This is a repository copy of *Nurse led care*.

White Rose Research Online URL for this paper:
http://eprints.whiterose.ac.uk/964/

---

**Article:**
Cullum, N, Spilsbury, K orcid.org/0000-0002-6908-0032 and Richardson, G orcid.org/0000-0002-2360-4566 (2005) Nurse led care. British medical journal. pp. 682-683. ISSN 0959-535X

https://doi.org/10.1136/bmj.330.7493.682

---

**Reuse**
Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

**Takedown**
If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.

---

[White Rose Research Online logo]
Nurse led care
Determining long term effects is harder than measuring short term costs

What's the difference between medical and nursing care? The answer is not straightforward, but shortages in the medical workforce mean that nurses are increasingly called on to undertake work that was previously done by doctors (such as undertaking surgery, prescribing drugs, performing triage in emergency departments), whereas shortages in the nursing workforce mean that healthcare assistants now do many tasks that nurses are trained to do. This fluidity in professional roles and competencies enables the health workforce to respond to highly active antiretroviral therapies (HAART) regimes to a cohort of HIV-infected naïve patients. ICONA. Study Group. AIDS 2000;14:499-507.


The second study, an evaluation of nurse led intermediate care in an acute setting (p 699), represents a more complex nursing role that demands multivariable clinical decisions (although patients reaching intermediate care have been “filtered” through medical diagnosis and initial treatments). These authors undertook a cost minimisation analysis—they viewed the clinical outcomes in the intermediate care and standard hospital care arms as equivalent and merely totalled up and compared the costs. Walsh et al found, as have others, that nurse led intermediate care in acute settings is more expensive than standard hospital care based for the inpatient phase, but the longer term costs and benefits are more uncertain.

Close inspection of the clinical outcomes in the trial by Walsh et al reveals that patients who received nurse led intermediate care had better functional outcomes at discharge, although this did not reach significance. However, this lack of statistical significance is not the same as “no difference” in functional outcomes. A meta-analysis of 10 studies of nurse led intermediate care (which includes the Walsh trial) identified a statistically significant benefit of nurse led intermediate care on functional status at discharge, as well as reductions in the proportion of patients discharged to institutional care and in readmissions. This indicates that the increase in functional status may be clinically (and potentially economically) important and warrants further study.

In an editorial in the BMJ Briggs counselled against cost minimisation analysis in favour of cost effectiveness analysis since studies are rarely powered to confidently identify clinical equivalence. Hence, the lack of a statistically significant difference in effectiveness should not be used as a justification for a cost minimisation analysis. While the higher costs of nurse led intermediate care are due to an increased length of stay, existing analyses have failed to determine whether these costs are offset by lower costs (of health care and particularly social care) and health benefits gained in the longer term.
Large scale food retail interventions and diet

Improving retail provision alone may not have a substantial impact on diet

Ensuring communities have good access to healthy affordable food is one of the government’s joined up strategies to improve public health and reduce health inequalities.¹ ² Policy solutions for deprived communities without good access—food deserts—have focused on improving provision of food retail as part of a wider suite of recommendations for population dietary change focused around food retail as part of a wider suite of recommendations for deprived communities without good access.

Recent completed projects in Newcastle, Leeds, and Glasgow have started to provide us with this evidence.³ ⁴ The Newcastle study concludes that food deserts exist only for a minority of people who do not or cannot shop outside their immediate locality and for whom the locality suffers from poor retail provision of foods that compose a healthy diet. Key predictors of healthy eating were found to be dietary knowledge, relative affluence, and healthy lifestyle—retail provision was not independently associated with diet.

The Leeds and Glasgow studies were both prospective evaluations of the impact of large scale food retailing. Utilising an uncontrolled before-after design the Leeds study concluded that access to food improved notably after the intervention. The average distance travelled to the main food store fell to under 1 km, and the percentage of people walking to the new store an improvement in shopping to the new provision. In contrast the Glasgow study, a prospective evaluations of the impact of large scale food retail interventions work. Despite the evidence for the widespread existence of food deserts and their impact on population health has been contested.³ ⁴ This has meant that although retail based policy recommendations to reduce diet related health inequalities now exist,¹ ² the evidence to inform how, when, and where to reduce these inequalities is only now emerging.

