King's Fund

Promoting Action on Clinical Effectiveness

Project Reports

June 1998 (Volume 2)

This document includes extracts from the progress reports provided by four local projects as background to the discussions at the PACE Project Group meeting on 15 July 1998. The extracts include material to describe 'the lessons and factors for success which have emerged from managing your projects'.

The reports included here are from:

- North Derbyshire
- Bromley
- Bradford
- Walsall

Michael Dunning
PACE Programme

North Derbyshire Health

PACE Project

Promoting Effectiveness in the Investigation and Management of Congestive Cardiac Failure

Final Report

Part One

June 1998

PROMOTING ACTION ON CLINICAL EFFECTIVENESS PROJECT REPORT 1998.

Part 1.

Changing practice, project management and lessons from the work.

1. Techniques and change mechanisms

The North Derbyshire PACE Project has employed a variety of techniques and change mechanisms over the 2 year period of the project both through the direct practical elements of the project (such as the audit and quality of life survey) and through a range of associated activities (such as the educational programme and practice visits) designed to ensure that there was a "drip-feed" approach to raising and maintaining awareness of the project. The focus has always been jointly on both the specific topic chosen, namely the diagnosis and management of heart failure, and on the overall aim of the PACE project, that is, to learn about what works in achieving change in clinical practice based on the evidence of effectiveness.

Audit

Following a pilot study involving 3 GP practices, an initial audit of the records of a sample of patients diagnosed as having heart failure was undertaken involving 48 (78%) of the practices in North Derbyshire and covering 86.5% of the population.

A re-audit of a random sample of records of patients diagnosed as having heart failure has been undertaken between 15 and 24 months after the first audit, involving 49 (80%) of the existing 61 practices, in order to establish change in clinical practice over the period of the project.

The results are presented in part II.

Practice information pack

An information pack was compiled and distributed to all the practices early on in the project. It contains several pieces of information (as separate pages for ease of use) including the aims of the PACE project, a summary of the size of the problem, the research evidence on the management of the condition, details of the audit, the use of ACE inhibitors and a cost-benefit analysis of the management of heart failure patients. It also includes some practical details on how to obtain PGEA approval for practice-based meetings - an example of our using evidence from

elsewhere on what works in helping change clinical practice, in this case, from the FACTS project in Sheffield.

Education programmes

A series of formal educational meetings were held during 1997 for the GPs in each locality. The content of the meetings centred around information about the PACE Project, echocardiography as a diagnostic tool and the results of the initial audit. The meetings were well attended involving 51 GPs from 32 (52%) of the 62 practices.

A second series of meetings is being held during 1998 when the focus will be on the use of open-access echocardiography services, including results on the analysis of the first few months of open-access services, the results of the re-audit and the management of those patients in whom the diagnosis of heart failure is not confirmed by echocardiography but who present with similar symptoms.

A practice nurses' study day has also been held in order to inform and involve the nurses of the project work and to explore with them how other members of the practice team can be involved in promoting change on the basis of evidence.

Development of new services

One of the objectives of the North Derbyshire project was 'to develop open access provision of echocardiography resources'. Following a pilot study which provided an interim service for several GP practices, open-access services have been set up at Chesterfield and North Derbyshire Royal Hospital, the main local provider. Stepping Hill Hospital, Stockport has been running a pilot service involving the GPs in the High Peak in conjunction with the PACE project. Three other Trusts have set up such services with the support and encouragement of the local project team and we have worked with them to "sell" their services locally.

Information booklet

An information booklet has been produced for both patients and carers, which is being distributed through practices, pharmacies and local centres. There is currently very little information available on heart failure and that which does exist is complex in its content. The locally developed booklet is easy to understand and explains the condition, the drugs which may be prescribed, life-style changes which may be advised and the tests which may be performed.

Working with the Community Health Council

The Community Health Council has been involved in the pilot studies of both the Quality of Life Survey and the information booklets and has been represented on the project team. Their support for and help with the project has been particularly valuable in the development of the information booklet. This support built on an on-going relationship with the CHC through the long-standing Coronary Heart Disease Working Group which first agreed the project topic and developed the PACE bid.

Working with practice managers

The project officer has attended many of the locality managers meetings over the two year period, informing everyone of the progress of the project and enlisting help and support from the practice managers in liaison with the GPs.

Meeting with the practice managers on an individual basis has also been very beneficial in terms of practice response to the various initiatives.

Invitations

The project team have found that the response from deliberately, individually and actively inviting the practices to take part in the audit, Quality of Life Survey, and education programme, rather than assuming participation following a passive mail shot, has been very encouraging. Peer pressure has also played a part in achieving such high levels of participation. This has resulted from within the GP group and not directly from the project team.

Newsletters

Regular newsletters have been produced and circulated to Primary Care, the Health Authority, local Trusts, community pharmacists and the PACE project team.

Practice visits

Visits to the practices to talk to the GPs have been made in conjunction with the various activities of the project e.g. the audit, the Quality of Life Survey and the education programme.

2. Managing the work

The project leader

The project leader is a consultant in public health, who has previously worked in general practice thereby experiencing and recognising the difficulties involved in changing clinical practice in primary care. Knowing the culture within general practice and being known to and respected by the GPs has undoubtedly contributed to the way the project has been taken forward.

The Project officer

The project officer has co-ordinated the work of the project on a day-to-day basis involving and informing primary care, secondary care and the Health Authority of the activities being undertaken. Prior to this project, the project officer was known to many GPs through the work of a local Trust and this proved to be very beneficial as the project was able to build on existing respect and relationships.

The Project team

The project team is made up of individuals from primary and secondary care and the Health Authority. In addition to the project manager and project officer, the team includes a consultant cardiologist, the pharmaceutical advisor, the Chair of the Primary Care Quality Group, a GP advisor to the Health Authority, an information officer, the Quality and clinical audit facilitator, a representative from the Community Health Council, the local Trust medical directorate business manager and managers from the Health Authority Commissioning directorate. Colleagues from external trusts are invited but rarely manage to attend.

Existing networks and established ways of working involving these individuals have been used wherever possible during the project. Two examples are the locality commissioning managers re-inforce the work of the project during practice visits and the organisation and management of the audit which has been arranged through the Primary Care Quality Group facilitator. The pharmaceutical advisor also raises prescribing issues related to the PACE project when visiting the practices. There are strong links between the PACE project team and the Coronary Heart Disease Working Group. Feedback on the project is given at various Health Authority meetings including formal feedback at least twice a year.

Good communication links also exist between North Derbyshire and Trusts outside the district, particularly in the High Peak, where the PACE project has enlisted the help of the High Peak Forum in piloting the Quality of Life Survey and the information booklets.

The GP education programme is another example of the project working within existing systems as the education meetings are arranged as part of an annual programme, through the University of Sheffield, to agree PGEA approval.

The value of the project being agreed, set up and managed as part of mainstream HA work has been demonstrated repeatedly throughout the two years.

3. Factors for success

Choice of topic

One reason for the success of the project has been the topic -heart failure- which was chosen by local GPs who identified the need to look at the diagnosis and treatment of heart failure as there was common concern that such patients were not being treated optimally. As the topic was chosen by the GPs themselves, a high level of participation has ensued. The importance of this cannot be underestimated.

The choice of topic was also very relevant to the Trusts as the timing coincided with a number of Trusts having thoughts about developing open-access echocardiography services.

Project leader relationship with GPs

The project has also been helped by the credibility of the project leader, who, having worked as a GP not only understands the issues facing the GPs but also has their trust and support.

Project officer

Having a designated project officer to co-ordinate and organise the events of the project has meant there has been a central contact point for communications and access to information. Whilst this project does not require a full time post holder, difficulties would have arisen in terms of communication when the officer was not in, had the secretarial staff not been as conscientious in their receiving and passing on of messages.

Again, the importance of employing a person known to and trusted by local clinicians in this post has been demonstrated.

Communication

Communication with everyone involved in the project has been regular, focused and concise. Having an agreed timetable/programme for this has been vital. The forms of communication have included meetings,

newsletters, individual correspondence and education programmes, all of which have contributed to the success of the project.

Newsletters have been produced 3-4 times each year and have been circulated within Primary Care, the Health Authority, the local provider Trusts, the Community Health Council, and to the community pharmacists and some individual meetings have been arranged with senior managers within the Trusts in order to ensure a continued awareness of the project.

