King's Fund

Promoting Action on Clinical Effectiveness

Project Reports

June 1998 (Volume 1)

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:

- Chase Farm Hospital
- Royal Berkshire and Battle Trust
- South Tyneside
- Dudley

Michael Dunning
PACE Programme

From Paper to Practice - *introducing evidence based pressure sore prevention*

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Funded by the Kings Fund PACE Programme - 'Promoting Practice in Clinical Effectiveness'

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INTRODUCTION

In the new NHS organisations will need to provide quality services that incorporate effective care and treatment (Department of Health, 1998) but despite the recent upsurge of interest in clinical effectiveness and evidence based health care few initiatives exist which actually help organisations learn how to act on the evidence successfully. The King's Fund Promoting Action on Clinical Effectiveness (PACE) programme, sought to do just this by supporting a group of project teams wanting to implement evidence based practice within their own organisations. In total, sixteen project teams from a range of sites across the country participated in the PACE programme, each working on a clinical subject of their choosing and each hoping to develop a model for change which could subsequently be applied to other areas of clinical work.

This report shows how the move toward evidence based practice was managed at one of the project sites; Chase Farm Hospitals NHS Trust. The report is divided into two parts; Part 1 details the project objectives, the change strategy used and the key tasks undertaken during the project period, Part 2 details how the project outcomes were measured and what lessons were learnt from the process of introducing evidence based practice.

The project ran from July 1996 - March 1998.

CHOICE OF SUBJECT

Pressure sores are common in hospital and community settings and represent a significant burden of suffering for patients and their carers (Effective Health Care, 1995). For many patients the development of a pressure sore will significantly slow their progress following illness or surgery and for some the presence of a sore will lead to complications such as chest or urinary infection; for a few, the development of a pressure sore may even lead to death. The importance of these issues combined with the results of a local fact finding mission, which included staff questionnaires and a pressure sore audit, prompted the Chase Farm project team to identify pressure sore prevention and treatment as a high priority subject for improving patient outcomes by establishing evidence based practice.

SUMMARY OF OUTCOMES

The project achieved an improvement in pressure sore prevention and management through the implementation of evidence based practice. The outcome measures show:

- A fall in the numbers of hospital acquired pressure sores
- A move toward the use of clinically effective wound dressings in the management of pressure sores
- The successful introduction of a new pressure relieving technique
- Earlier, more frequent risk assessment of patients
- A change in the usage of pressure care equipment

PART 1 - CHANGING PRACTICE

1. PROJECT OBJECTIVES

The project team proposed two main objectives:

1.1 To reduce the number of hospital acquired pressure sores

Key tasks
- Establish evidence base
- Establish accurate baseline of pressure sore incidence
- Improve return rate of weekly pressure sore audit forms
- Formulate pressure sore prevention policy
- Identify existing practice at Chase Farm
- Produce evidence based written resources for pressure care
- Identify pressure care equipment needs and develop guidelines for equipment selection
- Ensure continuity with community Trust
- Develop link nurse roles to facilitate changes in practice, the collection of pressure sore data and the dissemination of information
- Identify local project champions

1.2 To improve the management of all pressure sores

Key tasks
- Establish evidence base
- Identify existing wound management practice at Chase Farm
- Produce evidence based written resources for wound management
- Monitor dressings usage

2. PROJECT MILESTONES

2.1 Milestones marking the projects progress between April 1996 and March 1998.

April - June 1996 (1st quarter) :
- Staff questionnaires completed
- Identification of teaching needs
- Pressure Care workshop held
- Project co-ordinator recruited
- Recommendations for data collection made and data collection form revised

July - September 1996 (2nd quarter) :
- Induction of project co-ordinator
- Six months pressure sore information distributed
- Teaching programme developed
- Documentation audits completed

- Mattress and seating audits completed

October - December 1996 (3rd quarter) :
- Point prevalence study completed
- Teaching programme commenced
- Pressure sore grading system changed

January - March 1997 (4th quarter) :
- Resource documents completed
- New mattresses and seating purchased
- Revised risk assessment tool introduced
- New documentation for risk assessment introduced

April - June 1997 (5th quarter) :
- Pressure sore prevention policy formulated
- New objectives and milestones to be set by Project steering group
- Launch of resource folders
- Equipment training day
- Thirty degree tilt training commenced
- Chase Farm and G.P Project update through news letters

July - September 1997 (6th quarter)
- Development of clinical standards (nursing) for pressure sore prevention
- Repeat of education programme
- Staff educational requirements for 1998 agreed with Middlesex University
- Recommendations for future equipment purchase and management
- Six monthly feedback on pressure sore monitoring

October - December 1997-8 (7th quarter)
- Repeat of documentation audits
- Audit of standards
- Revision of standard

January - March 1998 (8th quarter)
- Completion of new database for collating pressure sore data
- Project evaluation / Outcome measures
- Final report
- Submission for publication

3. PROJECT MANAGEMENT - *how the work was managed*

3.1 Project Team Personnel

The project was managed by a project team:

Position	Role in Project Team
Project Leader	The Director of Nursing acted as Project Leader taking responsibility for maintaining a good working knowledge of the whole range of project activities and for facilitating longer term changes within the organisation. This level of seniority and experience proved essential in influencing key stakeholders at Trust Board and Health Authority level.
Project Co-ordinator	Responsible for the day to day running of the Project, the Project Co-ordinator was an external appointee. Their experience and background ensured credibility with clinically based colleagues, an in-depth knowledge of the subject to advance the clinical aspects of the project more quickly and good experience of change management in a clinical setting.
Steering Group	A large multi-professional group with members from a wide range of backgrounds: Physiotherapy, Medicine, Pharmacy, Business Management, Surgical Appliances, Performance Management, Nursing, Audit and Education. Established to maintain the Projects overall direction and to encourage Project input from all interested / affected parties.
Working Party	A smaller group with members drawn from a nursing background. Established to implement the Project changes day to day.

3.2 Communication

A written communication strategy was not developed at the beginning of the project however when it was it proved invaluable. A range of different approaches were adopted to ensure a wide range of hospital staff received information about the project. Wherever possible existing communication channels were utilised to minimise duplication and maximise use of resources.

- Monthly and quarterly meetings with Project Team Personnel - ensuring continuity and focus.

- Publishing updates in the internal newsletter - accessing a wide variety of people across the Trust.
- Publishing updates in the external newsletter - keeping local G.P.s up to date.
- Update flyers - accessing a variety of professionals within the Trust, in the community and at the local Health Authority.
- Setting up a Link Nurse system - cascading knowledge, spreading responsibility and workload, gaining access to clinical areas.
- Monthly pressure sore monitoring - feeding back to ward staff on a regular basis, identifying both good and bad practice.
- Annual Risk Management Report and monthly Corporate Report- maintaining a high profile at all levels within Trust.

4. BARRIERS TO CHANGE - *what slowed us down?*

- Lack of existing national clinical guidelines - promised for 1996 but withdrawn for further review
- Incomplete evidence base - lack of good research evidence in risk assessment and effectiveness of pressure care equipment
- Lack of framework for change within the organisation (at the beginning)
- Frequent changes of personnel
- Difficulties in measuring outcomes due to nature of topic - a need for both quantitative and qualitative methods of measurement
- Pressures on staff - existing and new
- Pressure sore data - ensuring accuracy and quick analysis for monthly feedback
- Time constraints - on everyone
- Limited resources - printing/publishing, secretarial support, information technology, storage and working space and access to slide and overhead projector

5. FACTORS FOR SUCCESS - *what speeded us up ?*

- Good team work
- Effective link nurse system
- Pooling of experiences and knowledge
- Sharing of resources
- Commitment to project objectives
- The support of unexpected champions - League of Friends
- New framework for change in the organisation

6. TECHNIQUES FOR CHANGE - *strategies and tasks*

6.1 The strategy for change

The strategy used for implementing the changes is illustrated in Box 1.

STRATEGY FOR CHANGE

STRATEGY	**RATIONALE**
Fact find - audit, observation and interview	To establish baseline from which to plan change and measure outcomes
⇩	⇩
Establish evidence base	To provide rationale for change
⇩	⇩
Decide target audience for evidence and most appropriate format for dissemination	To ensure the evidence gets to the people who need to know in the most accessible and digestible format
⇩	⇩
Plan educational programme for staff	To empower staff to change practice
⇩	⇩
Identify equipment and other resource needs	To argue for more resources if necessary and identify barriers to change
⇩	⇩
Develop new documentation as necessary	To support change
⇩	⇩
Re-audit	To monitor pace of change

Provide ongoing support and advice to staff and regular feedback of projects progress

Box 1

6.2 The tasks

The tasks needing completion in order to implement the strategy are illustrated in Box 2.

TASKS

⇩

COLLECT THE EVIDENCE

⇙

PRESSURE SORE PREVENTION

⇩

Collect baseline data (weekly pressure sore audit, documentation of risk assessment, staff knowledge)

⇩

Develop evidence based resource folders

⇩

Write pressure sore policy

⇩

Identify learning needs and start education programme

⇩

Develop supporting documentation (Risk assessment tool, audit forms, care plans, equipment selection poster)

⇩

Identify equipment needs (mattress audit, seating audit, equipment inventory)

⇩

Write clinical nursing standard

⇘

⇘

PRESSURE SORE MANAGEMENT

⇩

Collect baseline data (dressings usage, documentation of wound assessment, staff knowledge)

⇩

Develop evidence based resource folders

⇩

Produce dressing selection poster

⇩

Identify learning needs and start education programme

⇩

Develop supporting documentation (wound assessment and care plan, pressure sore grading key)

⇩

Revise hospital dressing formulary

⇩

Write clinical nursing standard

⇙

Develop link nurse roles in every clinical area

Box 2

PART 2 - PROJECT ACHIEVEMENTS

7. LESSONS LEARNT

The lessons learnt from participating in the PACE project are numerous. They are as valuable as the outcome measures in that they are drawn from the actual process of implementing evidence based practice and can be applied to many other areas of work where the effective management of change is fundamental to success.

7.1 Systematic review of the evidence is outside the scope of most organisations

In the absence of national guidelines the amount of time and expertise required to put together local clinical guidelines should not be underestimated. If they are to be attempted it is necessary to have in place a locally agreed framework for researching and writing them.

7.2 Target the right audience in the right way

It is important to decide who the target audience for change is and then put together the evidence in the most digestible and accessible form for that particular audience. It may be necessary to have several different formats to suit different professional groups *e.g. quick reference guides, detailed resource folders, fact sheets*

7.3 External appointees can be successful

Success is dependant on a number of factors *e.g. a planned induction period, preparation and briefing of other staff, careful consideration of resource needs.* The external appointee is advantaged by having 'legitimate' time to do the project work, a defined time frame to work to, less distractions from other areas of work and a high level of commitment. The disadvantages may be in encouraging shared ownership of work and in sustaining change after the 'project' end.

