select high quality articles to drive our work. This can be challenging and time-consuming. To help the front line staff at Homerton who are leading our improvement efforts, Library and Information Services have produced a series Evidence Summaries. Improving the quality of health care is a key priority for the NHS. Quality Improvement (QI) in healthcare is a relatively recent development and the use of QI methods and tools is growing. This Evidence Summary has been produced to help underpin quality improvement projects, research and initiatives with a suitable evidence base. It may be of interest to health professionals, managers, commissioners, the Quality Improvement Committee and anyone engaged in or interested in improving quality.

Further, more detailed Evidence summaries aimed at building on this Evidence Summary and plugging the knowledge gaps indicated in the Key Findings below are in the pipeline.

What this evidence summary covers

This Evidence Summary gives **an introduction and broad overview on Quality Improvement in healthcare.** It provides a descriptive summary of selected useful references on the topic.

It does not go into detail on the many frameworks, concepts and models of quality improvement in healthcare. And it is not intended as an expert guide. It does include some material from improvement science but does not cover the more academic and theoretical research essential to improvement science in depth. These themes will be covered in separate Evidence Summaries (forthcoming).

It is not a systematic review. It does not seek to summarise theoretical literature or synthesise all the available evidence. The results list relevant citations details (including abstracts where possible) of potentially relevant literature. References are indicative and not intended to be definitive. It has been written with an NHS audience in mind drawing on research relevant to the UK from both the UK and elsewhere as appropriate.
Key messages

- There are a wide range of initiatives aimed at improving quality in health care. Typically, they use models and tools first used in industry. Foremost among these are: Total Quality Management (TQM), Continuous Quality Improvement (CQI); rapid cycle change (aka the Model for Improvement, Plan-Do-Study-Act); Lean Thinking and Six Sigma.

- There is a lack of definition as to what makes up a QI method. There is also overlap between the methodologies. For example, Statistical Process Control (SPC) and Plan-Do-Study-Act (PDSA) cycles are common elements to CQI, TQM, Six Sigma and some Lean programmes. SPC can a methodology, but is also used as a real-time measurement tool for other methodologies. Some parts of the methodologies merge and develop into new ones (e.g. TQM (Total Quality Management) into Six Sigma).

- Many methodologies, especially Six Sigma and SPC, demand collecting lots of data as well as staff training in the methodology, and also in statistical analysis.

- No matter what model or approach to quality improvement is used, the broader literature on organisational change in health care suggests that a broad set of ‘necessary, but not sufficient’ conditions need to be in place for successful implementation.

- Successful system redesign requires coordinating and managing a complex set of changes across multiple levels rather than isolated projects. The success or otherwise of implementation depends crucially on the interaction between the local context and the approach as it is applied. (These issues will be explored in more detail in a follow up Evidence Summary).

- Managers need to be actively involved with quality improvement.

Gaps in the evidence base for quality improvement

Many studies are from groups writing up a idea from their hospital that was perceived to have worked, rather than specifically setting up and designing studies to test the effectiveness of an intervention from first principles. The wider literature tends to have many observations and often does not include statistical analysis. The quality of reporting has often been suboptimal. There are a number of case studies but fewer independent evaluations.
Getting the full text of documents

A direct link to full-text is provided where possible. You can find other free journal articles with your Open Athens account. If you still cannot obtain the article you need, please email: newcomb.library@homerton.nhs.uk with article details and your budget code. Library staff will usually be able to obtain a copy.

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2. References

A. Short introductions

B. Guides

C. Success factors for quality improvement

D. Key examples

E. Useful websites

A. Short introductions (8)

Batalden, P.B. & Davidoff, F., 2007. What is “quality improvement” and how can it transform healthcare? Quality & safety in health care, 16(1), pp.2–3. Available at: http://qualitysafety.bmj.com/content/16/1/2.long


Berwick, D.M., 1996b. We can cut costs and improve care at the same time. Medical economics, 73(15), pp.180,185–187. Available at: https://www.openathens.net

Colquhoun, H. et al., 2014. Towards a common terminology : a simplified framework of interventions to promote and integrate evidence into health practices , systems , and policies. Implementation science, 9(51), pp.1–6. Available at: http://www.implementationscience.com/content/9/1/51

Abstract: Background: A wide range of diverse and inconsistent terminology exists in the field of knowledge translation. This limits the conduct of evidence syntheses, impedes communication and collaboration, and undermines knowledge translation of research findings in diverse settings. Improving uniformity of terminology could help address these challenges. In 2012, we convened an international working group to
explore the idea of developing a common terminology and an overarching framework for knowledge translation interventions.