A good working relationship exists with the representatives from the seven pharmaceutical companies who are helping to support the education programme, all of whom have signed a service agreement with the Health Authority. Two of the companies have also agreed to help fund the printing costs of the information booklet whilst the audit of heart failure patients' records is currently being supported by other pharmaceutical companies.

The desire to work closely with these companies led to the development of an outline agreement for any work done in conjunction with a commercial organisation which is now in widespread use across the Health Authority and which is completed and signed before commencing any joint work. Such an agreement proved invaluable in the PACE project when we had an unfortunate incident at one educational meeting. The existence of the agreement was a key factor in the Health Authority having a complaint to the ABPI upheld. It has also allowed us to continue to work positively with the company involved.

Graduated development of the project

The different aspects of the project have been implemented in a staged manner, rather than introducing the audit and the practice pack, the Quality of Life Survey and the education programme all at the same time. The incremental build up of the different aspects of the project has allowed time for each activity to be developed and understood before the next one was introduced.

The timetable for the project is shown in Appendix 1.

Audit

Undoubtedly one of the reasons for the high participation was offering the practices either a financial payment for doing the audit themselves or offering the services of an audit nurse. The pre-existing strong primary care audit culture in North Derbyshire was another key factor.

Open access echocardiography services

It has been interesting when working with external providers to realise that the current purchaser/provider system means that it is very difficult to obtain support for such developments unless there is support from that trusts clinicians and management and also local purchaser support. With one Trust in the east, there was some clinician support but without either management or host purchaser support we were unable to progress with the development of an open access service. It was the strong clinician enthusiasm and management support at Stepping Hill that acted as the main catalyst for developing the service there.

Involvement of all the important players working in primary care

Involving not just the GPs but the practice managers, practice nurses in many cases and the community pharmacists has contributed to a greater awareness of the project and improved participation. Indeed, the project broke new ground in involving pharmacists which has reaped benefits in other development work with them that has occurred subsequently and should also help in the debates around involvement of key professionals in Primary Care Groups.

4. Self assessment and reflection

Time to visit the practices and explain the work of the project on a more regular basis would have been beneficial.

Easier access to groups of practice nurses would also have been helpful and perhaps we should have arranged to see them all early on in the project to ask for their help and involvement rather than later suggesting involving them to the GPs (who invariably have said no!)

The project officer working part time has been adequate for the work of the project but an answer phone would probably have been useful, at least from other people's point of view.

We could have developed an even more rigorous communication strategy and timetable and although we have involved other people from across the Health Authority in much of the work, the project is still seen as separate from mainstream work. It is vitally important to learn the general lessons from the approaches we and others have made and to capture these to use in other areas of work within the Health Authority. A summary report is being written for the benefit of the staff within the Health Authority so that everyone has the opportunity to gain from our experience.

The importance of choosing a 'sexy' topic of concern to all the key players cannot be ignored. As the choice of topic involved the input of so many

disciplines, it was bound to have a large, wide-ranging impact and also fitted in with the Health of the Nation strategy.

Working with the pharmaceutical companies has been very beneficial in terms of financial support for the education programme and audit and booklets. The possibility of staffing support for future projects is an issue which could be considered and is perceived to have potential.

Deciding on the range of outcome measures at the start of the project and using previous years data as the baseline has been valuable and, because only routinely available data are being used, can continue after the formal end of the project so that the impact of all our work long-term on the management of patients with heart failure can be assessed. It may be that to achieve significant change takes longer than two years, or that any initial impact wears off rapidly. North Derbyshire PACE project team considers this longer-term follow-up of vital importance when assessing whether the PACE projects and their findings represent real value for money and produce truly effective ways to promote action on clinical effectiveness.

5. Sustaining the changes

Echocardiography Service

The echocardiography service at Chesterfield and North Derbyshire Royal Hospital, initially set up as a pilot in October 1997, is now to continue on a permanent basis and the appropriate mainstream funding has been agreed and disseminated to practices.

The echocardiography service at Stepping Hill Hospital is still being run as a pilot study but it is expected that it will become a substantive service. The services at Macclesfield, Northern General and Derby are now well established and are to continue.

Quality of Life Survey

The Quality of Life Survey commenced in May 1997. This is very much a research study and can be viewed as a separate study in itself. Indeed, because there has been an unexpectedly slow start in recruiting patients, this work will continue after the PACE project has officially come to an end although funding and support have yet to be agreed. The "prescription pad" recruitment forms will continue to serve to remind the GPs of the need for the appropriate management of heart failure patients and the use of the echocardiography services.

Prescribing review feedback

Visits from the pharmaceutical advisor to the practices for prescribing reviews will sustain the message of the project and the use of ACE inhibitors and loop diuretics will continue to be monitored, as will be the costs of the drugs being prescribed.

Professional interest

We were interested to explore what members of the PACE project team felt about the project and their own personal input and experience. All members have been asked to tell us up to three bad things and three good things about their experience. A summary of the answers (suitably anonymised if necessary!) will appear in part II.

6. Using the learning

A considerable amount has been learnt by the PACE Project team throughout the duration of the project most of which will be directly transferable to projects on other clinical topics. Equally, much of what has been learnt will be applicable across the working of the whole Health Authority, particularly the aspects relating to communication and organisation.

As has already been mentioned, a summary report detailing the practical application of what has been learnt throughout the project is to be presented to the Health Authority at its next meeting and then circulated throughout the organisation, possibly in association with presentations from the project team.

Appendix 1.

Project Timetable

Visits to the practices and promoting effective prescribing have taken place throughout the project.

May 96 - Jan 97	initial audit of heart failure patient records
Jan 97 - April 97	GP education programme, series 1.
May 97 to date	Quality of Life Survey undertaken
June 97	Pilot echocardiography service, Whitworth hospital
July 97	Nurse education study day
Summer 97 to date	Pilot echocardiography service at Stepping Hill Hospital, Stockport.
October 97 - March 98	Pilot echocardiography service at Chesterfield and North Derbyshire Royal Hospital
April 98 - June 98	Re-audit of heart failure patient records
June 98 - Sept. 98	GP education programme series 2
April 98	Echocardiography service at CNDRH

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Friday, 19 June 1998

Dear Mike,

Re: PACE Programme : final report

Please find enclosed the PACE report for Bromley. Sorry for the delay.

Yours sincerely

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We have put our report together under five sections.

1. A review against aims, objectives and project plans
2. Managing the change and learning the lessons
3. Assessing the cost
4. Currently available materials
5. An evaluation of the programme.

Part 1: A review against aims, objectives and project plans

The aim of the project is to change clinical behaviour, in line with best evidence, to improve the health of those with a peptic ulcer. We have achieved this. We have changed clinical behaviour and we have audited the scale and the nature of this change. We are confident that the change is in line with evidence-based guidelines. We know that people with peptic ulcer have been appropriately treated for Helicobacter Pylori infection. We have achieved our aim but how did we get there, how many people have we reached, and how do we keep the good work going?

Our objectives give an indication of how we would reach our goal. We knew we would need to establish local ownership over guidelines, implement a strategy for dissemination and education, and establish a process for helping it actually happen. All these things were needed and all these we did. However, we also thought that we would tackle practice across both primary and secondary care, that we would run patient groups to help develop good patient information, and that we would formally evaluate our approach. We haven't fulfilled all these objectives, at least not yet.

We envisaged that the work would fall into the following six stages:

Stage 1: Identify, recruit and involve stakeholders
Stage 2: Researching the local case and reviewing national evidence
Stage 3: Establishing stakeholder consensus for change
Stage 4: Monitor and evaluate pilot implementation of guidelines
Stage 5: Review pilot implementation of guidelines
Stage 6: Dissemination and cascade strategies for guidelines district wide

This was a helpful structure. We have dedicated a couple of paragraphs to each stage in order to summarise some of the techniques we used and highlight lessons learnt along the way.

Stage 1: Identify, recruit and involve stakeholders

GPs were one key group of stakeholders for our project. We wanted GPs to influence the development of guidelines but also to commit to piloting the work in their own practices and help disseminate the final package. We aimed to recruit a mix of 'opinion leaders' and those less involved in local activities beyond the practice. On top of this we needed a group that would be 'representative', reflecting different types of practice, different localities, and different patterns of prescribing, so that the lessons learnt might be applicable to the rest of the district.