7.4 Project teams benefit from a broad membership criteria

Hidden talents emerge in groups, assumptions cannot be made about who will or won't contribute something useful, shared ownership is important in making changes actually happen.

7.5 Steering groups or working parties?

Large groups may be ineffective and difficult to manage. We found it better to set up steering group to oversee the project progress and a smaller working party to manage the day to day changes.

7.6 Personnel changes are inevitable

It is important not to rely too heavily on any one person. Staff will, and frequently do, move on.

7.7 Agree expectations early on

It is important for team members to agree and be open about their own agendas and expectations at the beginning of the project. The project will flounder unless everyone is committed to the same aims and objectives.

7.8 A written communication strategy is essential

A written communication strategy should be agree early on and should, wherever possible, utilise existing communication channels already known to be effective. Again different channels will access different staff.

7.9 Think about the longer term cost implications

Clinical effectiveness is not about saving money and project consequences may have unforeseen cost implications for an organisation. At Chase Farm the need for pressure care equipment has major cost implications and yet this was not part of the original project proposal.

7.10 Education programmes need to be imaginative and flexible

Educational programmes need to be tailored to the needs of staff. Timing, group size and the setting in which training takes place are all important factors in its success. We found both classroom and clinically based education to be necessary. Regular evaluation of sessions also ensured that they were revised as necessary.

8. SUSTAINING CHANGES

An important part of the project has been to ensure that changes which have been achieved are sustained. Factors which will help sustain the changes are:

- the development within the organisation of a framework for introducing evidence based practice
- the participation in a national pressure sore audit
- an improved pressure sore data analysis system

- the development of a new role within the Trust - Clinical Practice Facilitator - to help facilitate and sustain changes in clinical practice

References

DEPARTMENT of HEALTH (1998) The new NHS. London, **Department of Health**

EFFECTIVE HEALTH CARE (1995) *The prevention and treatment of pressure sores: how effective are pressure relieving interventions and risk assessment for the prevention and treatment of pressure sores?* **Effective Health Care Bulletin**. 2(1) 1 -16

ROYAL BERKSHIRE AND BATTLE HOSPITALS NHS TRUST
in conjunction with
WEST BERKSHIRE PRIORITY CARE SERVICES

The Kings Fund PACE Project in West Berkshire

-improving the care of patients with leg ulcers-

Final Report
compiled for
The Kings Fund PACE Programme

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CONTENTS

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SUMMARY OF PROJECT

Organisational Development

- The project aimed to reduce the duration, variation and cost of treating leg ulcers in West Berkshire.

- A joint assessment tool and treatment protocol was developed to support nurse led assessment and facilitate evidence linked decision making and continuity of care.

- A district wide education programme was organised to run concurrently with organisational development

- Patients views and opinions were sought to inform service developments.

- Clinical audit demonstrated that graduated compression was a clinically effective treatment for leg ulcers.

- Economic analysis indicated that assessment and graduated compression could halve treatment costs

Key lessons learnt from the project

- A communication strategy helped overcome the complexities of communicating with diverse groups

- It was important to integrate project objectives with those of individual professional groups and employment units

- Team building, networking, joint working practices and shared education initiatives all helped to improve co-operation between disciplines caring for the patient

- It was necessary to establish systems that helped sustain change beyond the life of the project.

Introduction

A leg ulcer has been described as
"a loss of skin below the knee that takes more than 6 weeks to heal"
(Dale et al 1983)

60-70% of leg ulcers are caused by chronic venous hypertension, occurring because of valve incompetence, obstruction of the deep veins and an ineffective calf muscle pump.

It has been suggested that 1% of the adult population may be affected by chronic leg ulceration at any one time. Elderly people are known to be especially vulnerable to the condition and the incidence rises to 2% of the population in the over 70 age group.

Leg ulcers are painful, reduce mobility and are slow to heal. Treatment is complex, time consuming and constitutes a high proportion of the work load of community and hospital based nursing and medical staff. (Cullum 1994)

Studies that have attempted to estimates the costs of treating leg ulcers vary between £150 - £600 million a year Some of these studies are 10 years old but in a more recent economic report, extrapolation of costs calculated by Freak et al (1995) suggests that over £236 million a year may be being spent on largely ineffective leg ulcer care

Even when treatment is successful the chances of the ulcer recurring can be as high 69%, and 35% of patients are likely to have four or more episodes during their life time. (Callam 1985)

As the acute and community trusts in West Berkshire serve a population of close to half a million, which includes a high proportion of older people, it is reasonable to assume that the condition presents a significant burden to local people and health care providers.

Evidence based Practice

A significant number of research and audit studies related to the management of leg ulcers have been conducted during the past 10 years. The images conjured up by such reports, and the facts and figures represented within the surveys, paint a depressing picture of costly and ineffective care provided against a background of uncoordinated and piecemeal services.

Findings suggest that the treatment of leg ulcers is often predominated by opinion led decision making, and short term cost containment resulting in wide treatment variations. There is also evidence that treatment of the condition is frequently based on inadequate assessment that fails to take account of the ulcer's underlying condition. (Elliott 1996, Audit Commission 1996)

The most effective treatment outcomes have been achieved where comprehensive assessment of the patients condition precedes a co-ordinated multi-disciplinary approach, such as that provided at a leg ulcer clinic, (Simon et al 1996), and where treatment focuses on correcting venous hypertension through the use of high compression bandaging. (Cullum et al 1997)

In response to the wide variation in treatment regimens often deployed, and the considerable potential for cost savings, several multi-professional groups nation wide, have produced treatment guidelines for the management of leg ulcers based on published evidence, and the consensus opinions of the disciplines represented. (Douglas et al 1995)

Recently a systematic review of research related to leg ulcer management has been undertaken at the NHS Centre for Reviews and Dissemination (1997). The findings of this review emphasise the importance of thorough patient assessment, including ankle to brachial pressure index and Doppler ultra sound, to exclude arterial disease.

The review also considers the use of below knee high compression bandaging systems producing 30-40 mm Hg pressure at the ankle, graduating to lower compression at the knee, as a key component of treatment in the absence of arterial disease.

Clinical Effectiveness - local challenges

This project provided those working in the Royal Berkshire and Battle Hospitals and West Berkshire Priority Care services with a focus for identifying key factors which contribute to clinical effectiveness in the treatment of leg ulcers.

The project working group utilised the talents and expertise of an established multi-professional Tissue Viability group, which has representation from both acute and community trusts. The project group also benefited from the contributions of a wide range of clinical and managerial staff from hospital and community bases, and from Berkshire Health Authority, the principle purchasing agency.

The principle challenge offered by the project was to find ways of achieving enduring and consistent changes in clinical practice, and through the development of co-operative practices, to provide patients with seamless care between hospital and home.

Although the Tissue Viability group members were aware of the evidence for effective leg ulcer management, the majority reported resistance to implementing changes to practice in their various clinical settings

There were also problems in persuading some health service managers and GP's to invest in Doppler equipment, and staff training, and supply graduated bandaging systems not covered by the drug tariff.

Although no formal audit procedures were initiated at this stage, the collective experiences of the multi-professional team pointed towards inappropriate, or lack of consistency, in the provision of leg ulcers treatment, especially between acute and community settings.

Difficulties were also reported when referring patients to the Vascular Department for arterial assessment, as there was no standardised referral criteria. Consequently some patients were inappropriately referred, whilst others experienced unacceptable delays.

The Project team also needed to overcome problems which limited effective communication and co-operation between diverse and widespread hospital and community personnel, provider units and commissioning agencies

Several UK studies have attempted to describe the impact that having a leg ulcer has on a person's quality of life, which refer to a wide range of negative collateral physical, psychological and social effects such as pain. These studies offer a glimpse into the lives of people suffering from a painful, limiting and socially isolating condition.

The studies also served as a reminder that any attempts at involving patients in evaluating and shaping leg ulcer services would need to take account of the possibility of patients' low expectations. There could also be difficulties with recruiting the opinions of people who may be socially isolated, demotivated or have low self esteem.

Undoubtedly in West Berkshire there were clear opportunities to improve the quality of patient care in this area. and funding from the PACE initiative provided an opportunity to embark on a two year programme of change management and organisational development designed to improve the care of patients suffering from leg ulcers.

Aims of the Project

As a joint venture between the West Berkshire Priority Care services and the Royal Berkshire and Battle Hospitals NHS Trust, the aims of the project were to:-

- Facilitate a patient focused, inter-disciplinary, evidence based approach to the continuing management of leg ulcers in hospital and community care settings.
- Rationalise regimens and reduce variation in treatment of leg ulcers in order to accelerate healing, alleviate associated pain and reduce the duration and cost of treatment
- Increase patient and carers understanding of factors which increase risk of ulceration and their involvement in optimising treatment.

Organisation of the project

Team approach

It was apparent that a multi-professional approach was essential in order to

- access a wide range of clinical expertise
- gain knowledge of local processes and systems
- build bridges across professional and organisational boundaries
- enable us to gain a wide perspective of patients needs

The project leader was the Senior Nurse in the Nursing Practice Development Service at The Royal Berkshire and Battle Hospitals Trust. This service provides nurses, and other members of the health care team, with practical help in implementing change in clinical settings and several previous initiatives have involved working in close co-operation with West Berkshire Priority Care

Project Advisory Committee

For the duration of the project a PACE Project Advisory committee was convened in order to:-

- plan the strategic direction of the project
- set and monitor targets outlined within the project plan
- consider and gain consensus on issues relating to clinical effectiveness of leg ulcer management
- receive progress reports from the various working groups on discrete topics.
- agree and administer the deployment of the grant

The PACE project advisory committee was responsible for administering the PACE initiative and provided a link between the Tissue Viability group and the Kings Fund. Membership consisted of:-

- Project leader
- Community and hospital representatives from the Tissue Viability group
- Clinical audit co-ordinator
- Dermatologist (1st year)
- Representative from Thames Valley University Research department
- Post Graduate Centre librarian
- Health economist from City University. (1st year)

The committee has met quarterly in order to set targets and monitor progress and the majority of meetings were also attended by a member of the Kings Fund PACE programme.

Appointment of Project Nurse

In order to raise the profile of the project and initiate much of the work, a Project Nurse was appointed for 16 hours a week for a six month period between Sept. 1996 and March 1997, and for a further 4 months between Dec. 1997 and March 1998.

The post holder, who was seconded from the community trust, undertook the following responsibilities during the appointment:-

- Training and supervision of community and hospital nurses in the assessment and management of leg ulcers
- Collection of audit data in accordance with the project plan.
- Providing information about the project to hospital and community staff, GPs and patients
- Organisation and participation in workshops for community and hospital staff.
- Advising the project advisory team and contributing to project management

Communication strategy

The complexity of ensuring effective communication with all interested parties quickly became apparent when the number of personnel, and range and distribution of clinical settings involved were considered.