*Abstract:* The phrase “Science of Improvement” or “Improvement Science” is commonly used today by a range of people and professions to mean different things, creating confusion to those trying to learn about improvement. In this article, we briefly define the concepts of improvement and science, and review the history of the consideration of “improvement” as a science.


*Abstract:* With the rapid expansion of knowledge and technology and a health care system that performs far below acceptable levels for ensuring patient safety and needs, front-line health care professionals must understand the basics of quality improvement methodologies and terminology. The goals of this review are to provide clinicians with sufficient information to understand the fundamentals of quality improvement, provide a starting point for improvement projects, and stimulate further inquiry into the quality improvement methodologies currently being used in health care. Key quality improvement concepts and methodologies, including plan-do-study-act, six-sigma, and lean strategies, are discussed, and the differences between quality improvement and quality-of-care research are explored.

**B. Guides (6)**


Summarises the improvement approaches and methods that have been successfully utilised by industry over the past 50 years. Evaluates the approaches from a healthcare perspective.


Most comprehensive overview in a single document covers the main methods, key examples, success factors and evaluations.


*Abstract:* A quick guide which aims to provoke thought rather than being a step-by-step guide.

C. Success factors for quality improvement (12)


Abstract: Identifies ten key challenges: convincing people that there is a problem that is relevant to them; convincing them that the solution chosen is the right one; getting data collection and monitoring systems right; excess ambitions and “projectness”; organisational cultures, capacities and contexts; tribalism and lack of staff engagement; leadership; incentivising participation and “hard edges”; securing sustainability; and risk of unintended consequences. Suggests tactics to respond to these challenges. Securing improvement may be hard and slow and faces many challenges. Formal evaluations assist in recognising the nature of these challenges and help in addressing them.


Abstract: Initiatives are unlikely to achieve their objectives without explicit consideration of the multilevel approach to change that includes the individual, group/team, organization, and larger environment/system level. Attention must be given to issues of leadership, culture, team development, and information technology at all levels. A number of contingent factors influence these efforts in both countries, which must each balance a number of trade-offs between centralization and decentralization in efforts to sustain the impetus for quality improvement over time. The multilevel change framework and associated properties provide a framework for assessing progress along the journey.


Abstract: This report describes a systematic review of the literature on the spread and sustainability of innovations in health service delivery and organisation. It was commissioned by the Department of Health via the NHS Service Delivery and Organisation programme and undertaken between October 2002 and July 2003. The brief for the project was to inform the modernisation agenda set out in The NHS Plan and other policy documents and led by the NHS Modernisation Agency.


Abstract: Increasing recognition of the failure to translate research findings into practice has led to greater awareness of the importance of using active dissemination and implementation strategies. Passive approaches are generally ineffective and unlikely to result in behaviour change. Most other interventions are effective under some circumstances; none are effective under all circumstances. Future quality improvement or educational activities should be informed by the findings of systematic reviews of professional behaviour change interventions.

Abstract: This article analyses and uses the NHS’s experience to identify the lessons for future quality improvement initiatives. At the heart of this article is an account of one recent initiative, the national booked admissions program, which illustrates both the opportunities and the challenges in introducing and sustaining change. By comparing the different impacts of the national booked admissions program on a number of pilots and interviewing the program’s participants to discover the reasons why some pilots were more successful than others, we identify those conditions that must be met in order to achieve quality improvements in health care organizations. We also examine the sustainability of the program and the factors that influence sustainability.


Abstract: Describes the experiences of several public hospitals which have implemented quality methods and management and lists some of the lessons they learned that could be usefully adopted by other services. Concludes that generally, the hospitals which had a greater success found ways to involve different professions and adapted the methods to their particular circumstances.


Abstract: Experience suggests that differences in context produce variability in the effectiveness of quality improvement (QI) interventions. However, little is known about which contextual factors affect success or how they exert influence. Using the Model for Understanding Success in Quality (MUSIQ), we perform exploratory quantitative tests of the role of context in QI success.