To meet these criteria we randomly selected a group of six practices, two from each group of low, medium and high prescribers, and checked if the selection met our criteria. We then wrote to each head partner with a specific contract for involvement that included payment for participation on a sessional basis. We would recommend this approach. Clear communication about the role you want your recruits to play, and appropriate payment for the time involved is a reasonable deal. We found it useful to establish the credibility of the approach by ensuring the recruitment letter was signed by a 'holy trinity' of key local opinion leaders, in this case the Director of Public Health, the chairman of MAAG and one of the hospital gastroenterologists.

Our full steering group included pharmacists, consultants, managers and GPs but looking back we didn't consider the pivotal role of Practice Nurses in implementing the work until late on. Given our chance again we would have included this group earlier.

Stage 2: Researching the local case and reviewing national evidence

We spent too many months in this stage. We would caution against the traps that lie waiting in this task. We fell into an increasingly complex, rigorous and detailed process of literature searching and appraisal without first checking what had been done elsewhere, or more importantly what major questions our group wanted to address.

We found our review of evidence was not contentious and didn't prompt debate about current practice. However, before a subsequent meeting we surveyed participants in order to establish current practice in relation to a number of short scenarios. We then placed evidence of divergent current practice alongside specific research evidence in a number of small group sessions. Debate raged and people engaged in the process of guideline development. At that point the group brought their experience to bear on the applicability of the research to their work at the sharp end. We found this approach very productive. Generating such debate enabled us to focus our evidence search and appraisal more usefully on areas of disagreement.

Stage 3: Establishing stakeholder consensus for change

Establishing a consensus is not easy. There are two elements to an agreement. First, establishing clinical guidance that everyone can put their name too, and second, setting up a process for promoting and facilitating change. Commitment is more important than a common perspective. Establishing the areas of mutual interest is as important as consensus. We needed to show the advantages of participation to general practice in terms of time, money and reduced future consultations. Different incentives may have motivated the participation of secondary care clinicians and managers. These personal and 'political' issues were more important than any philosophical discussion of a meta-analysis or systematic review.

Stage 4: Monitor and evaluate pilot implementation of guidelines

We made substantial changes to our material after piloting the process in 6 practices. We completely re-vamped our patient information; we realised the need for more resources to enable practices to take up the programme; we added extra clinical information on how to bring current medication to a close after eradication, and how to manage those patients who returned symptomatic post-eradication. Without these changes we would have launched our programme only to fall flat on our noses!

Piloting change is a valuable process. It is a chance to ensure that the process for driving change works. To succeed you need more than a good reason for change you need to ensure that making the change is easy. This was a chance to test our product on the market. When it worked we know we could promote a system in which we had confidence. At the district wide launch we could talk credibly about it's flexibility and applicability in a range of different practices.

Stage 5: Review pilot implementation of guidelines

This stage is crucial to a successful launch and implementation. Although self-evident, there is no point in piloting the programme if you don't leave time for learning the lessons. Too often 'pilots' are squeezed into a timetable right next too a launch and wide scale dissemination and implementation programme. We required substantial time following the pilot to tackle emerging problems.

The pilot also provided an important indication of the scale of resources required to implement district wide and the level of services required to support the change. We used this local evidence base to make our case

for additional resources to pay for Hp testing. However, the process of securing money and changes to services may take months. We also used our experience to model the hours of work required within general practice to do the audit. The pilot enabled us to set evidence-based targets and work towards obtaining appropriate resources to support implementation. We avoided the pitfall of high expectations without the resources to follow through.

Stage 6: Dissemination and cascade strategies for guidelines district wide

We launched an implementation programme and not a set of guidelines. We opted for a big post-graduate educational evening as the main event. We developed a marketing strategy for the meeting including individual invitations to all GPs, advertisements promoting the event and a programme that included a good meal, PGEA points and an emphasis on education and fun. Our launch went well. At the end of the evening we collected a registration form asking GPs to commit to a follow up visit from the team to discuss project participation with the whole practice. The first card out of the hat won the champagne! This has given us a sufficient number of practices to keep our team of 'implementers' busy for more than the next year. Although other smaller scale events and presentations continue.

Our strategy for cascading the programme has been to focus on making implementation practical. We haven't provided guidelines for every GP but have given a whole implementation package to interested practices. This includes someone to do the work! We have ensured a range of options to meet the preferences of any practice. These options include a community pharmacist as part of a Health Authority joint Community Pharmacist/ GP working project, payment for the 'in-house' practice nurse or practice manager to do the work, or using a pharmaceutical company sponsored independent nurse to apply the guidelines. Our strategy is based on building personal relationships with participating practices. We are now planning an event for participating practices to celebrate and reflect on achievements.

Reflection on performance against project plans

A number of general lessons learnt from the work are outlined in part two of the report. However, there are three areas of reflection when comparing project progress against aims, objectives and plans.

Our timescales for project implementation slipped considerably. Our expectations for progress were far from evidence-based. We didn't appreciate the time involved reviewing case notes and implementing audit in primary care. We hadn't considered the need to provide resources to ensure implementation could happen. We hadn't taken on board the fact that practices wouldn't implement this scale of change without help. Neither did we appreciate the time required to put together a viable, credible and practical programme that we could recommend to the GP community. We wouldn't expect to devise a credible implementation programme for evidence based change in primary care in under a year.

Plans for involving patients in developing patient information went awry. The key issue here was how much resource to put into work that might have been done elsewhere. However, when we piloted material that had been developed elsewhere practitioners didn't like the information and it was not reaching the patient. We then developed our own but without the time or resource to involve patients and are now engaged in evaluating how patients viewed this material.

We didn't met original estimates of impact in terms of numbers of practices and patients reached. We have evaluated our approach and part five of the report provides information on outcome. Our original expectations were high partly through ignorance of the million and one practical barriers to change that you only discover through doing the work. There is also often a need to present a positive view of anticipated benefits, however, evidence based expectations may be more helpful in the long run if sustained support for a programme of implementation over a number of years is to be nurtured. Remember this ain't a controlled trial and in the messy and uncontrolled world take up rates are lower, concurrent illness higher and the number of organisational hurdles between plan and reality too numerous to mention. It is often not the evidence base for establishing clinical effectiveness that is lacking rather the evidence to show realistic impact in real world settings that is completely missing.

Part 2: Managing change and learning lessons

Overview

An important part of managing such a project is maintaining the commitment of your steering group. Members of our group were major decision-makers in their respective fields and their individual motivation changed as the programme developed. We identified three specific phases during the project.

The professional interest phase
At this stage members want to ensure that guidelines reflect best practice informed by their experience and professional opinion. The emphasis on professional responsibility has implications for how to manage the process. Specific issues are best identified through discussion with individual members of the steering group outside of whole group meetings. Appropriate evidence to enable the group to consider the issue can then be supplied in a reader-friendly and summary format before or at the meeting. The agenda needs to reflect that these initial meetings are a forum for informed discussion as well as decision making.

The implementation phase
Stakeholders are particularly aware that guidelines can have an effect on the demand for services. Therefore as the programme moves into implementation steering group members often focus their attention on ensuring that necessary resources are available. Managing the process through this phase means focusing on maximising resources and ensuring the support for associated services.

The sustaining phase
As the programme moves on to ensure that the change in practice becomes part of the everyday, steering group members focus interest on addressing issues arising from implementation. Management of the group needs to concentrate on establishing facts, discussing problems with those concerned and achieving favourable future decisions. At this point motivation may change and the future benefit of having developed and established a skilled team who understand and have experience of implementing clinical effectiveness emerges as a key driver for people's continued participation.

Managing change- lessons learnt and success factors pinpointed

Managing the stakeholders
Every project requires a steering group. Without a steering group progress is limited because change is dependent on motivating and co-ordinating new ways of working across a whole range of services. Members of the steering group need to ensure that plans for that co-ordinated change are practical and acceptable and should lead the process. We found the best method of managing the steering group was to maintain an equality of status amongst participants. We didn't appoint a group chairperson. Instead, as project workers, we facilitated the group. At most meetings we prepared small group exercises, even when asking for help in designing materials or planning an implementation strategy, and encouraged small groups to debate and feedback responses their views.