The PACE advisory team were keen to promote the opportunities that existed for improving patient care whilst making best use of resources, rather than suggesting that the project was a fault finding exercise designed to challenge established practices!

It was agreed that using existing communication channels such as local newsletters, committees and groups, wherever possible, would save time and resources and also ensure that information was received more readily.

Eventually a Communication Strategy was devised (Appendix), that identifies the target and routes for communicating with specific personnel in each organisation. Updated information bulletins were also circulated via this system. Individual project team members took individual responsibility for monitoring the effectiveness of communication, and also provided any additional information required by their target group.

This proved to be a helpful way of ensuring that people received current, consistent and accurate information, and made the best use of individual's time, and interest. The communication was monitored and updated at each quarterly project advisory committee meeting.

Project Plan

The Project plan agreed jointly by members of the PACE advisory and Tissue Viability groups and the Kings Fund provided the framework for the two years of project activity .

Five key development areas were identified in the Project plan:

- Clinical Audit
- Economic Analysis
- Assessment tool and Protocol Development
- Staff Education
- Patient Involvement/Education

Members of the Tissue Viability Group were recruited into four working sub-groups and a co-ordinator identified to provide feedback at quarterly Tissue Viability meetings. A link member of the advisory team was also identified for each group in order to facilitate communication.

The objectives, activities and a summary of the main developments planned, are outlined below and further details on how the work was progressed, including methods, results and conclusions, are outlined in the sections that follow.

Clinical Audit Group

Objectives

To investigate the application of graduated compression bandaging and it's effect on healing chronic venous leg ulcers within a twelve week period.

To test the effectiveness of the leg ulcer assessment tool and protocol, the impact of staff education and the level of co-operation between various care providers.

Key activities

In conjunction with Clinical Audit dept. and the Project Nurse, design and conduct an audit on the healing outcome of leg ulcers on an identified cohort of patients.

Design and conduct a tracking audit to monitor assessment and decision making processes, referral and treatment deployed, for an identified cohort of patients receiving care in both acute and community settings

Economic Evaluation

Objective

To influence service and clinical management by providing an analysis of current costs within local service providers and suggest implications for future service development.

Key Activities

As the Tissue Viability group did not have the necessary expertise readily available to undertake the economic evaluation an independent health economist was commissioned by the Project team to conduct an economic analysis concurrently with the programme of clinical audit.

The Project nurse and members of the clinical audit sub-group provided the health economist with relevant data for the economic analysis

Assessment and Protocol group

Objective

To ensure consistent, evidence based assessment and treatment of leg ulcers across community and hospital settings in accordance with an agreed assessment and treatment protocol.

To gain consensus on referral procedures to the Vascular Dept.

Key activities:
Gain consensus within the multi-disciplinary team to design and produce a combined leg ulcer assessment tool, treatment and referral protocol that is based on current evidence and best practice.

Reach formal agreement that the assessment tool and protocol is to be used by all health care professionals in hospital and community settings throughout West Berkshire in the treatment and referral of people with leg ulcers

Produce and distribute the assessment tool and protocol to treatment settings across West Berkshire

Provide nurses with the equipment, advice, support necessary for performing accurate leg ulcer assessment.

Staff education
Objective
To provide clinical staff in hospital and community settings with the knowledge and skills required to base clinical decisions on the assessment and treatment of patients with leg ulcers on current evidence.

Key activities:
Assess the educational needs of clinicians related to leg ulcer management, and determine and mobilise resources required.

In conjunction with the Project Nurse, and established education providers, plan and deliver a programme of education for hospital and community personnel that meets their requirements.

Produce an accessible education resource for use in clinical areas
and plan for on-going educational requirements beyond the end of the project.

Patient Involvement
Objective
To ensure that the development of leg ulcer services are informed by patient's needs, preferences and experiences.

To highlight contextual issues related to peoples experiences of leg ulcer care and solve problems which cause patients difficulties or dissatisfaction.

To enable patients to play as active role as possible in their care and treatment.

Activities:
Interview patients to gain their opinions and preferences and use these as a basis for service development and patient education programmes.
Liaise with community health council, Health Promotion and patient groups to design, produce and distribute written patient information on leg ulcer care.

Developing the Assessment Tool and Protocol

It was vital to ensure that practitioners had access to information on current evidence based practice at the point of clinical decision making.

A practical solution was to develop an agreed assessment and treatment protocol in consultation with the all health care professionals, in acute and community settings, involved in providing services to patients. This proved to be a slow, painstaking process which took over a year.

From the start it became apparent that expecting busy clinicians to attend regular meetings in order to review successive drafts of the protocol was a non starter. PACE funding enabled the appointment of a project nurse and her role in facilitating, co-ordinating and monitoring the protocol's development was crucial in maintaining momentum.

The project nurse spent 2-3 hours a week circulating and discussing successive drafts of the protocol mainly through personnel communication on the telephone or in surgeries, clinics and wards or through Fax.

Gaining consensus

Given the strength of the evidence there was very little disparity on the content of the protocol. However there was less agreement on the protocol's style and design, which for convenience individuals wanted to appear in sequence according to the way they conducted their own particular processes.

The priorities of each health care professional obviously influenced the importance attached to the type and amount of assessment information which should be collected, and in the end a balance had to be achieved between comprehensiveness and utility

Negotiation and achieving compromise can't be rushed, and it was for this reason that the development of the protocol appeared to be so slow.

The form is single fold A3 which provides space for recording information on 4 sides of A4. (Appendix)

A box format organises information into discrete sections e.g. medical history, blood results, nutrition, pain, ulcer history and appearance. The form uses lists and tick boxes, prompts, questions and diagrams in order to facilitate recording of qualitative and quantitative data that is relevant, unambiguous and measurable.

A flow chart for the referral procedure outlining the agreed criteria for referral and further management, and a branching algorithm to assist decision making for treatment, is printed on the back of the form. Key references, including the systematic review published in the Effective Health Care Bulletin, also appear on the form.

Distribution and implementation

The final draft was submitted to policy committees in both Trusts to ensure it's adoption in the various practice settings. At this stage a few minor amendments were suggested which meant a further round of review.

Once printed an extensive communication exercise preceded the circulation of supplies to practice settings around West Berkshire.

The results of the tracking audit (see p.32), suggest that whilst the education programme appeared to have had a positive impact on decision making according to the protocol, the form was not always completed. This was disappointing for all those who had worked so hard at producing it.

However the timing of the tracking audit coincided with the forms initial distribution, therefore many clinical areas, especially in community bases, did not have access to supplies.

It was encouraging that demand for supplies of the form increased during the subsequent three months, and as a result two further re-prints were ordered.

A further measure of success of the acceptance and confidence attached to the assessment tool and protocol, concerns the changes made to referral procedures. Vascular surgeons now use the form as a basis for their own interventions, and within the terms of the policy, are happy to take a direct referral from a nurse if necessary.

In addition the surgeons report a significant improvement in the appropriateness of referrals since the protocol has been used.

Education on using the protocol has been included in a district wide education programme on leg ulcer management.

Staff Education Programme

The staff education needs assessment revealed that education was required on different levels depending on roles and functions. Therefore an education programme was designed accordingly on three levels.

- Specialist level
- Practitioner level
- Raising Awareness

Specialist level

In order to fully assess a patient's leg ulcer and make recommendations for further management required, the availability of nurses with specialist knowledge and skills, including Doppler ultrasound, was required.

ENB N18 Course

The ENB N18 course in leg ulcer management is acknowledged as the specialist course in this subject. The project nurse had already completed the course, and PACE funding enabled 3 nurses in the two acute hospitals, 3 nurses in community bases and 3 nurses in community hospitals to undertake the N18 course. Nurses attending this course continue to maintain their duties in their established roles, but in addition they act as a resource for leg ulcer management in their local place of work. They were issued with their own Doppler ultra sound equipment if they did not already have access to the equipment and provided with a range of educational material

Networking and on-going education

In order to support the leg ulcer specialist nurses, and ensure that their skills and expertise are utilised to the maximum, a leg ulcer specialist nurse network is being convened. The idea behind the network is to provide opportunities for these nurses to establish and maintain contacts with colleagues, and help them to refresh their knowledge and enthusiasm in the topic. There are also plans to involve the specialist nurses in contributing to an on-going education programme organised through the established Tissue Viability link nurse scheme. In addition a programme of assessment and treatment workshops is being jointly organised by the Practice Development departments of the Acute and Community Trusts.

Nursing Resource Directory

A Nursing Resource Directory containing the names and availability of nurses with specialist expertise in a wide range of topics is already available in the Acute Trust. The Practice Development Nurse in the community Trust has decided to extend this scheme to the community bases and details of the leg ulcer specialist nurses will be included in this directory as a point of reference for nurses seeking help and advice on assessment and treatment.

Practitioner level

Workshops

This level of education was directed at nurses involved in the day to day care and monitoring of patients with leg ulcers. 6 quarterly workshops, and a series of study days, have been organised at different venues in the Reading area in order to attract community, hospital and practice nurses. The two day workshops, supported by a leading pharmaceutical company, have concentrated on providing nurses with the knowledge and skills required to treat patients according to the agreed assessment and treatment protocol, with supervision and assistance from a specialist nurse as required.
To date 325 nurses have attended one of these events.

Exchange visits

15 educational exchange visits have taken place facilitated by the Project Nurse. These exchange visits have enabled nurses from acute and community settings to experience first hand the leg ulcer care of patients in settings different from their usual place of work. The level of co-operation and understanding of each others problems, skills and expertise has increased as a result and the Project nurse also reports more co-operative working practices between acute and community nurses.

General Awareness

Briefing sessions and seminars have been organised for all health care professionals interested in clinically effective leg ulcer management. As well as providing information on the PACE programme generally, and the West Berkshire project in particular, it was also intended to promote a more positive image of leg ulcer management and draw attention to local resources available as a result of development work undertaken.

A written information Bulletin outlining the project's recent progress, and Kings Fund leaflets explaining the PACE scheme, have been made available to those attending these sessions.

Details of the sessions attended by various professional groups are given below.

Raising Awareness Sessions

Professional Group	Nos.
GPs	50
Dieticians	12
Chiropodists	15
Managers	20
Medical Audit Advisory Group	65
Practice Nurses	80
Berks. H.A.	3

In addition the project's developments have been presented at a number of policy committee meetings, clinical effectiveness strategy meetings, research and audit groups, and educational events at local universities and colleges.

INVOLVING PATIENTS

Gaining patients views

Asking patients about their priorities for care and collecting information about the lived experiences of their condition and treatment has been integral to each of the project initiatives.

Qualitative data collected during the clinical audit programme helped inform the design of the assessment protocol which, for example, includes recording patients own words to describe pain and social conditions. Case studies and the use of patients' narratives are an important feature of the education programme, and these are used to encourage participants to use a problem solving approach.