Abstract: The purpose of this report is to take stock of developments in thinking on service redesign in the NHS for quality improvement. Covers origins and meaning of redesign ((TQM, CQI, BPR, Lean Thinking. Discusses UK national improvement programmes. Local experience of NHS redesign- examples, lessons and reflections. Explores lessons to be drawn. Older report but still relevant and essential.


Touati, N. et al., 2006. Clinical leaders at the forefront of change in health-care systems: advantages and issues. Lessons learned from the evaluation of the implementation of an integrated oncological services network. *Health services management research : an official journal of the Association of University Programs in Health Administration / HSMC, AUPHA*, 19(2), pp.105–122. Available at: [http://hsm.sagepub.com/content/19/2/105.full.pdf](http://hsm.sagepub.com/content/19/2/105.full.pdf)
Abstract: Based on lessons learned from the evaluation of the implementation of an integrated oncological services network in Quebec, this paper discusses the following question: to what extent is strong clinical leadership a propitious means of transforming health-care systems, especially when the change leads to significant evolution in inter-professional and inter-organizational relations?

C. Key examples

Jonkoping County, Sweden (4)


Power point presentation on the same available at: http://www.ha.org.hk/haconvention/hac2011/proceedings/pdf/Plenary%20Sessions/P3.2.pdf


Abstract: Generally, the spread was more successful in the counties where the top management was strongly committed to the mission and the concept. Important factors for the national spread have been the establishment of a broader planning group as a network, the education of access coaches, the standardization of methods, and scientific assessments of the concept.

The IHI's '100,000 Lives Campaign' (4)


Gosfield, A.G. & Reinertsen, J.L., 2005. The 100,000 lives campaign: crystallizing standards of care for hospitals. Health affairs (Project Hope), 24(6), pp.1560–70. Available at: http://content.healthaffairs.org/content/24/6/1560.long
Abstract: The 100,000 Lives Campaign has the attention of U.S. hospitals, professional groups, and the media. Its aim has been endorsed, and its planks are being implemented, by more than 2,300 diverse hospitals in every state. We posit that the six planks of the campaign have become national standards of care and propose four theories of liability for hospitals that ignore the campaign or fail to implement its planks. As a result of the campaign, hospitals and their boards now face a legal incentive to reduce needless deaths through six specific interventions.


Abstract: BACKGROUN: On June 14, 2006, the Institute for Healthcare Improvement (IHI) announced that its campaign to save 100,000 lives had far surpassed its goal—by saving 122,300 lives. Although the 100,000 Lives Campaign succeeded in catalysing efforts to improve safety and quality in American hospitals, the promotion of rapid response teams as a national standard is problematic, and methodological concerns regarding the “lives saved” calculations make it difficult to interpret the campaign’s true accomplishments.

Leading hospitals (7)


Abstract: Draws on the findings from an international study designed to help practitioners and researchers understand the factors and processes that enable healthcare organisations in the United States and Europe to achieve - and sustain - high quality services for their users. The in-depth case-studies from seven leading hospitals give an international, evidence-based outlook that focuses on both the organisational and cultural processes of quality improvement. Implication for research and practice are considered, and a checklist of possible challenges has been drawn up to help identify any “gaps” in initiatives.


**Abstract:** The purpose of this paper is to show how over the last 18 months Bolton Hospitals NHS Trust have been exploring whether or not lean methodologies, often known as the Toyota Production System, can indeed be applied to healthcare. One’s early experience is that lean really can save lives. The Toyota Production System is an amazingly successful way of manufacturing cars. It cannot be simply translated unthinkingly into a hospital but lessons can be learned from it and the method can be adapted and developed so that it becomes owned by healthcare staff and focused towards the goal of improved patient care.


**Abstract:** A “learning report” which provides a checklist for building improvement capability. Provides five case studies from NHS Trusts and sets out some key lessons based on them.


**Abstract:** The purpose of this report is to take stock of developments in thinking on service redesign in the NHS for quality improvement. Covers origins and meaning of redesign ((TQM, CQI, BPR, Lean Thinking. Discusses UK national improvement programmes. Local experience of NHS redesign - examples, lessons and reflections.