Thinking of the practicalities
Promoting clinical effectiveness assumes a staring role for the research evidence. However, in our project it wasn't the evidence that got top billing. Consideration of the evidence, or even the techniques of evidence based practice, were minor guest stars to the important parts played by practicality, adequate resources and the support of local opinion leaders. A stage of appraising and discussing the applicability of research evidence is crucial. However, this stage may not be prolonged or heated. We found the practical rather than the philosophical to be more contentious. How to establish appropriate services to support the change? How to flag notes in a way that worked for GP's, was easy for practice nurses, and still allowed Lloyd George notes to be filed in the existing cabinets? All these problems were more central and generated lengthier debate.

Putting resources into implementation

Designing a system for change is not difficult. Even getting a large group of stakeholders to agree to such a system including clinical guidelines, patient information, and proposed audit, may not be that difficult. But finding the resources to implement the change is a big headache. At some point in any project the question has to be faced. Who is going to do the actual work? Particularly when implementing change in General Practice someone has to undertake a whole series of practical tasks in dozens of separate and unique organisations. Who is going to interrogate the practice computer? Who is going to pull the notes? Who is going to review medication, discuss changes with patients, and alter long term prescribing? Many implementation projects seek to motivate general practice staff to do the work themselves. We knew from our pilot that change in an average practice took weeks of work. So, we sought to also provide resources to enable this to happen on a wide-scale. Without support, we did not believe that change would happen. We believe that providing a range of practical implementation resources such as community pharmacists, in-house training, and audit nurses were key to making it happen.

Establishing credibility

Change will not occur unless the change agent is seen to be credible. Our team had joint funding from Health Authority and Hospital Trust. Because we had joint status, we could project an independence from the organisational politics of both purchaser and provider. We had a separate and clear remit. We could establish credibility with stakeholders and emphasise our neutrality in any debate over the form that guidelines should take or it's implication on future services. We even discussed the clothes to wear in order to ensure that we were not perceived as stereotype manager or commissioner. Establishing such credibility whether through asserting professional over corporate identity, or whether through the clothes you wear, or the organisational structure within which you work, is key to achieving trust and commitment to change.

Reflecting and applying learning

Our reflecting and learning centred upon regular planning and debriefing sessions. However, one useful motivator for learning is the process of regular presentations to different local audiences. Another impetus for reflection has been the triple layer of external review, evaluation and peer group support provided by belonging to a national programme of projects. Not only does a national perspective ensure that learning is kept at the forefront of the mind, but it also provide a series of structures specifically designed to support the process of learning and reflection. First, the regular peer group support of other PACE project leaders. Second, the process of planning and review facilitated by regular visits to the project. Thirdly, the more formal independent evaluation of the Templeton College.

As a team you learn to trust intuition. As confidence grows from experience so it is important to treat seriously any discomfort or unease at the next step in the process. Putting off a meeting with a key stakeholder, not finishing the paper work for an aspect of the audit, or not collating the figures for one of the process measures, may all be signs of more serious and real issues. Perhaps uncertainty over what we want from a particular stakeholder, or what an aspect of the audit might tell us about our achievement of the overall aim.

Sustaining the change and building for the future

The best way of sustaining change is to recognise that your main investment is the people involved. The project represents significant input from a range of people from project team to steering group, to a group of multi-professional 'implementers'. In our project we have invested in the clinical, audit and implementation skills of practice nurses, practice managers, community pharmacists, and general practitioners. This is an investment in a cohort of people able to implement future programmes of change as well as initiate and develop similar programmes in their own organisations or professions. The project aims to channel individuals into personal learning in relation to the techniques of evidence based practice as well as the concepts that will be needed to drive Clinical Governance. The development of these skills for the future is one of the most important, if intangible, benefits of the whole process.

We have taken the opportunities that are generated by one piece of work to start others. On the back of the audit identifying proven ulcer disease patients, for Hp testing and treatment, a majority of participating practices are also implemented a review of medication prescribed for those with unproven ulcer disease, reflux or other dyspeptic conditions. This review aims to reduce prescribing according to agreed guidelines for minimal clinical and cost effective treatment.

Similarly, we are about to use our personal contact with all participating practices to launch a wider set of guidelines to rationalise endoscopic and barium investigation for upper GI disease. This sustainability can be attempted by building on the credibility of the project team to deliver the programme. It is enormously helped by the 'hands on' approach taken to supporting implementation.

Part 4: Currently available materials

Following is a list of materials, papers, and audit tools that we are happy to share:

- Case study scenarios;
- Education / Evidence Packs for three areas, 'Who to treat', 'How to test', and 'How to treat';
- Bromley's Guidelines;
- An operational guide for a proven ulcer disease audit;
- The implications of changing treatments for proven ulcer disease patients;
- A draft contract for a pharmaceutical contract;
- Bromley patient information.

Promoting Action on Clinical Effectiveness
Bradford PACE team Report

1. Background

The PACE programme was established in 1995 to demonstrate the effective implementation of evidence based practice and to identify the factors for success. Sixteen pilot sites were selected from 98 original applicants, Bradford was one of those chosen.

One of the key components of the Bradford PACE project was the focus on effective implementation of the guidelines produced and a rigorous evaluation of their impact.

2. Techniques and Change Mechanisms Used

The importance of effective professional practice has now been recognised by the National R&D strategy which has established an advisory group to clarify which methods work the best. There is also an International Cochrane Group on the subject. From what is known at the moment, there is no magical solution, and strategies to implement effective change will vary according to clinical setting, practitioner characteristics, patient characteristics and convenience.

The Bradford approach to ensure effective practice was multi faceted.

The development of the local, evidence based guidelines was undertaken by representatives from primary and secondary care. The following methods of implementation were used:

- Audit of current practice in primary and secondary care using evidence based criteria was undertaken. The criteria for primary care and both acute trusts were the same.
- Outreach visits to individual general practices and hospital practitioners. These visits were used to feedback relevant audit results from the practice or hospital, and describe the guidelines.
- Locality and specialty workshops were arranged and supported by the gastroenterologists who were asked to explain the guidelines and their implications to their primary and secondary care colleagues. These workshops included ones with Community Pharmacists as well as practice teams.
- Postgraduate educational events were held, although we were aware that these were likely to be less effective than other interventions we felt that for those GP's who preferred the more traditional events it would be worthwhile. In the future we hope to do less of this type of intervention and more participate work.
- Patient mediated interventions through the development and dissemination of patient information were part of the implementation process. The development of patient literature was difficult and with hindsight needed more time and resources. Local media was utilised to share key messages about the guidelines, as well as focus groups to consider the quality of the literature developed by the team.
- Patient prompts through the development of guideline specific referral forms and adaptation of primary care computer prompts were other facets of the change process. The referral forms were developed by the professionals involved in the guideline development team.

- Feedback of guideline information in structured reports or letters after referral requests were produced by the gastroenterologists.
- Triple therapy packs were developed by the acute trusts to aid compliance
- In one of the acute trusts changes were needed in the provision of breath tests

3. Management Arrangements

The management of the PACE project was split between the project manager and project leader. The Multi- disciplinary Audit Advisory Group (MAAG) manager was designated as the PACE project manager and a Consultant in Clinical Epidemiology and Public Health was the PACE project leader.

Using a manager who already knew the practitioners and the networks was invaluable for this project. The costs for the manager and leader have not been included in this report and both felt that this type of working was their part of their core work and was now mainstream. There was a culture change in the MAAG during the PACE project and they now produce or are involved in the majority of evidence based guidelines for the district, using the PACE model. They now lead on Clinical Effectiveness and Audit in Primary Care for Bradford and Airedale.

The Project Leadership was very important for the success of this project. His expertise in research and change management allowed the group to move through a steep learning curve quickly and effortlessly. His commitment to the project was paramount to its success.

4. Factors for Success

- Ensuring the service provided is able to cope with any changes that may occur as a result of evidence/guidelines is vital to ensure effective implementation
- Using existing networks saved time and other resources. The MAAG had already undertaken some primary care audit and had good networks with the practices in Bradford.
- There were clear benefits in adopting the " project approach" with clear timescale agreed and roles and responsibilities identified
- Dissemination of guidelines through the education network that was established allowed better access to more of the practitioners.
- Production and design costs of the guidelines were felt to be a good use of the resources allocated, clear messages with the evidence displayed and graded was seen by many as very influential.
- Choosing a topic where relationships were good and where outcomes could be achieved was seen as important by the team.
- Working with pharmaceutical companies was viewed as a success as the group felt they were able to influence work being undertaken in the area to ensure it was in line with key lessons from the guidelines.