In order to ascertain more precise information about patient's preferences and concerns, a small number of patients were interviewed in their own homes by a District Nurse from another area.

The results of these interviews have caused us to find ways of improving the availability of compression hosiery. Listening to patients accounts has highlighted the problem of getting compression stockings on and off, especially if the patient has arthritis or a hip replacement. Learning the knack of correctly putting on compression stockings is included in the leg ulcer workshops and District nurses also have access to a gadget which some patients find helpful in getting stockings on and off.

As a result of the interviews we intend to address concerns expressed in relation to accessing services, especially the transport problems of rural areas.

Those involved in the project are keen to extend the choice for accessing leg ulcer care. Leg ulcer clinics may be one option, but these shouldn't necessarily replace District Nurse visits for patients requiring a range of nursing services, and who also need the reassurance and regular social contact that an enduring and trusted relationship brings.

Healthy Legs for Life

As mentioned at the beginning of this report, a significant number of patients whose leg ulcer finally heals, suffer a recurrence. Some studies suggest that half of the healed ulcers will recur within three months, and a much larger percentage (up to 70%) within a year. (Callam 1985))

However lower recurrence rates are reported in patients who comply with wearing compression stockings once the ulcer had healed. (Mayberry et al 1991) 0ther preventative practices mentioned within the literature include exercise, diet, elevating the legs at rest. However at present there is no evidence that preventative treatment other than compression hosiery is effective in preventing or delaying recurrence.(Peters 1998)

Those involved in the project have been keen to help patients learn more about what they can do to help themselves especially in:-

- preventing leg ulcers developing in the first place
- encouraging people to seek help early
- maintaining skin integrity once the ulcer is healed

The most important part of preventative care is wearing suitable compression hosiery. Many people, including patients and staff, that we encountered during the course of the project, had an outdated image that all elastic stockings were unfashionable, heavy, ugly and uncomfortable. However modern materials have resulted in the availability of compression hosiery that is much lighter and more comfortable to wear. Hosiery companies have produced a range of products that, whilst providing adequate support, are more fashionable and available in a range of weights, colours and styles including sports socks.

The group were also keen to move away from the negative images usually associated with leg ulcers sufferers which does little to improve people's self esteem or confidence. In particular the group did not approve of the stereotyped images of elderly people, often illustrated unflatteringly in cartoon form, that appeared on many of the patient education leaflets available.

By way of contrast the project's Healthy Legs for Life logo designed to accompany displays at community talks and on patient information leaflets, aimed to promote an image unrelated to age or gender but conveying a positive message of being well and in good spirits. (Appendix)

Written information

In order to provide up to date written information on current treatment and outline what patients may expect from health care professionals and local services, a sub group was convened to design an information leaflet.

The Community Health Council and local Health Promotion Unit were consulted on the format and design of the leaflet. They offered expert advice on it's style, content and distribution and helped us avoid making costly mistakes.

Plans are in hand to publicise the Healthy Legs for Life initiative and distribute the information leaflets through

- Health Promotion Unit
- care agencies
- local clinics including Well woman/men clinics,
- pharmaceutical and hosiery retailers
- chiropodists
- talks to community groups

Learning lessons about implementing clinical effectiveness

Quarterly meetings of the PACE Advisory team meetings and the Tissue Viability group, have provided regular forums for planning and monitoring project work, but they have also given those involved an opportunity to reflect on more general issues such as discussing what has gone well, or not so well. The conclusions reached as a result of these reflections helped shape the development of the project, and a summary of the most significant lessons learnt is offered in order to share experience and add a sense of realism.

Keep on communicating

The development of the communication strategy was in response to problems we had encountered with communication. The sheer size of the problem threatened to overwhelm us. There were literally thousands of people who we felt needed to know about the project, all widely dispersed in various locations across Berkshire, in GP surgeries, clinics, community and acute hospitals. The cost of producing and distributing a PACE project Newsletter would have been prohibitive, and then there was still the problem of trying to get people to read it!

It was for this reason that we decided to access as many locally produced newsletters as possible. Accounts detailing progress on the project's developments were submitted to publications which were already in circulation and which, we were reliably informed, people actually read. Examples of these newsletters include:

- ROBA Hospital Newspaper
- Newsletter to GPs, Service Unit Managers, Clinical Directors and the Community Health Council issued by the acute trust
- Thames Valley University newsletter
- The MAAG magazine
- Age Concern Newspaper
- Practice Nurses Newsletter
- Health Authority Newspaper

A written information leaflet was produced and updated quarterly for those requesting additional information and this was also sent to new members of staff.

Although no formal evaluation has been performed, the number and distribution of enquiries received asking for further information indicates that messages did manage to reach a significant number of people.

It was also necessary to negotiate a route through various organisational structures in order to identify and communicate with the relevant committees responsible for policy making. This proved to be a delicate operation especially as some of these committees had informal practices and covert gate keeping which made access relatively complex.

Locking into organisational priorities

Health care organisations are constantly evolving in response to a wide range of social, demographic and political influences, consequently there were a number of important changes taking place in both the Trusts affecting the way services were organised and managed. Inevitably this project found itself competing for attention against an ever changing organisational background.

In order to maintain momentum there was a need to remain flexible and alert to the impact that other developments may have on people's receptiveness to the work being undertaken.

For example at the end of the financial year increasing attention was being given to the costs of purchasing the surgical supplies required for graduated compression A number of enquiries were received as to whether the supplies were likely to be available against FP10 in the near future.

To ensure that we managed to maintain the commitment of those responsible for the deployment of resources, there was a need to focus attention on the eventual cost savings to be made following initial modest investment. In the majority of cases the economic evaluation proved to be an important lever for change as it managed to persuade managers that graduated compression was cost and clinically effective.

Promoting evidence based practice is ineffective unless underpinned by evidence based management, and it was important to involve managers in the critical appraisal of evidence. However despite our best efforts at including managers in the project, there remained one or two areas where clinicians reported being unable to implement evidence based practice because budget holders refused to sanction the purchase of supplies.

It is worth while remembering that there may be more opportunities for preventing wasteful use of resources as for realising cost savings. Drawing attention to this proved to be a persuasive argument in discussions with those concerned with budget management.

Developing co-operative working practices

Networking

Emphasising joint working practices not only ensured that we promoted ownership within the various professional groups it helped build a network of useful contacts. However as well as the expected professional roles, consciously or unconsciously, a network of people with useful skills evolved. This included people who could help with graphic design, advise on health promotion material, could influence stock held in central supplies, repair Doppler machines, or knew the mechanisms for getting education points. The list went on and on. Keeping a record of these useful contacts from the

outset was a practical and useful ploy for making the most of each others talents and certainly helped "oil the wheels" later in the project.
As a self directed process which encourages individuals to assume responsibility for their own development, networking also proved to be a valuable personal and professional development tool. Networking exposes individuals to a diversity of opinions, offers opportunities to challenge assumptions and helps develop critical thinking.

Another important advantage of networking was the way in which the collective views and opinions of a widely dispersed group, such as Practice nurses found a voice at a more central level This in turn helped strengthen professional influence on strategic thinking on developments such as the introduction of Primary Care Groups

Allowing time for networking within education events brought the benefits of improved resolve and commitment, better communication and more co-operative working practices. Hopefully the leg ulcer specialist nurse network will help sustain these benefits beyond the life of the project.

Finding time

It quickly became apparent that the most rare and precious resource afforded to the project was time. No-one ever seemed to have enough time. Meetings started late because people were juggling priorities, struggling through traffic, trying to find a place to park. People left early, or didn't turn up at all, because of a staffing crisis or an unforeseen problem. Meetings were constantly interrupted by clinician's bleeps or urgent telephone calls.
The time management strategies advocated in management courses began to appear irrelevant and idealistic when faced with hard pressed clinicians desperately trying to meet their responsibilities to patients and employers.

This proved to be the real world of implementing change. The very people who needed to be involved in designing and implementing clinical effectiveness initiatives were essentially those whose main priority was clinical work. Pragmatism and compromise necessitated finding different ways of bringing together the inputs of the individuals concerned. Much group development was indirect or achieved through proxy, and without the benefits of regular face to face contact within a stable group environment, the consensus development process proved to be lengthy and somewhat disparate.

However the assessment tool/ protocol did eventually prove to be worth the time and effort invested, and it has become an important lever in promoting evidence linked decision making and changing behaviours. The protocol has given health care professionals a common language and shared understanding for managing leg ulcers, provided a benchmark for good practice and offered a system for consistent and evidence based clinical decision making.

Educating for Practice

Recent discussion in the nursing literature draws attention to the blurring of role boundaries between nurses and medical practitioners with regards to leg ulcer management. Husband (1996) draws attention to the hazards of medical staff delegating the management of leg ulcers to nurses without first providing a medical diagnosis, or adequately educating the nurses in diagnostic techniques. Brereton et al (1998) propose that nurses need sufficient knowledge of underlying pathology to perform comprehensive leg ulcer assessment, and a study by Moffatt and O'Hare (1995) concludes that recording accurate resting pressure is an important part of nursing management.

The education sub-group concluded that it was the confidence attached to the way a diagnosis was established that was more important than who actually made the initial diagnosis. No health care professional works in a vacuum and therefore the diagnosis and management of the patient's condition should remain a team responsibility. Consequently the development of the protocol was a multi-disciplinary exercise, and the form emphasises consultation with other members of the health care team. In addition a multi-professional education programme was designed to reinforce and support the functions and procedures outlined in the protocol.

Knowledge and understanding of comprehensive assessment and the attainment of competence in skills such as estimating ankle/brachial pressure index, performing Doppler ultra sound and applying graduated compression bandaging, provided the focus for two day leg ulcer workshops. These were open to all health care professionals but nurses were by far the most frequent attendees.

Medical staff were invited to attend an afternoon seminar which supported their role in diagnosing and prescribing treatment. The programme included sessions on aetiology, pathology and treatment of leg ulcers from medical consultants and attracted PGCE points. Given the time and expense given to organising the event it was disappointing that only 12 medical staff attended.

However as the project progressed, requests were received from GPs for local teaching sessions. These seminars conducted on GPs own premises have been attended by local teams of medical and nursing staff together and this has proved to be an effective way of providing education and support for practice development.

"Learning by doing" became the watchword for the education programme which ran concurrently with implementation. The availability of the project nurse meant that lessons learnt at workshops could be reinforced by supervised clinical practice. As a respected colleague the project nurse was able to provide on-going support with decision making until individual practitioners developed confidence in their own abilities. It is hoped that the specialist nurse network will continue to provide this level of support once the project is ended.

Sustaining change

One of the challenges faced by any change project, and the acid test of it's success is how developments in practice are sustained once the spotlight has moved away, the nature of the research evidence changes or local champions move on.