**Abstract:** In 2008, researchers at the Institute for Healthcare Improvement (IHI) proposed the Triple Aim, strategic organizing principles for health care organizations and geographic communities that seek, simultaneously, to improve the individual experience of care and the health of populations and to reduce the per capita costs of care for populations. In 2010, the Triple Aim became part of the US national strategy for tackling health care issues, especially in the implementation of the Patient Protection and Affordable Care Act (ACA) of 2010. Since that time, IHI and others have worked together to determine how the implementation of the Triple Aim has progressed. Drawing on our 7 years of experience, we describe 3 major principles that guided the organizations and communities working on this endeavor: creating the right foundation for population management, managing services at scale for the population, and establishing a learning system to drive and sustain the work over time.
The Safer Patient’s Initiative, UK (2)


Abstract: This learning report provides an overview of the Safer Patients Initiative (phases 1 and 2) and its evaluation, and highlights the impact of the programme, key lessons and further issues for exploration. The report explains: There were significant improvements at a micro-system level where participant sites saw improvements in patient safety in specific clinical areas, such as a ward or critical care unit. The initiative was effective in raising awareness and galvanising action around the issue of avoidable harm to patients. The programme was successful in engaging senior managers whose support and enthusiasm helped to make safety an organisational priority. However, at an organisation-wide level the evaluation found no additional impact of the programme within the timeframe.


Abstract: This report has been superseded by Learning Report: Safer Patients Initiative, The Health Foundation 2011.

D. Introduction to methods (13)


Abstract: Improvement of health care requires making changes in processes of care and service delivery. Although process performance is measured to determine if these changes are having the desired beneficial effects, this analysis is complicated by the existence of natural variation-that is, repeated measurements naturally yield different values and, even if nothing was done, a subsequent measurement might seem to indicate a better or worse performance. Traditional statistical analysis methods account for natural variation but require aggregation of measurements over time, which can delay decision making. Statistical process control (SPC) is a branch of statistics that combines rigorous time series analysis methods with graphical presentation of data, often yielding insights into the data more quickly and in a way more understandable to lay decision makers. SPC and its primary tool-the control chart-provide researchers and practitioners with a method of better understanding and communicating data from healthcare improvement efforts. This paper provides
an overview of SPC and several practical examples of the healthcare applications of control charts.


Abstract: The Model for Improvement is a rigorous and reasonable method for busy health care practitioners to use to improve patient outcomes. The use of this model requires practice for clinicians to be comfortable, but mastery is critical to develop the necessary skills to participate in quality improvement initiatives. The case study demonstrates how this methodology can be applied in any busy health care setting. Incorporating this approach to quality improvement into daily work will improve clinical outcomes and advance health care delivery and design.


Abstract: Two popular quality improvement (QI) approaches in health care are Lean and Six Sigma. Hospitals continue to adopt these QI approaches-or the hybrid Lean Sigma approach-with little knowledge on how well they produce sustainable improvements. A systematic literature review was conducted to determine whether Lean, Six Sigma, or Lean Sigma have been effectively used to create and sustain improvements in the acute care setting. Generally, the studies provided limited data, with only 15 articles providing any sort of follow-up data; of the 15, only 3 report a follow-up period greater than two years. Lean, Six Sigma, and Lean Sigma as QI approaches can aid institutions in tackling a wide variety of problems encountered in acute care. However, the true impact of these approaches is difficult to judge, given that the lack of rigorous evaluation or clearly sustained improvements provides little evidence supporting broad adoption. There is still a need for future work that will improve the evidence base for understanding more about QI approaches and how to achieve sustainable improvement.

IHI, How to improve. Available at: [http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx](http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx)

Abstract: Learn about the fundamentals of the Model for Improvement.


Abstract: The article describes the Breakthrough Series, a collaborative improvement model developed by the Institute for Healthcare Improvement. The model adapts and applies existing knowledge to multiple, similar sites to accomplish common aims. It has been used to address several of the most pressing issues in health care today.
Abstract: This IHI white paper describes and promotes the use of a system of metrics, called the Whole System Measures, to measure the overall quality of a health system and to align improvement work across a hospital, group practice, or large health care system. The Institute for Healthcare Improvement and colleagues developed the Whole System Measures, a balanced set of system-level measures, to supply health care leaders and other stakeholders with data that enable them to evaluate their health systems’ overall performance on core dimensions of quality and value, and that also serve as inputs to strategic quality improvement planning.