5. Self Assessment and Reflection

A time-out was arranged part way through the project to look at the successes and challenges faced by the group. The successes were listed as

- Important to have a leader who has respect of all the professionals involved.

- Project plan agreed by and signed up by all professionals
- Backing of the King's Fund name had been crucial in securing higher level of support at the beginning of the project, the work itself became the "selling point" as time moved on
- Winnable topic vital for the "first" one
- Clear evidence
- Having an already employed facilitator has both benefits and risks. The benefits are the links and relationships have already been established, the down side of this is they are already working on a number of other issues and have to juggle the project work in with their other work.

Challenges faced were as follows:

- problems uncovered through the external evaluation included hostile attitudes to guidelines, therefore in the future it was felt that pre-existing attitudes and opinions about guidelines need to be assessed and accounted for in their promotion.
- Patients should have been involved earlier, this could have been achieved by commissioning work from an already established patient representative group
- Planning manager on board earlier to ensure all the planning implications were achievable.
- Asian voices needed. The group felt we could have engaged the small practices commissioning group more to ensure that their representative attended the meetings
- Team building for the project team would have been useful at the beginning to agree action plan and identify missing links, as well as objective review meetings.
- When work is allocated ensure understanding and commitment gained, some "team" members did more than others. New members recruited later in the project meant that the facilitator had to try and get them up to speed which was time consuming

6. Plans for Sustaining the Changes and Using the Lessons

An Evidence Based Locality Education Network
PACE Education

PACE Education is a name used to describe a series of events which will be held in primary care groups (through education network practices) which are problem based and have evidence based guidelines, audit and education at their core. One component of this will be the establishment of educational visits by hospital specialists to these groups.

This will combine clinical audit and postgraduate education to encourage effective practice and aims to reach all Primary health care teams within Primary Care Groups in Bradford and Airedale. This proposal aims to compliment the current provision of education for professionals.

Eleven projects will be undertaken over the next two years. These are:-

1. Asthma
2. Back pain
3. Depression
4. Diabetes
5. Epilepsy

6. Heart Failure
7. Ichaemic Heart Disease - Stable Angina
8. Leg Ulcer management
9. Managing the menopause
10. Secondary prevention of heart disease - including lipid's
11. Stroke management - with an emphasis on management of hypertension.

Each team will produce:-

- evidence based guidelines
- an evidence based audit tool,
- patient literature where there is no suitable alternative
- presentation slides with the projects key messages and
- an education programme, including aims and objectives

The PACE education network will provide the dissemination forum for this work. The MAAG office will co-ordinate this type of education activity across the district through the network and will provide each project team with support and advice for their topic area and in the development and piloting of the audit tools.

Professionals who develop guidelines and who are involved in the dissemination of them will be paid an honorarium for this work by the PACE education steering group.

Approximately ten practices will be approached by the PACE team to become Education network practices. The number of practices will be dependent on the number of Primary Care Groups identified. Their role will be pivotal in the success of this initiative. Practices who are education network practices will be paid an administration fee for arranging and hosting the events. This money will cover all administrative costs incurred by the practice. The practices will be supported by the MAAG office.

The finance to support this initiative will come from pharmaceutical companies using a corporate sponsorship approach.

9. Project Materials

- Evidence based guidelines for dyspepsia management and post endoscopy
- Open access referral forms
- Computer template for the EMIS system for the management of dyspepsia
- Patient Information
- Audit tools, including data collection sheets and reminders
- Checklist for future local guideline development produced
- Summary of methodology and group members involved in guideline development.

Part II: Changes in practice

Auditing change in primary care

All one hundred practices in the Airedale and Bradford district (population 350,000) were invited to participate in the study. Practices were requested to produce a list of patients on repeat prescriptions of the above drugs. In view of the relapsing nature of peptic ulcers we defined long term therapy as more than one prescription of acid suppression therapy in the previous twelve months. A trained project worker examined the practice records and extracted details on each patients on long term acid suppressing therapy.

43% of practices agreed to take part in this study. From this sample 6037 patients on long term acid suppressing treatment were identified. Figure 1 shows the diagnosis or indication for treatment with long term acid suppressing therapy in the patients identified.

Figure 1

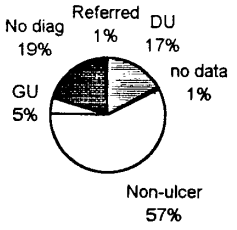
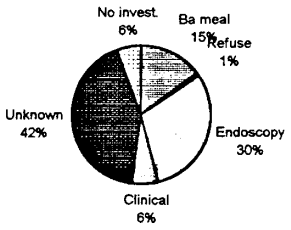


Table 2 shows how the above diagnosis had been made.

Clinical	372
Unkn	
No in	

Figure 2



REAUDIT

Reaudit was undertaken in 27 (67%) of the original practices. Of the 518 patients with a confirmed diagnosis of duodenal ulcer, 140 had been tested for H.pylori (15 were negative) and 236 (47%) had been offered eradication therapy at the time of reaudit. 15 (3%) had declined eradication therapy. Of the 134 patients with a confirmed diagnosis of gastric ulcer, 46 had been tested for H.pylori (5 were negative) and 54 (40%) had been offered eradication therapy at the time of reaudit. No patients had declined eradication therapy.

The number of patients with unconfirmed diagnoses had fallen from 646 at first audit to 269 at second audit. 17 patients at second audit had refused investigations and a further 7 had been referred but the results were not available at the time of data collection.

WALSALL *H.pylori project*

PACE Project Report 1998 - Changing Practice

1. Key Objectives

At the commencement of the project these included:

1. The introduction of local guidance on the management of upper gastrointestinal disease developed by the district gastroenterologist, GPs and Walsall Health Authority.

2. Assessing the practicality of the guidelines.

3. Promoting the guidelines and key therapeutic messages in partnership with the local gastroenterologist, GP educators, audit groups, the Department of Medicines Management, Keele University through the IMPACT project and, possibly, a pharmaceutical company. IMPACT is an educational outreach project, developed at the University of Keele, whereby community pharmacists visit GPs to influence, by applying the techniques used by the pharmaceutical industry, rational, cost effective prescribing.

4. Obtaining demonstrable benefits for Walsall patients, GPs, hospitals, and the Health Authority.

5. Auditing compliance with the guidance.

6. Ensuring that other pharmaceutical companies with an interest in dyspepsia understand the project. (NB; this was discarded as an objective with the decision not to work with a pharmaceutical company)

2. Timetable

Project plans for phase I, January 1996 to March 1997, and phase II, April 1997 to March 1998 are appended. Sections 3-10 of this report are written with reference to the project plans.

3. The Original Project Plans

3.1 Developing the clinical management pathway ("finalise guidance")

One of the reasons to submit a project bid for the PACE Programme, was that consultation between local GPs, the local gastroenterologist, the Pharmaceutical Adviser and a Consultant in Public Health Medicine had already taken place, and draft guidance on the management of upper gastrointestinal disease had been developed. Progress on this, however, had stalled with the departure of the Consultant in Public Health Medicine to take up general practice.

The process was restarted by the PACE application, 'trialed' by the participating GPs and the guidance finalised following consultation through the GPs on the Steering Group with various, but not enough, GPs. In view of the antagonism shown by the majority of GPs to 'guidance' or 'guidelines', the Steering Group decided to rename it a 'clinical management pathway'.

Two criticisms can be levelled at the end result:

1) based on the same evidence, the pathway for managing dyspepsia that clinically is not reflux differs from that developed in the other two PACE Project sites. This reflects the weighting given to the, apparently, most cost-effective approach identified in Andrew Moore's publication[1] and the Scottish guidance to purchasers, and the local situation with regard to endoscopy capacity.

2) the proposed final version of the CMP was probably inadequately 'tested', i.e. not 'vetted', by enough GPs. Had it been so, it is possible that there would have been far greater ownership and acceptance of the pathway.

3.2. Notify LMC and MAAG

3.2.1 The 'team' who presented to the PACE Programme selection panel in December 1995 included the GP Tutor (Dr SR). His involvement was considered essential for implementation. As well as having the lead on GP Postgraduate education, he was a member of the LMC and MAAG.

Prior to the selection day the project lead (a CPHM) had spoken with the Chairman of both the LMC and MAAG requesting that they endorse Dr SR as the formal representative of the LMC and MAAG, since it seemed sensible to limit the number of people on the presentation team. Both agreed.