The sub groups organisers have attempted to provide sufficient infra structure to ensure that systems are in place to support future practice and service developments and to buffer the impact of inevitable organisational change.

In addition to the specialist nurse network, videos on leg ulcer management will be made available to clinical areas.

The Practice Development nurses of both the community and acute Trusts intend to capitalise on the closer working relationship resulting from the project and have planned a shared programme of events relating to leg ulcer care.

Project leaders have also been in liaison with the Royal College of Nursing (RCN), to ensure that recommended practices follow those contained within the Leg Ulcer Guidelines the RCN are due to issue later in the year. Copies of this guideline will be included in a resource pack to be issued to all specialist nurses, community bases, appropriate hospital wards and departments, libraries and education providers.

A letter detailing Information on how to access further supplies of the protocol has been sent to all clinical areas. Review of the protocol will occur through the various policy making committees in due course, and the Tissue Viability Group will continue to have a role in advising these committees on new developments in relation to leg ulcer care.

An area of concern is the difficulty of providing on-going education and support for Practice Nurses now that the Health Authority no longer has central representation for this professional group. This has already proved to be a barrier to communication and limited access to educational events for some Practice Nurses. Attempts at organising a conference for Practice Nurses later this year failed because of lack of central organisation.

However it is possible that if Practice and community nurses are able to contribute to the emerging Primary Care Groups then the provision of evidence based care for patients with leg ulcers could receive a higher profile

Conclusion

Taking part in the PACE programme has enabled health care teams in West Berkshire to improve the quality of care for patients with venous leg ulcers. It has also been an unprecedented opportunity for those taking part to learn some important lessons about organisational development.

To date relatively little attention has been paid to the process of adopting evidence based practice within health care settings and as a result our knowledge base in this area has been incomplete. Perhaps this is because the messy, unpredictable nature of daily practice is not seen as an ideal arena for rigorous scientific enquiry. The project team hope that this report has helped throw light on the reality of introducing developments in clinical practice.

Dawson (1997) draws attention to the diversity of contributions made to health care services by researchers and practitioners, suggesting the existence of four separate worlds inhabited by quite different species, who have evolved in response to the requirements of the task in hand.

The first world is that of the research centres where evidence is generated and where a natural scientific ethos prevails. In this world scientific rigour and validity supersede those of applicability.

The second world is a more recent phenomenon. Occupants are statisticians, economists and epidemiologists who sift over the evidence produced by research centres, and within a strong evaluative culture, abstract and judge it's worth against pre-determined yardsticks.

The results of their efforts are then handed over to the occupants of the next world concerned with designing systems for packaging and translating evidence for use in practice through for example guidelines or protocols. Essentially this world is populated by specialists with a strong personal interest in a particular topic or condition and who seek to influence peers. Typically they may be temporary residents or part-time contributors.

Finally there is the world of practice occupied by pragmatists in direct contact with the end users of research the patients. Less homogenous than inhabitants of the other worlds, they are pre-occupied with providing bespoke evidence, tailoring it for individual situations and drawing on a wide range of experience which would prove an anathema to those working in the other worlds.

This project has directly or indirectly involved occupants of all of Dawson's four worlds As a result the individual values and beliefs for patient care that occupants in each possess has become less alien to each other, and health care professionals have found meaningful ways of working together to improve patient services.

The project has also helped us gain access to a fifth world - that of the patients. Despite all the advances made in medical technology, pharmacology and nursing practice, it was sobering to meet with people suffering from a painful, debilitating condition, who had received largely ineffective care for almost as long as the NHS has been in existence. Their world had often been one of lasting endurance, insidious resignation and increasing isolation. The continuing resolve of those working in West Berkshire is to ensure that people with leg ulcers receive the services they need to improve the quality of their lives.

The Kings Fund PACE Project in West Berkshire

-improving the care of patients with leg ulcers-

COMMUNICATION STRATEGY JAN-JULY 1998

TARGET	ROUTE	RESPONSIBLITY
Community Chief Executive	Meeting June 1998	C. Dunn/T Powell
Neighbourhood Managers General Managers DNS	District Nurse Practice Development Group (Mthly) Letter to DNS as update Meeting Nurse Mgrs Meeting N'hd Mgrs	Tissue Viability Group N'hood Manager Rep. CD
GPs	Acute Unit GP Newsletter GP Study Day 17 Sept.	CD via Jane Brooks PACE Advisory Group
District Nurses Practice Nurses	T.V Link Nurses Update Practice Nurse Newsletter Jan.98	Maggie Woods Renza Manning
Self Management Group (BIP and TIP)	via Ann Owen	Helen Bapty
Acute Unit Chief Executive and Board	Board Report via Ann Sheen DNS	CD
CSU Managers Lead Sisters Ward Sisters	Nursing Policy Meeting Lead Sisters Meeting Flyer to wards Jan. 1998	CD
Nursing Staff	Practice Develop. Nurses Tiss. Viab.Link nurseUpdate PACE Flyer to wards. Elderly care Newsletter July Eld. Care Heads of Dept. Meeting. May 27	MW CD CT CD
Senior Medical Staff	Individual meetings with Consultants. CSU Directors	CD/TP
Other Medical Staff	Post grad.library Services	Marie Hickman
PAMs (NB includes relevant community personnel) Dieticians Physiotherapists Pharmacists Chiropodists	Departmental Meetings Community Trust Newsletter Chiropodist Head Dept. Mtg Dieticians Mtg Jan. '98	Representative on Tissue Viability Group: Jane Willis Thea Thompson Tina Coggin

Thames Valley University College Staff Students on Relevant Post Grad Courses	College Newsletter Module Leaders via Practice Development Nurses	JS/CD
Other Agencies		
Kings Fund PACE Team	PACE Meetings K. Fund 10 July/ 13 Nov. PACE Advisory Mtgs 7 Aug. /10 Nov.	PACE Advisory Group members
Berkshire H.A. (Purchasers)	E Mail Meeting with Jane Laesham re Practice Nurses.	Sarah Bellhouse CD
Royal College of Nursing	Mtg with Liz Mackinnes re nnational Guidelines 2.2.98	CD/TP
Community Health Council	Newsround Acute Unit Newsletter Quarterly (Aug. 97) via Jane Brooks	

SOUTH TYNESIDE
PACE
ANGINA PROJECT

SECOND YEAR
REPORT

The South Tyneside PACE Angina Project has continued its momentum during the second year, the project having been further modified through the practicalities of the work and the workload of the key project team members.

Current Progress.

Following the introduction of the Guidelines in April 1997 the education programme commenced and continued through to February 1998. A study guide was prepared for Practice Nurses, accredited by the University of Northumbria, and has been well received. A draft of a study guide for GPs is currently undergoing evaluation from an Educationalist. Additional educational needs have been identified and will now be addressed.

The audit is currently underway; each practice being audited six months after their education session. The second data collection will be completed by August, for the supplementary report to the Kings Fund. The other data set will also be extended to this point.

The Patient-held Record has been produced following patient focus groups and a health professionals' focus group. This has just been launched and its implementation, evaluation and a third round of audit will provide a third year of the project.

PART 1: Changing Practice - Project management and lessons from the work.

This section describes our approaches to managing the changes and the lessons derived from our experiences.

a) Techniques and Change Mechanisms.

We would identify the following:

- Local Ownership - we have built a network of professional interest; support for the project aims and objectives locally; and developed upon our previous activities in Ischaemic Heart Disease .
- Guidelines Pack - we simplified our message and provided adequate supporting literature, supplementing additional items during the project when required. The evidence has been credible and shown scope for health gain, for change and support to personnel in practices.
- Audit - feeding back audit results to practices has been effective in highlighting current shortcomings within management
- Education - within the practice-based sessions groups and practices had the opportunity to view their individual practice audit data as a learning exercise; subsequently "league tables" have compared their practice data with others across the District (re-enforced by the setting of PACE Charter Marks for our target of achievement). Education sessions have helped practices think through management issues and practices have felt supported. Provision of studyguide workbooks has been a positive educational gain for Practice Nurses. Opinion leaders do not seem to have a major role in the District.
- Service Developments - the provision of Open Access Exercise ECG Testing was a

strong positive incentive, which was then re-enforced through the production of protocols and algorithms. This has helped develop a model for delivering other service changes within the District.

- Communications and Marketing Strategy - publicity was directed through newsletters, posters, media, and patient-directed leaflets on angina management.
- Academic Detailing - this has been a minor aspect, principally through a BMI Calculator. (Further items including cholesterol stickers; angina stickers; mugs; and note pads are planned).
- Patient-held Record - we still feel this will be a major change mechanism, being our principle form of patient empowerment.

Our strategy so far has some shortcomings - as the project is ongoing it is difficult to quantify the success and failures of these individual components on the project, with the impact of some being delayed. The Trust and District Health Authority input and support has been disappointing.

b) Managing the Work.

- The Project Group.

A small group of people ended up doing the work. Some group members felt less involved and it took time for newer project members to get the "feel" for the project. Team members had opportunities to develop and acquire new skills e.g. MS Access usage and the design/marketing of materials such as the Patient-held records. All team members were involved in the communications and contributed to newsletters. Representatives were present at all associated meetings and lectures.

- Individuals.

The two key appointments worked independently and developed their own action plan for their work. They promoted a high profile for the education programme and audit activities. Having defined points of contact e.g. MAAG and audit offices, was important - a change in site of the MAAG office led to a reduction of profile and deterioration in continuity role of the MAAG Facilitator.
Keeping the project focussed and on track has proved challenging; some team members proved adept in this role e.g.costing the use of resources rather than performing an economic evaluation.

- Focus Groups

Patients were involved through focus groups; however defining their role has been problematic and we realise they have probably not been involved sufficiently.

- Network Group

The project leader, educator and MAAG facilitator were the main liaison with these groups and their work. Members also volunteered to assist as the "medical expert" in the practice-based education sessions.

c) Factors for Success.

- Project Team.

The members were highly motivated, enthusiastic, cohesive, and hard working, their major strength being the commitment of the team.. Having already been through the stage of natural selection they worked very well together, with the leader displaying appropriate project management skills

- Focus on Aims and Objectives of the Project.

The participants shared the objectives and identified with the project's aim. The evidence-base was credible and the perceptions of the project were identified with health gain.

- Previous Work.

The previous Aspirin Audit and CHD Case Flagging Project established the team's good reputation and credibility. This resulted in excellent working relationships particularly between the MAAG and Practices.

- Approach to Practices.

The team was sensitive to the problems experienced in Primary Care, principally their workload, the "threats", and resources available. The method of conducting contacts with practices was not "high pressure-hard sell" but co-operation and avoidance of the big stick.

- Locality

South Tyneside is a small District, enabling us to define our market more easily and allowing easier access to the practices.

- Key Appointments.

The people appointed to the key positions of auditor and educator were able to work well unsupervised; to formulate their own agenda; to build good relationships with practices and be good advocates for the project.