Abstract: The PDCA cycle had its origin with Dr. W. Edwards Demings lecture in Japan in 1950. Where did he get these ideas and how have these ideas evolved since those lectures? This presentation will move from the 1600s with Galileo and the philosophy of science through the evolution of the scientific method and the science of improvement. Walter Shewhart in 1939 applied the scientific method with his cycle: specification-production-inspection. W. Edwards Deming in 1950 modified the Shewhart cycle: design of the product, make it, put it on the market, test it through market research, then redesign the product. The Japanese interpretation of the Deming wheel in Dr. Demings lectures of 1950 and 1951 lead to the plan-do-check-action or PDCA cycle. This cycle was integral to the Japanese QC, TQC, and QC circle activities. Deming introduced his Shewhart cycle for learning and improvement in the USA in 1986. Dr. Deming introduced a more abbreviated PDSA cycle in 1993. In 1994, the PDSA cycle was accompanied by three questions to aid in the planning step of the PDSA Cycle. In 1996 and 2009 publications, the PDSA cycle was broadened to include strategies and methods to develop, test, and implement changes that would result in improvement. This version was called the Model for Improvement. As an introduction to a framework for improvement, the model for improvement has been found to support improvement efforts in a full range from the very informal to the most complex.


Abstract: Measurement and feedback are fundamental to quality improvement. There is a knowledge gap among health care professionals in knowing how to measure the impact of their quality improvement projects and how to use these data to improve care. This article presents a pragmatic approach to measurement and feedback for quality improvement efforts in local health care settings, such as hospitals or clinical practices.

Abstract: People often want to know about the relationship between the IHI approach to quality improvement and Lean, and how they can best utilize one or both approaches to improve their own care systems. This white paper aims to address these issues, and argues that because both methods are complementary ways of approaching improvement, it is not necessary to choose one over the other as a guide to action. We also point out the fundamental congruence between the two approaches, as well as key differences. Finally, we suggest ways that practitioners of both Lean and IHI-QI can use the principles and methods of the other to extend their capabilities.


Abstract: Plan-do-study-act (PDSA) cycles provide a structure for iterative testing of changes to improve quality of systems. The method is widely accepted in healthcare improvement; however there is little overarching evaluation of how the method is applied. This paper proposes a theoretical framework for assessing the quality of application of PDSA cycles and explores the consistency with which the method has been applied in peer-reviewed literature against this framework. NHS Evidence and Cochrane databases were searched by three independent reviewers. Empirical studies were included that reported application of the PDSA method in healthcare. Application of PDSA cycles was assessed against key features of the method, including documentation characteristics, use of iterative cycles, prediction-based testing of change, initial small-scale testing and use of data over time. 73 of 409 individual articles identified met the inclusion criteria. Of the 73 articles, 47 documented PDSA cycles in sufficient detail for full analysis against the whole framework. Many of these studies reported application of the PDSA method that failed to accord with primary features of the method. Less than 20% (14/73) fully documented the application of a sequence of iterative cycles. Furthermore, a lack of adherence to the notion of small-scale change is apparent and only 15% (7/47) reported the use of quantitative data at monthly or more frequent data intervals to inform progression of cycles. To progress the development of the science of improvement, a greater understanding of the use of improvement methods, including PDSA, is essential to draw reliable conclusions about their effectiveness. This would be supported by the development of systematic and rigorous standards for the application and reporting of PDSAs.


Abstract: Problem-solving teams, involving front-line staff, are widely used to achieve continuous process improvement. Approaches such as “plan-do-study-act” (PDSA) cycles, are now a core element of many health-care improvement initiatives. This paper evaluates the use of PDSA improvement cycles within the UK National Health Service, using emergency care improvement activity as a source of research evidence. It was found that, despite an abundance of information on how to implement this type of change, many senior professionals still misinterpret how this should work. This has implications for how such methodologies are implemented. There is a long way to go in allowing greater employee involvement, moving much
further away from the “management committee” style of change. Care has to be taken to ensure that empowered employees are working to consistent and appropriate objectives. It is important that senior personnel develop process understanding alongside the workforce, rather than simply providing distant support.