3.2.2 Ref Project Plan - Phase 1: this was achieved as scheduled.

3.2.3 Factors for success or failure

There were problems from the start which were critical to the likelihood of success or failure - in this case, a bit of both:

- The project was health authority driven or imposed and some GPs, including those on representative bodies, appeared antagonistic to the authority. In addition, the topic chosen was probably not seen by them as a priority for action.

- The two GP representatives on the group that developed the clinical guidance were both elected members of the LMC but were neither viewed, nor accepted, by the LMC as representing the committee. One of the GPs was also a member of the MAAG. Since this work had commenced prior to the appointment of the CPHM leading the project, it is not known if there had been any consultation with the LMC or MAAG but it is considered unlikely since both GPs were paid appointees (GP Advisers) to the authority.

- With the pre-existing initiative to develop clinical guidance at the time the call came from the King's Fund for bids to the PACE Programme, it was inevitable that a project on the management of dyspepsia, to include H. pylori eradication therapy, would be worked up

[1] Moore RA. Helicobacter pylori and peptic ulcer. Health Technology Evaluation Association, Oxford. April 1995

and submitted. The CPHM, recently arrived in the district, did not know of the tensions between the health authority and both the LMC and MAAG who considered the proposals an authority-initiated and led imposition on primary care. This was aggravated by the perception that there had been inadequate 'consultation' which, in retrospect, was probably true:

i) The CPHM erroneously assumed that they were already aware of and supported the development of local guidance.

ii) Even if the CPHM had accurately appraised the situation, the timescale from receiving the request for project bids, working up the project and submitting it to the King's Fund was tight, limiting the opportunity for 'formal' consultation and seeking agreement.

- In spite of the liaison with the Chairmen about Dr SR representing the LMC and MAAG on both the presentation team and, thereafter, on the steering group, both insisted that they had not been initially informed, nor kept informed, of the project. This view continued to be expressed for at least a year after the project was accepted onto the PACE Programme. In addition one of the GP advisers who participated in developing the clinical management pathway, renamed as considered less irritant to GPs than guidelines or guidance, was also considered by the LMC officers as 'not representing' them.

  It is considered that the attitude of the LMC Officers and some members of the MAAG, was determined by the request from the CPHM which precluded them from nominating their 'own man'.

  Personal and formal written contact with the respective Chairmen explaining that their representatives should act as a two-way conduit for information, that is transmitting relevant opinion and information from the LMC and MAAG to the steering group and project lead as well as feeding information back, did not appear to gain acceptance and produced no improvement in the situation.

- As part of the implementation, the CPHM addressed an open meeting of the LMC well before the start of the campaign in September. At this meeting the LMC endorsed the project and expressed their support which, according to the hearsay evidence of one LMC member, was not their real position. According to his report, not content with passive resistance the LMC were, initially, actively exhorting GPs not to participate in the programme. Whether a genuine position or a mischievous one, there were requests from the LMC Officers about payments to GPs for managing their dyspeptic patients in accordance with the suggested district approach, including H. pylori eradication which was "...the responsibility of secondary care". Such requests wer resisted by the CPHM.

It is likely that there were other 'political' views determining the LMC attitude. Whether there were or not, this complex of local medico-political issues meant that the implementation of the programme was undermined from the start. Since then the relationship between the LMC and authority, although improved generally, continues to be inconsistent; helpful and cooperative on occasions, difficult and obstructive on others and we are now unaware of active opposition to the project.

The MAAG insisted on demonstrable independance from the authority and so refused a request to consider supporting and developing the audits necessary to measure practice in accordance with the recommended guidance. This was reinforced by a degree of pique on the part of the MAAG audit coordinator who resented the appearance of the stage "develop and pilot audit (1^{o} care)" on the project plan without having been consulted. The CPHM was of the opinion that as an employee of the authority there was no necessity to consult with her, particularly given the short timescale for pulling together a project. This view was not accepted by the coordinator who saw herself as having a responsibility only to MAAG, accountable only to the Chairman. In retrospect it would have been diplomatic at least to discuss, briefly, intentions with her.

However, even if the MAAG had been prepared to cooperate and provide a lead, there was no guarantee that practices would participate since MAAG consider the local audit groups to be autonomous, as are practices.

This remained the position until this financial year (1998/99) when MAAG agreed to develop and offer to local audit groups an audit on the management of gastro-oesophageal reflux disease.

3.3.4 Learning from the above

A situation such as that described above is unlikely to arise now since the whole process of agreeing clinical effectiveness projects has become formalised with options presented to the 'Extended Walsall Health Executive Board' (EWHEB) on which sit representatives from the LMC, fundholders, the Commissioning Group and MAAG.

In addition, MAAG now agree priorities for district-wide audits as part of the annual planning/commissioning/resource allocation cycle.

3.3 Notification of GPs and practice staff

This proceeded according to plan by placing an article in Brass Tacks, a quarterly newsletter to all primary care teams including GPs, a follow-up letter to all practices inviting them to 'sign up' to participate in the programme, the presentation to the open meeting of the LMC and, at the 'official' launch of the educational campaign in September 1996, a formal postgraduate educational meeting at which the Consultant Gastroenterologist and CPHM project lead presented.

All of these reached some of the target audience with some success since an adequate number of practices sent staff for the first and, so far, only session of training for case-finding. Although only three practcies had completed case-finding at the time of the mid-term review these practices subsequently generated enough workload to occupy the specialist nurse for more than a year.

Although aware that lectures to GPs are of limited effectiveness we considered that some GPs, wedded to the time-honoured forms of postgraduate education, would take the project seriously only if such a meeting was held. Additionally such an event would demonstrate the commitment of the local consultant to the project. Unfortunately, in response to questions, some of the replies were inconsistent with the clinical management pathway that had been

developed; although probably reasonable with regard to consultant practice it would have been preferable to avoid confusing the message to the GPs.

In spite of the limitations with regard to their effectiveness, we still consider the formal presentation by a consultant to be emblematic to GPs and, until more effective ways of postgraduate education and training ***become the norm****, will incorporate such a presentation into our programmes.*

3.4 Develop data collection (2^{o} care): collect baseline data (2^{o} care)

This has been covered to some extent in previous reports.

Problems still remain in the acute Trust. In summary:

- approximately one-third of endoscopies undertaken in the local hospital are open access whilst two-thirds are generated internally.
- there was a pre-existing, administrative stand-alone system for the open access endoscopies which had been designed for the purpose of producing a post-investigative report for the referring GP.
- the system had not been designed to allow efficient analysis of the data; in other words the system was a 'data gobbler' which did not permit the production of meaningful, aggregated information that could usefully support the project.
- the person who designed the system and was working fitfully on an analysis package left to a new job.
- much of the useful data was held as free-text.
- there appeared to be little commitment from the clinical lead to implementing a system for the routine collection of outcome data.
- there was no system for the collection of data for endoscopies undertaken at the behest of Trust clinicians.

None of these foibles had been recognised when drafting the project plan.

Additional factors that have contributed to the difficulties are:

- plans within the Trust to upgrade their IT system with, naturally, a reluctance to work on developing existing systems, particularly an unintegrated one.
- the number of clinicians undertaking upper GI endoscopy, approximately 8 or 9; any method for the collection of outcomes data would have to be agreed and implemented by all. We understand that this activity is, however, directed towards intra-hospital referrals and does not cover open access procedures which are undertaken only by the gastroenterologist and a staff grade physician.
- failure to gain agreement that the programme should be implemented within the Trust, with opposition to assessment of the urgency of referral and of outcomes even after the introduction of new endoscopy referral forms that reflect the 'urgent' part of the CMP.

6.1 Feedback to individuals (Project Plan - Phase 2)

With reference to secondary care, three sets of data are being collected and are currently being analysed with the intention of feeding back the results to practices:

a) for open access referrals since the start of the programme: comparisons, according to the clinical management pathway, between the categorisation into urgent, soon or routine from the referring doctor and the categorisation by the 'admitting' nurse in the endoscopy suite

b) comparative referral rates for upper GI endoscopy; this has been delayed for three reasons:

- belated recognition that for some GPs a substantial number of referrals are made to out-of-district units and we have only recently received the relevant data.
- data from out-of-district units is unavailable for the period prior to the implementation of the programme so we are unable to establish a baseline
- failure within the authority to develop a software programme to generate age-standardised rates for outpatient or 'diagnostic' referrals - until developed, we will be making do with crude age-specific rates, e.g.endoscopy rates per annum per 1000 patients aged 45-85.

c) requests for HP serology - trend over time, if possible by practice

When processed, the results will be fed back to practices. Since this work is not yet complete, we have not yet had the opportunity of using the data to influence GPs.