- Staging of Interventions.

Staggering the interventions of Guidelines, Education Programme and introduction of the Patient-held Records has enabled practices to adjust rather than be overwhelmed. It proved more feasible for the Project Team to fit into their own working schedules.

- Factors limiting Success.

The small critical mass of enthusiasts increased the difficulties. The lack of support from the Health Authority and Trust, partly deriving from changes within both organisations, were difficult to overcome. Lack of direct involvement by the Cardiologist limited the Trust involvement.

d) Self-Assessment and Reflection.

- Project Group Meetings.

These meetings, held every two months enabled an assessment of the progress of the project and allowed team members to comment upon, offer support and suggestions, and sometimes solutions to difficulties encountered. Following the Audit and Educational Assessments from various meetings and sessions a smaller number of Project Team members were able to evaluate and discuss the results and their significance, before presenting to the formal meetings.

- Feedback from Practices.

During the education sessions practices identified barriers and opportunities which we were able to incorporate into the project. These sessions also generated much enthusiasm for the aims and objectives we had set.

- Focus Groups

The feedback from the patient focus group was most illuminating; in addition to undertaking major modifications of the Patient-held Record the comments allowed the Project Team to re-enforce the aims and objectives to Health Care Professionals, and change some details of the project where required.
The feedback from the Health Professionals focus group, whilst supportive in principle, identified additional barriers to be overcome. It also presented opportunities to involve some sceptics.

- Formal Meetings

Presentations to the Health Authority and Trust Boards, and to a Postgraduate Centre audience enabled wide-ranging discussion of important professional, managerial and contracting issues to be discussed.
Presentations to other groups e.g. Community Pharmacists, enabled the team to include groups who were potentially valuable to achieving the aims and objectives; the feedback obtained was highly valuable.

- Individual Contacts

These were important and whilst too numerous to record, provided direction, thought and action in many instances.

e) Sustaining the Changes.

- Active Commitment from the Health Authority and Trust.

A sustained commitment is necessary to institutionalise the lessons of the PACE project into everyday practice. This involves *active* management of IHD Services, for example:

i) Health Authority – through the commissioning forum and contracting process; by identifying targets for practices to achieve and by maintaining the Network Group;
ii) Cardiology/Primary care – absorbing the lessons of PACE into clinical practice; to undertake much of the work done by PACE through development of the practice

links and Network Group; update of and production of education materials and training in conduction with the training bodies, MAG and Health Authority; involvement in Continuing Education for all Health professional groups;

iii) Trust – raising the “cardiac” profile within the District and developing cardiology services for Primary Care access e.g. Open Access Echocardiography, Cardiac Risk Assessment, and Cardiac Rehabilitation.

- Patient Held Record.

Whilst we are just at the implementation stage we firmly believe that patient empowerment, through the Patient-held Record, will prove the most successful tool. The formal evaluation and third audit will be performed in 1998/9.

- Introduction of specifically targeted mechanisms.

These will include:

a) Supporting practices - "Rewards and Carrots" - helping to put together their action plans; obtaining a commitment from the Health Authority to provide support and resources (finance and manpower) for "Risk Assessment" sessions; and provision for practice development e.g. IHD register

b) A defined Health Authority lead/facilitator on IHD (e.g. for Primary Care Groups) who will provide high profile leadership, with a similar level of enthusiasm and commitment to the PACE team, and enjoy support from a Network Group.

- MAG

Their role will be in updating the Guidelines, continuing the audit and re-enforcing the changes, together with strengthening their facilitatory role with practices. These will result in identification of training needs and developmental issues.

- Publicising Success.

An effective Dissemination Strategy within the District and locality will promulgate the lessons from the PACE Project.

- Clinical Governance.

This initiative will offer opportunities to take forward evidence-based practice. The nucleus of the PACE project team and Network could contribute to a Clinical Effectiveness forum on Ischaemic Heart Disease management, and work collaboratively or with individuals in the various organisations. This work could then be incorporated as a model for the Health Action Zone initiative.

f) Using the Learning in Other Projects.

- General Principles.

The general lessons from this project would be applicable to any project aimed at introducing evidence-based practice and will be fed back through the Health Authority and Trust Clinical Effectiveness forums.

Specific items would include:

- 80% of the project is planning with only 20% in its performance; plan to institutionalise the outcomes from the onset;
- projects rely on good teamwork; developing close relationships to Primary Care teams; and engendering close ownership of the project in the participants;
- use multiple strategies to achieve changes;
- get the "levers of change" committed to the project;
- immediate gratification is important to participants and a powerful stimulus for continuation.

- Diabetes Services

The pilot study for the PACE Project audit sheet was initially performed on diabetic patients; this has been repeated. The study guide for Practice Nurses will be adapted by the Diabetes Nurses to use as an educational resource for Practice Nurse education in Diabetes Care. A Regional Audit of CHD Management in diabetic patients is planned and will utilise PACE Project materials.

- MAG.

The Gateshead and South Tyneside MAG have persuaded Gateshead Primary Care to undertake parts of the PACE Angina Project. Gateshead Primary Care professionals will be invited to the local Dissemination Workshop.

- Service Development.

Our model for resourcing service development is applicable to other areas, involving collective resourcing from several interested groups. Small quantities of funding have been shown to prime a development, which is time specific and politically supported.

g) Project Grant.

The funding from the Kings Fund for the second year of the project has been utilised for:

1. Salary of Educator - 10 hours per week Nursing Grade I = £6,146.
2. Salary of Audit Officer - 20 hours per week A+C Grade 4 = £7,532.
3. Project expenses (£1,338) towards the printing of Patient-held Record;

and the production of an AudioTape for implementation of Patient-held Record.

h) Additional Resource Items developed for the Project.

The additional items have been:

a) for the Guidelines Pack;
    - an algorithm for Exercise ECG;
    - a "Healthy Eating" Guide.

b) Patient-held Record;
    - the record itself;
    - an audiotape for its use (primarily for the visually handicapped, but an extra re-enforcement for other patients;
    - a patient's take-away leaflet;

c) a draft study guide for GPs;

d) a BMI calculator.

PART 11: Project Achievements - Changes in Practice and Services..

a) Major Achievements.

The Project Team has defined the following as the general achievements:

- Raising awareness of the angina guidelines and condensing them onto an A4 form.
- Re-enforcing the need for good clinical data recording.
- Putting ischaemic heart disease management onto practices' agendas.
- Getting access to some many practices and demonstrating to practices that positive changes can be achieved without a great deal of extra effort.
- Demonstrating to the Trust and Health Authority the value of such projects as mechanisms for change.
- Demonstrating that a good multi-disciplinary, multi-sector team can achieve results; (and survive still speaking to each other!).
- Improving the working relationships and communications with key individuals, and with other organisations.
- Achieving the establishment on an Open Access Exercise ECG service.
- Bringing together (and overcoming prejudices) patients and professionals to develop a Patient-held Record.

b) Things We would do Different Next Time..

These would be the following:

- use a simpler, clearer message and be less ambitious e.g. concentrate on professionals treating hypertension, giving aspirin and stopping their patients smoking.
- have a smaller project working group but involve other people more e.g. define the tasks and specifications better. Employ more people to do the specific tasks.
- use GP Focus groups more.
- use better IT facilities - if they exist!
- have a better Communications Strategy, defined from the outset.
- set aside for time for thought and reflection.
- use market feedback more as a change tool in education sessions;
- involve the Educator more in planning the audit (the lack of knowledge detracted from the credibility of the message).
- have a strong Health Authority figurehead in the project group

The following section deals with the results of the project as they stand on 31.5.98, in accordance with the original outcome measures. These are reported in the Appendix.

1) A reduction in Annual Mortality Rate.

The Annual Mortality Rate for coronary artery disease has been falling in South Tyneside and will achieve the Target 2000 figure. It will take several years to determine the effect of the introduction of evidence-based guidelines for the management of chronic stable angina upon the Annual Mortality Rate and SMR.

2) PACT and Hospital Aspirin and Beta-blocker Prescribing.

We have continued to record an increase in the prescribing of 75mg aspirin (expressed as either total doses, total doses per 1000 patients or doses per 1000 Astro PU's), through PACT data. It is too early to demonstrate an absolute effect from the PACE project, although there did appear to be a flattening out of prescribing in the March to August 97 quarters prior to the anticipated effects of PACE. All individual practices showed an increase in prescribing. The prescribing of 300mg aspirin has been static.
As yet there have been no demonstrable differences in prescribing aspirin between Gateshead and South Tyneside; both Districts had undertaken projects prior to PACE directed towards increasing aspirin prescribing to patients with coronary artery disease.
There has been a small but definite increase in beta-blocker prescribing, principally in Atenolol prescribing, as a direct result of the PACE project.

Following the introduction of the guidelines a definite increase in the prescribing of 75 mg aspirin, oral nitrates and beta-blockers (atenolol) occurred in hospital prescribing, although only for patients discharged for the beta-blocker group.

3) Admissions to South Tyneside District Hospital for MI and CHD-associated conditions.

A 17% increase in inpatient FCEs occurred for all diseases in the Department of Medicine during 1997/8. Within this context there has been a 24% increase in patients admitted with coronary heart disease; this is principally with angina with a small fall recorded in patients admitted with myocardial infarctions. A similar increase occurred in Gateshead for total admissions with coronary heart disease but with a smaller percentage for angina and myocardial infarction patients.

4) Referrals to the Tertiary Centre for Coronary Angiography and CABG surgery.
There has been a marked increase in referrals for Coronary Angiography, partly resulting from increased availability of angiography facilities at the QE Hospital, Gateshead. The figures for Coronary Artery Bypass Graft surgery are not complete for the year but will probably also show an increase in operations performed.

5) Use of Resources.

There has been an increase in the use of resources following the introduction of the guidelines. The figures for Bed Occupancy for angina, myocardial infarction, and CHD-associated conditions on the CCU and medical wards are influenced by the increased admission rate. There has been minimal change in the Average Length of Stay reflecting the management strategies for these conditions.
Referrals for open access ECGs and exercise ECGs from GPs have increased substantially, the latter following the introduction of open access service, and additional sessions. Myocardial scans are the province of Hospital doctors and their use remains constant. Lipid measurements are partly distorted by the availability of non-fasting estimations from 1.2.97 (before the guidelines) which resulted in an immediate increase of about 150 estimations.
- Attendances at Risk Assessment Clinic.

6) Intervention data for the use of the Patient-held Records by Health Care Professionals and Patients.
This data will not be available till 1999 as the Patient-held record will not be introduced till 1.6.98, with its evaluation and then third audit being performed in late 1998.

7) Data from Practices, before and after the implementation of evidence based guidelines and the education project, for

Risk Factor Modification
Investigations
Therapeutic Prescribing
Secondary/Tertiary Referral.