Recently completed projects in Newcastle, Leeds, and Glasgow have started to provide us with this evidence.³ ⁴ The Newcastle study concludes that food deserts exist only for a minority of people who do not or cannot shop outside their immediate locality and for whom the locality suffers from poor retail provision of foods that compose a healthy diet. Key predictors of healthy eating were found to be dietary knowledge, relative affluence, and healthy lifestyle—retail provision was not independently associated with diet.

The Leeds and Glasgow studies were both prospective evaluations of the impact of large scale food retailing. Utilising an uncontrolled before-after design the Leeds study concluded that access to food improved notably after the intervention. The average distance travelled to the main food store fell to under 1 km, and the percentage of people walking to the new store an improvement in shopping to the new provision. In contrast the Glasgow study, a prospective evaluations of the impact of large scale food retail interventions work. Despite the evidence for the widespread existence of food deserts and their impact on population health has been contested.³ ⁴ This has meant that although retail based policy recommendations to reduce diet related health inequalities now exist,¹ ² the evidence to inform how, when, and where to reduce these inequalities is only now emerging.

Recently completed projects in Newcastle, Leeds, and Glasgow have started to provide us with this evidence.³ ⁴ The Newcastle study concludes that food deserts exist only for a minority of people who do not or cannot shop outside their immediate locality and for whom the locality suffers from poor retail provision of foods that compose a healthy diet. Key predictors of healthy eating were found to be dietary knowledge, relative affluence, and healthy lifestyle—retail provision was not independently associated with diet.

The Leeds and Glasgow studies were both prospective evaluations of the impact of large scale food retailing. Utilising an uncontrolled before-after design the Leeds study concluded that access to food improved notably after the intervention. The average distance travelled to the main food store fell to under 1 km, and the percentage of people walking to the new store an improvement in shopping to the new provision. In contrast the Glasgow study, a prospective evaluations of the impact of large scale food retail interventions work. Despite the evidence for the widespread existence of food deserts and their impact on population health has been contested.³ ⁴ This has meant that although retail based policy recommendations to reduce diet related health inequalities now exist,¹ ² the evidence to inform how, when, and where to reduce these inequalities is only now emerging.

Recently completed projects in Newcastle, Leeds, and Glasgow have started to provide us with this evidence.³ ⁴ The Newcastle study concludes that food deserts exist only for a minority of people who do not or cannot shop outside their immediate locality and for whom the locality suffers from poor retail provision of foods that compose a healthy diet. Key predictors of healthy eating were found to be dietary knowledge, relative affluence, and healthy lifestyle—retail provision was not independently associated with diet.

The Leeds and Glasgow studies were both prospective evaluations of the impact of large scale food retailing. Utilising an uncontrolled before-after design the Leeds study concluded that access to food improved notably after the intervention. The average distance travelled to the main food store fell to under 1 km, and the percentage of people walking to the new store an improvement in shopping to the new provision. In contrast the Glasgow study, a prospective evaluations of the impact of large scale food retail interventions work. Despite the evidence for the widespread existence of food deserts and their impact on population health has been contested.³ ⁴ This has meant that although retail based policy recommendations to reduce diet related health inequalities now exist,¹ ² the evidence to inform how, when, and where to reduce these inequalities is only now emerging.

Recently completed projects in Newcastle, Leeds, and Glasgow have started to provide us with this evidence.³ ⁴ The Newcastle study concludes that food deserts exist only for a minority of people who do not or cannot shop outside their immediate locality and for whom the locality suffers from poor retail provision of foods that compose a healthy diet. Key predictors of healthy eating were found to be dietary knowledge, relative affluence, and healthy lifestyle—retail provision was not independently associated with diet.

The Leeds and Glasgow studies were both prospective evaluations of the impact of large scale food retailing. Utilising an uncontrolled before-after design the Leeds study concluded that access to food improved notably after the intervention. The average distance travelled to the main food store fell to under 1 km, and the percentage of people walking to the new store an improvement in shopping to the new provision. In contrast the Glasgow study, a prospective evaluations of the impact of large scale food retail interventions work. Despite the evidence for the widespread existence of food deserts and their impact on population health has been contested.³ ⁴ This has meant that although retail based policy recommendations to reduce diet related health inequalities now exist,¹ ² the evidence to inform how, when, and where to reduce these inequalities is only now emerging.