adherence was 87 percent, while the lowest was 33 percent. The distribution of the scores was highly concentrated around the mean value, with thirty-four BIAs (87 percent of total sample) showing a level of adherence $\geq$ 60 percent. Only two BIAs reported an adherence $<$ 50 percent (5 percent of total sample). Six representative features showed a level of adherence $<$ 50 percent: off-label use (0 percent); uncertainty (26 percent); validation (33 percent); choice of computing framework (44 percent); eligible population (44 percent) and relevant features of healthcare system (49 percent).

CONCLUSIONS:

Compared to the Principles of Good Practice, the BIAs included in the systematic review were overcomplicated and deterministic, ignoring the impact of possible scenarios relevant to budget holders. The research advocates a wider use of scenario planning as a tool to link uncertainty to the economic assessment of new interventions.

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OP73 Using Visualization In Scoping The Literature For A Prognostic Health Technology Assessment

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INTRODUCTION:

One of the challenges of large scale Health Technology Assessment (HTA) projects is managing the large volume of studies retrieved by the requisite comprehensive literature searches. At the scoping stage of the project, a pragmatic judgement needs to be made as to how sensitive the search strategy should be in order to find all the relevant papers without returning an overwhelming volume of irrelevant studies.

METHODS:

For this HTA (evaluating prognostic and predictive markers in rheumatoid arthritis), the research team already had prior knowledge of several key markers of interest, but wanted to ensure that no others had been missed. Advice from practising clinicians was obtained, but for additional validation, a broad scoping search was conducted for 'rheumatoid arthritis' using the sensitive Haynes filters for prognostic (1) and clinical prediction (2) studies. Unsurprisingly, this initial search retrieved too many studies for them all to be admitted to the full review; but once those dealing with known markers had been removed, a sample of the remaining records was loaded into a software visualization tool (3) to display "heat maps" of frequently occurring terms and phrases.

RESULTS:

On this occasion, no additional markers were identified, however this provided reassurance that the advice obtained from clinicians was comprehensive, enabling the HTA team to proceed confidently with its evaluation of the selected markers.

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CONCLUSIONS:

Visualization offers an alternative means of exploring and interrogating large text archives, and has the potential to complement the role of traditional search methods in identifying literature for systematic reviews and health technology assessments. As processing power increases and more and more full-text papers become available open access, it may provide a solution to some of the limitations associated with comprehensive searching.

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OP75 Implementing Risk Stratification In Primary Care: A Qualitative Study

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INTRODUCTION:

A predictive risk stratification tool (PRISM) to estimate a patient's risk of an emergency hospital admission in the following year was trialled in general practice in an area of the United Kingdom. PRISM's introduction coincided with a new incentive payment ('QOF') in the regional contract for family doctors to identify and manage the care of people at high risk of emergency hospital admission.

METHODS:

Alongside the trial, we carried out a complementary qualitative study of processes of change associated with PRISM's implementation. We aimed to describe how PRISM was understood, communicated, adopted, and used by practitioners, managers, local commissioners and policy makers. We gathered data through focus groups, interviews and questionnaires at three time points (baseline, mid-trial and end-trial). We analyzed data thematically, informed by Normalisation Process Theory (1).

RESULTS:

All groups showed high awareness of PRISM, but raised concerns about whether it could identify patients not yet known, and about whether there were sufficient community-based services to respond to care needs identified. All practices reported using PRISM to fulfil their QOF targets, but after the QOF reporting period ended, only two practices continued to use it. Family doctors said PRISM changed their awareness of patients and focused them on targeting the highest-risk patients, though they were uncertain about the potential for positive impact on this group.

CONCLUSIONS:

Though external factors supported its uptake in the short term, with a focus on the highest risk patients, PRISM did not become a sustained part of normal practice for primary care practitioners.

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