We have so far completed a re-audit of approximately 32% of patients. 8% of patients have not been seen since the first audit, and another 8% have either died or moved away. We have presented a comparison for the data set items that have been recorded at all timepoints (i.e."at diagnosis, within 5 years of diagnosis and ever") to the point of re-audit. The data so far available shows improvements in some areas e.g. Risk Factor Modification and Investigations (principally performed by Practice Nurses) and Secondary/Tertiary Referrals. However the lack of changes in therapeutic prescribing, principally the GPs territory, is disappointing. The exception has been in the prescribing of Statins where there has been a doubling of the number of patients taking Statins from 27 to 45 (20%).

TIMETABLE FOR THE SECOND YEAR.
FOR THE SOUTH TYNESIDE PACE (ANGINA) PROJECT.

TIMETABLE FOR THE SOUTH TYNESIDE PACE (ANGINA) PROJECT.

STAGE 1 (3 months).

Identify All Participants.	**MAY 96**
Explanation of Project .	**MAY 96, SEPT 96**
Define Work Schedule and Responsibilities of Participants.	**MAY 96**
Produce Presentable Form of Guidelines and Evidence.	***MEETING 29.11.96**
Identify Routine Data Sources and Collection Systems - to be incorporated into Project and normal "working".	**JULY 96**
Appoint the Educator and	**OCTOBER 96**
Audit Officers	**AUGUST 96**
Plan Regular Meetings and IHD Group Meetings.	**MAY 96**
PGEA Approval.	**ONGOING 1996/8**

STAGE 2 (1 month).

Begin Baseline Audit of Current Practices.	**PILOT COMPLETED OCT 96**
and Assessment of Services/Resource Usage	**HOSP AUDIT STARTED OCT 96**
Patient Focus Groups (CHC)	**JULY 97**
Publicity Campaign.	**APRIL 97**
Production of Protocols.	**JAN 97**
Preparation of Patient-held Records.	**MARCH 98**
Design of Education Programme.	**JAN 97 ONWARDS**
Preparation of Educational Material.	**JAN 97 ONWARDS**

STAGE 3 (3 months).

Implement Educational Programme for Multidisciplinary Staff in Primary Care and Hospital Practice.	**JUNE 97 ONWARDS**
PGME Meetings	**MAY 96**
Follow up Literature (Information Leaflets)	
Newsletters	**3 MONTHLY**
Implement Changes upon Evidence-based Guidelines.	**APRIL 97 ONWARDS**

STAGE 4 (12 months currently in progress).

Implement Educational Programme for Multidisciplinary Staff in Primary Care and Hospital Practice.	**MAY 97**
Regular Meetings and IHD Group Meetings.	**MAY 96**
PGEA Approval.	**ONGOING 1996/7**
Preparation of Educational Material.	**APRIL 97**
Follow up Literature (Information Leaflets)	
Newsletters	
Regular Meetings of Contact Groups and updating.	**ONGOING**
Gather Additional Data eg Tertiary Referrals, QE Data.	**MAY 98**
Implement Changes upon Evidence-based Guidelines.	**ONGOING FROM APRIL 97**
Prospective Audit In Trust in Progress.	**JUNE 97**
Regular Reports on Activities.	**ONGOING**
Regular Interactive Meetings for Participants.	**ONGOING**
Evaluation of Education Project.	**MARCH 98**
Implementation of Patient-held Record	**JUNE 98**
Monitoring of Patient-held Records and Interventions.	**ONGOING FROM SEPT 98**
Ensure Systems for Longer Term Monitoring.	**FROM APRIL 98**

STAGE 5 (3 months).

Repeat of Audit of Current Practices.	**FROM MARCH 98**
Assessment of Services/Resource Usage.	**MAY 98**
Patient Assessment of Results.	**PLANNED SEPT 98**

STAGE 6 (3 months).

Analysis of Results.	**PLANNED SEPT 98**
Presentation of Results.	**PLANNED SEPT 98**
Define Follow-up Measures and Action Plan.	
Distribution of Results for Comment.	**FROM FIRST AUDIT - 1998**
Implement Changes to Contract Processing and Service Specifications.	**FROM APRIL 98**
Action Plan for Other Guideline Implementation.	**FROM SEPT 98**
Prepare Final Report for PACE/Commission/Trust/MAAG/CHC.	**JUNE 98/SEPT 98**
Additional Education and Training Needs.	**ONGOING FROM FEB 98**
Third Audit Cycle	**DEC 98/JAN 99**

Dudley Continence Project

A report to the King's Fund PACE programme, June 1998

Dudley Health Authority
Dudley Priority NHS Trust
Dudley Group of Hospitals NHS Trust

Dr. Wendy Phillips
Dudley Health Authority
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On behalf of the Continence Working Party

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PART I CHANGING PRACTICE

Project management and lessons from the work

Aims and objectives of the project

The overall aim of the project was to reduce the prevalence of urinary incontinence, alleviate the distress caused by urinary incontinence and in particular to;

1. develop a local multidisciplinary strategy for the promotion of urinary continence and management of incontinence which incorporates primary and secondary care and health education initiatives;
2. promote clinical effectiveness in line with regional initiatives and foster a culture which promotes the practice of evidence-based medicine
3. raise public awareness of the issue
4. raise professional awareness
5. encourage opportunistic screening for incontinence
6. encourage regular and frequent pelvic floor exercises in women
7. produce a district formulary for incontinence aids and appliances
8. identify robust measures of measuring progress

The focus of the project has been on women under 65 years with stress incontinence. We decided on this group as they were felt to be the group with the largest un-met need. Incontinence is much more common in women than in men, especially in the younger age group but resources are spent mostly on those over 65 yrs, in part because symptoms get worse with advancing age. However, the major potential for prevention or early treatment of urinary incontinence lies with younger women.

The commonest type of incontinence in women under 65 years is stress incontinence. This is where leakage of urine occurs when intra-abdominal pressure increases e.g. on coughing, sneezing, laughing or exercise. These symptoms are mostly a result of pelvic floor weakness. Weakness of the pelvic floor may occur in any woman but is much more common in the middle years (30 plus to 50 plus) and may result from damage to the musculature or nerve supply during childbirth. Pelvic floor exercises will result in cure or significant improvement in 70% of women and men with stress incontinence. The exercises are also important in the treatment of urge incontinence as they enable sufferers to hold their water long enough to get to a toilet.

For these reasons, a major part of the project has involved training practice nurses in the identification and management of women with stress incontinence. Training materials were developed and piloted in a small number of practices before recruiting borough-wide. Practice nurses are ideally placed to work with this group of women as they are often seeing them regularly for cervical smears and at "well woman" clinics. Our focus group work has also shown that women would prefer to discuss a continence problem with a woman rather than a man and with a nurse rather than a doctor.

Project management and development

Personnel

A continence working party had been established before we an application was made to the King's Fund. The working party included the director of public health (DPH), managers from the health authority and community trusts, medical and nursing staff from urology and gynaecology departments, continence advisors, health promotion advisors and a general practitioner (GP) with a special interest in incontinence. The committee was later extended to include the chief officer of the community health council, a physiotherapist, a midwife and a couple of practice nurses.

Before being accepted onto the PACE programme we had tried to secure funding for an additional continence advisor but it took until December 1996 to organise funding and fill the post. We had initially intended to use only existing personnel for the co-ordination of the project but the existing staff in the continence advisory service (CAS) were unable to dedicate the time required. Further attempts to arrange a nursing secondment from the acute trust failed because the trust was short-staffed and could not spare someone part-time for 18 months. We therefore decided that the new continence advisor, when appointed, could take on the co-ordination of the project.

Shortly after appointing the new member of staff, the senior continence advisor/nurse manager went on long term sick leave, leaving us with only 2 continence advisors again. Despite the staffing problems, the new continence advisor devoted her time to the project for the first year until her remaining colleague went on maternity leave. Without this dedicated time from a continence advisor we could not have achieved the recruitment and training in general practice and collaborative work with secondary care.

Managing the project has meant frequent revision of the plan to take into account delays and the development of our ideas. We also found it useful to review our aims and objectives to ensure that we were keeping "on track" and not forgetting anything. We took up some additional issues in the latter half of the project in response to local needs. These were the development of a self help leaflet for men and work with residential homes to improve the education of care staff.

Managing the project has involved a huge time commitment and everything has taken longer and involved more work than anticipated. There has been consistent input from the project manager, continence advisors and health promotion advisors. Without this, the project would not have progressed very far.

The majority of the work involved myself or Gill Wellington (continence advisor) as we were the only two key members of the project team who had set aside a large amount of time for working on the project. In other circumstances, the allocation of tasks could have been organised differently. For instance some of the data handling could have been done by information support staff and desk top publishing by secretarial staff. It is not always possible for any one individual to allocate a large chunk of their workload to a particular project and this case it would obviously be possible to share the work out amongst a larger number of people. In practice we found that the project had to be run by a small sub-set of the continence working party who met more frequently and did most of the work while the larger working party ratified important decisions and were available for consultation when necessary. Many members of the working party had difficulty attending meetings regularly and so they were often consulted informally at their convenience.

The project planning team had prior experience of change management and some of the principles involved but there were still problems which we did not anticipate. It is unreasonable to expect everything to run smoothly and it is therefore important to recognise problems early and find ways of managing them.

The part of the project involving primary care training was particularly difficult as staff were being asked not just simply to change they way in which they were working but to take on an additional workload, in the short term at least. They were also reluctant to get involved in any data collection because of fears that it would cause a lot of extra work. To overcome this, the data collection sheets were tailored to suit practice staff and doubled up as a patient record in general practice.

Progress against original aims and objectives

Many of the objectives are difficult and time-consuming to measure and would have required extensive survey work before the project could start. Consequently, we identified a large number of tasks to complete before the end of the project and have measured our success in part from achieving the tasks we identified as important. One of the project objectives was to develop a strategy for urinary continence promotion and so some objectives were deliberately broad and non-specific to permit flexibility in the way in which the aims and objectives could be achieved.

We have developed a strategy for continence promotion and this has been incorporated into a service specification for continence services. The strategy encompasses all client groups and types of urinary incontinence and involves primary and secondary care.

We have not managed to develop a clinical effectiveness strategy *as an integral part of the project.* There are two reasons for this;

- The Regional Office initiative to co-ordinate the development of clinical effectiveness strategies has taken precedence over the PACE project.

- Senior Health Authority staff, Trust staff and GPs who are responsible for the local clinical effectiveness strategy have not had enough time to be closely involved with the PACE project.

The Continence Project has therefore developed in parallel with the clinical effectiveness strategy. However, key members of staff responsible for the clinical effectiveness strategy were included in the working party and have therefore been aware of project progress and had access to local information and the "shared experience" of other PACE projects.