E. Useful websites (10) * = especially useful

The Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

http://www.health.org.uk/

*HQIP (Healthcare Quality Improvement Partnership)

The Healthcare Quality Improvement Partnership (HQIP) is an independent organisation led by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices. HQIP was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality improvement. Lots of case studies.

http://www.hqip.org.uk/

**Homerton Improving Quality Intranet Page

Learn more about Quality Improvement at Homerton, including the Model for Improvement approach adopted in the Trust.

http://intralive/working-at-homerton/quality-improvement/

**Institute for Healthcare Improvement, Institute for Healthcare Improvement

Founded in 1991, led by Dr. Don Berwick, the Institute for Healthcare Improvement (IHI) is a US based independent not-for-profit organization helping to lead the improvement of health care throughout the world. Launched the 100,000 Lives Campaign. Responsible for the “Breakthrough series” of white papers and the rapid cycle change approach which includes the Model for Improvement and the Plan-Do-Study-Act (PDSA) tool.

http://www.ihi.org/Pages/default.aspx.

NHS England

At national level, NHS England leads the delivery of improvements within the NHS Outcomes Framework and of more choice and control for patients. Runs a number of quality improvement programmes.

https://www.england.nhs.uk/
**NHS Improving Quality (NHS IQ)**
Part of NHS England, NHS IQ seeks to bring expertise on quality improvement from across the NHS.

**NHS Scotland Quality Improvement Hub**
The NHS Scotland Quality Improvement Hub is a national collaboration among special health boards and Scottish Government Health Directorates which aims to support NHS boards with implementation of the Healthcare Quality Strategy through effective partnership working between the collaborating organisations.
[http://www.qihub.scot.nhs.uk](http://www.qihub.scot.nhs.uk)

**Public Health Wales, 1000 Lives Plus**
The National Improvement Programme for Wales.
[http://www.1000livesplus.wales.nhs.uk](http://www.1000livesplus.wales.nhs.uk)

**Quality Improvement Scotland**
The national healthcare improvement organisation for Scotland and part of NHS Scotland.
[http://www.nhshealthquality.org](http://www.nhshealthquality.org)

**Social Care Institute for Excellence, SCIE (Social Care Institute for Excellence)**
Independent, UK-based, research organisation that seeks to identify and disseminate good practice on social care. Research, reports, briefings, Social Care TV (videos) and educational materials (especially e-learning). Strongly focused on person-centred care, integration, co-production and transformed services. SCIE is a partner in the NICE Collaborating Centre for Social Care and a HQIP partner for quality improvement in social care.
[http://www.scie.org.uk](http://www.scie.org.uk)

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### 3. Further information

**How this review has been produced**
The Newcomb Library and Information Service uses the skills and expertise of qualified librarians who carry out searches of the most appropriate and authoritative sources of information available on your behalf. This might include searching biomedical databases such as MEDLINE, PubMed, CINAHL (Cumulative Index to Nursing and Allied Health Literature), EMBASE, HMIC (Health Management Information Consortium), PsychINFO, Health Business Elite, Cochrane Library etc.
We may also use other search methods such as searching organisational websites (e.g. NICE, Health Foundation, Nuffield Trust, Government Departments, the Royal Colleges), citation searching, hand searching key journals and reference harvesting for relevant publications. The exact mix will depend on the topic.

Results of literature searches are subject to the limitations of the databases and/or websites searched and are also restricted by contractual database licenses.

We have tried to select the better available evidence, but the included material has not been critically appraised. It is your responsibility to determine the accuracy, validity and interpretation of the references in this Evidence Summary.

**Requesting a literature search**

The Newcomb Library Literature Search service is available to anyone working on a work-related quality improvement or service development project and it is FREE. If you have already started (or completed) your project, you are still welcome to request a literature search as this will help you when writing up your results (especially if you are publishing).

We use the skills and expertise of qualified librarians who carry out searches on your behalf, including biomedical databases such as MEDLINE, CINAHL, EMBASE etc. The results will list relevant citations details (including abstracts where possible) of potentially relevant literature.

Please email Newcomb.library@homerton.nhs.uk with details of your search request and your phone number. We will call back to agree a delivery date for your search results.

Please note, the library staff do not do searches to support coursework or for individual research, but we do offer free search training sessions to help support you do a literature search for your studies and/or professional development. We can also give advice on how you might approach your literature search.