3.5 Patient panels ref information support/publication of patient information

A patient information booklet was developed usings the results from three patient panels, work undertaken by Dr Shirley McIver of the Health Services Management Centre, University of Birmingham, and incorporating clinical material provided by the Department of Public Health in the Authority.

This work was not completed to the timescale originally planned, but was completed by March 1997, in time to support the work of the specialist GI nurse in primary care.

3.6 Plan educational campaign/intensive educational campaign including outreach (IMPACT)

The launch of the clinical management pathway (CMP) took place in September 1996 at a lunchtime postgraduate meeting when the lead clinician presented the clinical issues and the CPHM described the programme and it's objectives. Over forty GPs attended and all were presented with a 'dyspesia pack'. Those not attending were sent copies by internal mail. All GPs were targeted.

Preparation prior to the postgraduate meeting included:

- development and production of the 'Dyspepsia Pack', which contained two laminated copies of the clinical management pathway with supporting clinical information on the reverse, a pack of open access referral forms developed to reinforce the CMP and a synopsis of evidence supporting the CMP.
- planning the postgraduate lunchtime meeting
- the supporting IMPACT campaign, including development of detail aids, training materials and the training of the IMPACT community pharmacists

The first IMPACT campaign commenced following the postgraduate meeting and continued until January 1997. This will be discussed more fully later in the report.

3.7 Specialist Gastrointestinal Nurse (SGIN)

The original project proposal stated "Wider implementation of the final guidelines will involve a variety and combination of methods including.....specialist nurses to help GP practices in reviewing long term patients on ulcer healing drugs and providing H. pylori testing and counselling".

A specialist nurse was recruited in September 1996. Her contribution so far, both clinically and educationally with practice nurses, is considered one of the successes of the programme.

Having learnt the lesson from the problem reported in Section 6, that it was essential to develop effective monitoring arrangements *prior to* implemention, the SGIN, CPHM and Trust Director of Information spent the first few months after recruitment developing documentation and a database that would support the SGIN in her clinical role, and also support data entry by a non-clinician. The system is designed to be efficient with data entry required once only to the pro-formas and the data scanned into the database. The SGIN is able to amalgamate the data in relation to peptic ulcer disease, concomitant upper GI pathology and patient outcome.

It was apparent from the data provided by the first two practices to complete case-finding that, if the emphasis of the SGIN's work in primary care was H. pylori eradication she would be unable to review and advise on the large proportion of patients with hiatus hernia and reflux. She has, therefore, as a matter of policy, reviewed in detail only those patients who might need eradication therapy.

3.7.1 Activity to date

Case selection started in February 1996, since when the SGIN has completed her duties in five practices with a total patient population of 27,970 and case-finding and casenote review is ongoing in two further practices.

725 cases have been reviewed so far with follow up data at six months available for 227 patients. Fuller details, with outcomes data, will follow in Part II of the final report.

3.7.2 Practice Nurse Training (Project Plan - phase 2)

One session has been undertaken during the Autumn in 1997, involving the SGN, a practice nurse trainer - who is a member of the Steering Group and based in one of the first three practices in which the SGIN worked - and a health authority nurse manager from the Primary Care Directorate.

(I am awaiting greater detail from the relevant HA manager)

3.8 The rest of the planned Phase II

3.8.1 Data collection from secondary care remains an almost 'black-hole', as described in Section 6 above.

3.8.2 No audit linked to the programme has been undertaken within any practice. As mentioned previously, the MAAG has agreed to develop and offer an audit on the management of gastro-oesophageal reflux disease to local audit groups.

3.8.3 Feedback to individual practices will be undertaken when the data has been suitably processed and presented.

3.8.4 With reference to training practice staff and identifying potential cases, various other avenues, such as visits from the Pharmaceutical Adviser, Medical Adviser or an IMPACT pharmacist, have led to practices wanting the SGIN to assess their patients. Training for practice staff in case-finding has, therefore, been undertaken on an individual basis as necessary. Consideration is currently being given to the necessity to run a further session to be offered to all practices.

3.8.5 Another IMPACT campaign on gastro-oesophageal reflux disease ran during the second quarter of 1998. This has renewed interest from some practices in accessing the SGIN.

4. Achieving Change and Managing the Project

4.1 Techniques and change mechanisms used:

It was recognised in the original project proposal that to achieve implementation a variety and combination of methods would be necessary. These included:

- provision of written guidance, with key references and details of the method by which the guidance was developed - this was partially met by the contents of the 'dyspepsia pack'. Details of how the guidance was developed were provided in the primary care newsletter "Brass Tacks", at the postgraduate meeting and during presentations by the CPHM to local audit groups.

- postgraduate meeting(s) for GPs/discussion and dissemination through the MAAG and local (GP) audit groups - one 'formal' meeting was planned as part of a regular programme of such events (ref. Section 3.6). The Consultant Gastroenterologist presented at two further meetings for GPs and the CPHM presented to a number of local audit groups. It is considered that these efforts have been of limited effectiveness in changing clinical behaviour.

- a team of pharmacist facilitators to promote and explain the guidelines to individual GPs and practices (IMPACT) - this has been an extremely important and, we believe, successful component of the programme.

IMPACT is a project run by the Department of Medicines Management at Keele University across a number of health authorities in England. The project uses community pharmacists to

provide GPs with independent advice on prescribing. This is facilitated by appropriate printed materials and reviews of the latest clinical literature and in Walsall is jointly developed and managed by the University Department and Health Authority. The project has been further developed in Walsall to include not only prescribing but also issues around disease management. IMPACT has become a strategic tool to deliver key therapeutic messages in a number of disease areas to GPs.

The first example of this was in dyspepsia where IMPACT was incorporated into the PACE project from the very beginning. The role of IMPACT was to promote and explain the guidelines to individual GPs and GP practices. There were two IMPACT campaigns:-

- September - December 1996, to coincide with the launch of the guidelines
- March - June 1998, to review the messages from the earlier campaign and concentrate on gastro-oesophogeal reflux disease.

The first campaign was launched on September 26 1996 following the joint presentation from the consultant gastroenterologist and the CPHM at a lunchtime postgraduate education meeting.

The IMPACT pharmacists then met with many GPs in Walsall to discuss the guidelines and other key messages in more detail. These included:-

- description of the guidance in more detail
- the role of H.Pylori testing and eradication treatment
- the rational choice of, and use of, ulcer healing drugs
- promoting the use of new endoscopy referral forms
- promoting the role of the specialist nurse and recruiting practices for her to work in

The pharmacists saw 45 practices during the campaign, a coverage rate of 62.5%. Analysis of prescribing data following this campaign suggested that in the intervention groups there was:-

- a 10% increase in the use of cimetidine, the cheapest H2 antagonist
- greater use of lansroprazole relative to omeprazole
- less use of ranitidine bismuth citrate (Pylorid), which was not recommended for H.Pylori eradication.

NB: it is not possible to ascertain from PACT the use of H.Pylori eradication therapy.

Anecdotal feedback from GPs suggests that the IMPACT was perceived to be useful in terms of the guidelines, choice of H.pylori eradication therapy and the use of ulcer healing drugs. A large number of practices showed interest in using the services of the specialist nurse. In hindsight, we should have tempered the expectations of GP practices with regard to help from the specialist nurse.

The second IMPACT campaign was run towards the end of the PACE project. The key objectives for this campaign were to:-

- reinforce the key messages of the first campaign around the guidelines, endoscopy referral forms and H.pylori eradication

- promote a step-wise approach to the treatment of gastro-oesophogeal reflux disease
- where proton pump inhibitors are prescribed, promote the appropriate use of treatment courses and maintenance doses of PPIs.

This contrasted with the first campaign which concentrated on peptic ulcer disease.

Almost without exception, GPs were able to produce their guidelines which were close to hand in the consulting room along with the detail aid and patient information leaflets, these guidelines were again used to discuss gastro-oesophogeal disease in more detail. This campaign achieved far greater coverage of GP practices than the previous campaign with 60 practices (83%) of practices being seen during the campaign. Early feedback from the pharmacists have shown that most GPs readily accepted the messages the pharmacists were disseminating and that there was a commitment by GPs to review their treatment of gastro-oesophogeal disease and to review the use of long term PPIs. Early indications from prescribing data suggests that the use of low dose PPIs is steadily increasing and that the rate of increase was higher during April 1998. If this is sustained then it would indicate that this is as a direct result of the campaign itself.

The two IMPACT campaigns have been an important and an integral part of the PACE programme and have helped to improve GPs' knowledge of dyspepsia and improve their approach to treating this disease area. We are confident that it has contributed to the success of the project and that it has developed the IMPACT project further by placing prescribing initiatives within disease management. In Walsall this has been extended beyond dyspepsia into other campaigns such as menorrhagia, the use of lipid lowering drugs and management of heart failure which have been district wide initiatives involving both primary and secondary care.

- input from the authority's pharmaceutical and medical (CPHM) adviser as necessary - this has changed into a routine rather than " as necessary". Whenever possible, both advisers enquire about the GP/practice approach to the management of dyspepsia with particular refence to the CMP.

- the specialist nurse when working within a practice liaises closely with the GP(s) an integral part of which is to influence the GP(s) in favour of routinely applying the CMP. There has, as yet, been no evaluation of the effectiveness of this.

- the patient information booklets, designed to support the work of the SGIN, have not yet been disseminated widely but could influence change in practice *if we could ensure that they reached the relevant group of patients.* Even so, a global offer inviting all relevant patients to request a copy has significant financial implications, particularly since a very small budget has been allocated this year for all clinical effectiveness projects within the district. However, we are considering a media campaign later this year to publicise the approach and which we hope will inform and thus 'empower' patients with peptic ulcers.

- monitoring of practice performance and providing feedback remains on the agenda as discussed in Section 3.4.

A number of other methods have been used to maintain awareness of the project:

- two workshops were held during 1997 using the clinical vignettes developed by Bromley. The intention was to hold a series of such events inviting GPs personally and covering the whole GP population. This approach turned out not to be feasible. 15-16 were invited to each workshop yet less than half accepted, of whom some failed to attend - in effect wasting money. In order to achieve the coverage intended it would have been necessary to hold at least 15 workshops at significant expense and with a limited professional resource (the CPHM, the GP Clinical Effectiveness Coordinator [CEC] and one GP Tutors specifically allocated to HA initiatives) to meet the commitment. Nevertheless a programme might have been possible but for the resignation of the GP Tutor (not yet replaced), the advent of new, time-consuming responsibilities for the GPCEC associated with his practice becoming a PMS pilot and his taking on reponsibilities with the GP Commissioning Group and additional, major areas of work allocated to the project lead. This idea has, therefore, been abandoned.

The lessons from this have been that an apparently reasonable plan can place excessive demands on the capacity to deliver and not to take for granted the manpower available - resignations happen and new commitments, including that of the project lead, can supersede that to a given project.

- a simple survey of GPs enquiring about their knowledge of the existence and use of the CMP

4.2 Managing the work

Managing the work has previously been difficult and lately almost impossible. A deliberate decision was made at the start of the project not to recruit a project manager in order to see if the project approach could be incorporated with the routine, 'day-to-day' work, some of which, at the strategic level, the project lead in particular would deem of greater importance and potential benefit than a project on curing some peptic ulcers and managing bellyache.

Possible but difficult is the verdict. Some momentum has been lost over the last nine months. The last year, with a new administration and major policy initiatives aplenty, has been demanding on all health authority staff and the attention necessary to keep the project afloat has been jeopardised - to say the least. Part-time support with an operational focus, the GP CEC, has been helpful but, because of a lack of managerial and health authority experience, also quite demanding on the time of the project lead.

*It is important to have a person with **dedicated** time allocated to a project. Ideally this person should have knowledge of the clinical area, previous experience of project management and good administrative expertise.*

The original intention was to establish a representative Steering Group - done - with working sub-groups established to deal with specific issues. This did not happen: organising a meeting of the Group always proved difficult because of clinician's commitments, some Group 'members' never attended, there were significant and unbridgeable philosophical differences between the GPs on the Group and the project lead, and a lack of commitment to 'real' work

which was understandable since there was no remuneration attached. HA staff have, with one or two exceptions within the Trust, had to carry the work.

Even with hindsight, I believe that the original concept is best and workable given a shared and agreed agenda to which all parties are genuinely committed and see as a priority. This should achieve a critical mass of product champions.

4.3 Factors for success - and failure!

Success:

- a shared and agreed agenda to which all involved in the project are committed - vested self-interest has no place.
- agreement between all concerned, particularly clinicians, that the topic is important and, therefore, a priority.
- staff responsible for a project to have time, agreed within the organisation, as *explicitly dedicated* to that project.
- make sure that monitoring and audit arrangements are agreed and established *at the outset* - linking effectiveness to audit is essential.
- recognise and utilise the input of non-clinicians.
- there must be a consistency of approach amongst all clinicians - the failure to implement this programme in the Trust has clearly sent a mixed message to GPs, affected the prospects of successful implementation in primary care and perpetuated (probable) inappropriate management in secondary care.
- find one or more product champions from amongst clinicians
- employ a variety of methods to changing clinical behaviour *and attitudes* - unless the message is very simple, always include some form of educational outreach.
- build in slippage and be flexible
- don't let the ******** get you down

Failure - potentially:

- commence the project in blissful ignorance of local medico-politics, GP paranoia and the tensions between GPs and the HA.
- inadequate efforts to achieve shared ownership - if achievable!
- not recognising incompatible agendae - e.g. the GI consultant, and to an extent the Trust, and the DHA
- competing priorities outside one's control
- inadequate human and financial resource to support an initiative
- have too broad a project and an unrealistic timescale
- fail to find a product champion from amongst clinicians

4.4 Self assessment and reflection

For those within the HA directly involved in the project, this has been undertaken in an informal, ad hoc way, usually in response to hitches, glitches and meetings, both formal and informal, about 'what next and how?'. No systematic approach (as documented by Gifford Batstone) involving all stakeholders has been initiated. However, discussions with others in the district about better progressing the clinical effectiveness agenda, which will be usurped by

clinical governance, often involves the phrase "what we have learnt from the PACE projects is ...".

The necessity to report also necessitates reflection and internal evaluation, so the reports become a record of the 'plusses and minusses' and lessons learned.

Given the difficulties encountered in the Trust, it could be enlightening to try and mutually evaluate the project but I consider that such an approach would require skilled,objective, probably external, facilitation.

4.5 Sustaining the changes

It has been accepted from the start that continuing effort is required to achieve this. In addition to the endoscopy referral forms which should reinforce the CMP whenever completed, a number of other methods will continue to be employed including:

- feedback to practices on referrals for endoscopy and their request rates for HP serology
- articles in Brass Tacks
- reinforcement during visits from the pharmaceutical or medical adviser
- using the influence of practice-attached pharmacists
- enquiry into the management of dyspepsia and compliance with the CMP as part of practice quality asessment visits
- continuing pressure to audit

It is, of course, possible that Primary Care Groups will pick up this agenda given the benefits to patients with peptic ulcer, the possibility of restricting the financial demands, from PPI prescribing, on the drugs budget and reducing expenditure on endoscopies.

Efforts are continuing to get agreement to implement the CMP with Trust clinicians and this could possibly be more easily enabled with pressure from Primary Care Groups.

4.6 Using the learning from the project in other clinical settings

The PACE reports and bulletins have been shared with others with lead responsibility for delivering clinical effectiveness projects, but there are no obvious signs that any notice has been taken of the contents and advice contained therein. 'You can take a horse to water but you can't force it to drink'; the Medical Director of the acute Trust is also aware of the problem and between us we are trying to exert influence in a low-key way since we wish to remain 'advisory' only. In addition a strategic and operational framework for clinical effectiveness projects was developed in 1996, but this, too, is being ignored.

An important piece of strategic work for the CPHM this year has been striving to achieve agreement with the acute and community Trusts to unify resources allocated to audit and effectiveness, including relevant budgets held by the HA. When achieved, because it is agreed in principle, we intend that the staff, and clinicians likely to lead areas of work, will be 'educated' in the principles of changing clinical practice and the lessons learnt from GRiPP and PACE programmes.