Most of the work has been towards meeting objectives 3 to 6. Details of the tasks we completed to meet these objectives are included in Part II of the report. We planned initially to include schools in the awareness raising, educating girls about the importance of pelvic floor exercises. On closer examination we decided that this would require a lot of work, sensitive handling and was beyond the scope of the project. We also had to cut back on our plans to raise awareness among the general public because of staffing problems in the Continence Advisory Service and fears of creating a demand which could not be met.

We did not find it necessary to produce a district formulary of aids and appliances. Equivalent products were very close in price and the main potential for saving money seemed to be in avoiding inappropriate use of certain products e.g.silastic catheters rather than in using more expensive brands of the same product. The Continence Foundation produce a comprehensive directory of continence products including information on choice of products and we obtained their permission to copy this for circulation to general practices.

The methods of measuring progress we identified are outlined in Part II.

Grant expenditure

Item	Unit cost	No	Sub-total
NEEN perineometers	£70	45	£3,150
Additional probes	£10	80	£792
Condoms (1 gross)	£19	3	£56
Condoms (1 gross)	£25	1	£25
Condoms (1 gross)	£31	5	£155
1 flip chart easel	£74	1	£74
1 portable OHP	£372	1	£372
Spare bulb	£9	1	£9
14" video presenter	£329	1	£329
Continence products directory	£45	1	£45
Pelvic floor schools pack	£25	1	£25
PC	£1,050	1	£1,050
Colour printer	£240	1	£240
MS Office 97	£187	1	£187
Expenses for reference groups			£41
Supplement for continence advisor salary			£16,000
Floppy disks (10)	£5	1	£5
OHP transparencies	£35	2	£70
Transparency pockets	£16	1	£16
Display stand and bag	£200	1	£200
Focus group venue	£43	1	£43
Posters			£350
Female pelvic floor leaflets incl translations		10,000	£3,575
Male pelvic floor leaflets		3,000	£1,500
Toilet stickers		2,400	£250
Leaflets, additional copies			£976
Expenses for reference groups (travel and refreshments)			£20
Continence promotion seminar			£446
		TOTAL	**£30,000**

Table 1 Expenditure of grant over two year period

The expenditure of the project grant from the King's Fund is outlined in Table 1. The money has been spent in four main areas;

- Subsidising the CAS to allow for the work of the continence advisor in coordinating the project.
- Educational equipment to support the work of continence advisors.
- Self-help leaflets and posters for raising awareness and educating the public and patients.
- Equipment for assessing pelvic floor strength for use in general practice.

Personnel involved and time commitment

The project has involved a wide variety of people from different disciplines. The working party comprised continence advisors, health promotion advisors, public health specialists, managerial staff from the Health Authority and Trusts, medical and nursing staff from primary and secondary care.

Core project staff were asked to estimate the time they devoted to the project outside minuted meetings. Minutes from formal project meetings have been used to estimate the time spent by "non-core" personnel. In addition to the time spent in meetings, personnel were assumed to have spent an equal amount of time in support of meetings (on travel and committee-related work).

Time spent in meetings and in support of meetings

Type of personnel	Estimated no. of hours
Senior management including Director of Public Health	84
Project co-ordinator	84
Continence advisors	100
Health promotion advisors	100
Medical	20
Other nursing and physiotherapy staff	56
Community Health Council representative	20
TOTAL	464

Additional time spent in supporting the project

Project Planning Team

Type of personnel	Estimated no. of working days over duration of project (approx 2.5 years)
Project manager (SpR public health medicine)	165
Continence advisor coordinator	237
Health promotion advisors	10
TOTAL	412

Other personnel

Type of personnel	Estimated no. of hours over duration of project
DPH (progress meetings)	10
Secretarial support	200
Librarian	20
Information specialists	40
Finance	10
Commissioning staff	25
Medical and pharmaceutical advisors	10
TOTAL	315

510
395
115

Assuming a working day of 8 hours, the estimated number of working days spent on the project was 510. Project money was used to pay for approximately 6 months of whole time equivalent continence advisor salary along with training and expenses for the duration of the project. Approximately 395 of these working days were therefore in addition to those funded by the project.

These estimates do not include the large amount of time spent by a wide variety of staff throughout the borough in informal meetings and training sessions; in particular community nurses and physiotherapy, nursing and medical staff in secondary care. Examples of such time commitments are;

- Seminar attendance by clinical staff from the community and secondary care
- Training sessions for practice staff in primary care
- Data collection by staff in primary care and physiotherapy departments

- Involvement of the public in developing patient information, in focus group discussions and in satisfaction survey completion
- The organisation of a focus group and preparation of report by the Community Health Council
- Informal meetings and telephone conversations particularly with clinical staff in secondary care who were not able to attend working party meetings
- Clinical audits undertaken by the gynaecology department
- Time spent by staff in general practice and residential homes completing surveys
- Proof reading and evaluation of patient leaflets by clinical and managerial staff

Lessons learned and approach to self-assessment

The approach to self-assessment was informal and was mostly a matter of identifying problems and how to over come them. Sometimes this meant a different approach to achieving an objective. Some tasks were put aside as they were felt to be unimportant, unachievable or unsound. Others were given a lower priority or delayed while circumstances changed and allowed the task to be achieved more easily. It was more difficult to identify what had worked or why something had been successful as we were much more aware of the problems than the successes.

At the end of the project, the project planning team considered how they would organise the project if starting again from scratch. We agreed that the project would not change fundamentally from the final plan. There were however many unforeseen problems and delays in achieving the tasks we set out to achieve. Some of these could be avoided if the project were repeated but some were due to circumstances which were difficult to control. These were usually specific local problems which would not necessarily be present e.g. personalities or organisational problems which usually change over time.

The two major factors which delayed progress with the project were;

- the length of time it took to recruit pilots in general practice
- staffing problems in the Continence Advisory Service (delays in appointing a new advisor to act as a coordinator for the project and extended absences due to sickness and maternity by other advisors)

Learning from mistakes

There are a number of areas where we feel we could improve if we were starting from scratch with the same project;

- We made false assumptions about agreement from general practice. We anticipated that finding a small number of innovative pilot practices would be quite easy and that we would then have a hard time trying to persuade the rest. In practice, it was finding the pilot practices that was the hardest part.

Once we had recruited a couple of pilot practices and they were able to talk about their experiences, other practices were willing to follow.

- Earlier involvement of those using the training pack would have been beneficial. However, this was difficult to achieve in practice as practice nurses did not want to get involved without knowing exactly what would be expected of them and we had to produce a draft training pack to show them.
- We underestimated time scales and the amount of work which would be involved in ensuring we completed the tasks we set ourselves.
- When recruiting pilot practices we should have focused on those who would be doing the work not those who were organising or approving it i.e. by talking to practice nurses rather than GPs.
- The project would have progressed more quickly if we had put more effort into informal contacts and visits (e.g. in general practice) at an early stage. Unfortunately, we were well into the project before an appropriate person (Gill Wellington) was available to spend the time required.

Problems encountered during the project

We had many problems during the life of the project. Some of these are particular to the topic area but many apply to other clinical areas.

- Maintaining enthusiasm and commitment particularly from managerial staff. After the first rush of enthusiasm, interest in a project wanes and people are often keen to go on to something new.
- Engaging interest from those who see topic as unimportant and uninteresting. This was a particular problem with incontinence as a topic; it has low status and is associated with stigma.
- Some doctors saw the focus on women as sexist. Men were not actively excluded from the project but we chose to focus on younger women as they have a greater un-met need and there is potential for prevention.
- Some women with a continence problem didn't want medical interference.
- Very few women readily admit to having a problem.
- It was difficult involving secondary care in an appropriate way because of time constraints and because the initial focus of the project was on training in primary care. Consultants and nursing staff had difficulty attending meetings and finding the time to organise developments in secondary care. They were also reluctant to try to improve services without additional funding.
- Health professionals universally feel they do not have the time or resources to do something new no matter how important (something has to give).
- Staff changes caused problems with continuity. This occurred both in the project team but also among the nurses being trained.
- There are difficulties in evaluating a health promotion project with long-term outcomes with a project funded for 2 years.

- Organisational upheaval. For some time there was a degree of uncertainty over who would be managing the CAS. This caused us all sorts of problems relating to the use of trust logos and telephone numbers on posters and leaflets.

Factors for success

On reflection, these are some of the features of our project which we think helped to make it successful.

General change management

These are factors which are easily transferable to other projects involving changing clinical practice.

- “Knowing the patch”. This means an understanding of the organisations involved, knowing key personnel and their responsibilities.
- Making the most of existing networks. Establishing new networks is time consuming and difficult. There are a large number of committees and working groups who are involved in improving clinical care and it makes sense to involve these whenever possible.
- We used staff from successful pilot sites as 'product champions'. This was a much more effective way of persuading other practices to join the project than any amount of cajoling from Gill and myself as we were naturally regarded with a degree of suspicion.
- Multidisciplinary working has been extremely successful. The project has involved working with a wide variety of staff in primary care and acute and community trusts. Those involved with the project have been able (on the whole) to work as a team with a common goal. These effective working relationships remain and will be valuable in future developments.
- Being able to adapt the project to circumstances and not being overly prescriptive about the way things should be done. Both the staff who were being asked to change their practice and the members of the working party have been encouraged to work in a way which suited them. We believe that this resulted in a greater degree of co-operation than might otherwise be expected.
- Personal, informal contact has been much more successful than formal meetings i.e. an academic detailing type of approach. This has been very time consuming but it did achieve results. Writing letters or making phone calls may look much more efficient but in our experience, it achieved little. People like to work with someone they have met and feel they know. A personal visit is the best way of achieving this. Phone calls are preferable to a letter but not as good as face to face contact. Once a relationship has been established, then phone calls and letters may be adequate to maintain interest.
- Enthusiasm for a project is infectious

- Persistence and hard work
- Clearly defined aims and objectives
- A project with tangible benefits to patients
- Better still, a project with tangible benefits to staff! We had difficulty persuading people that our project fell into this category.
- Involving the public; useful comments were obtained from both a user group and a focus group. Health care personnel may have a quite different perspective on health care interventions than the public or patients.
- Adequate resources (time and money) to manage the change. It is vital that those directly involved with the project have protected time otherwise something else will always be more urgent.
- Capitalise on circumstances which are to your advantage and circumnavigate any environmental barriers.

Working with primary care

- Face to face contact was particularly important.
- Our local practice nurse mentoring network were vital to us in recruiting pilot sites. Mentors are accustomed to trying out something new and encouraging others to follow. They worked well together, providing mutual support.
- Training was offered at the practice premises at a time to suit the staff.
- Practice managers were very helpful and much easier to contact than GPs in the first instance.

Raising awareness amongst the public

Many of the problems we faced arose because of the embarrassing and stigmatising nature of the problem we were dealing with. We found producing information for the public, particularly patient information, was very time consuming.

- We had difficulty getting the local press interested in our subject. We did make use of "Health Link", a paper produced by the Health Authority which is delivered to all houses in the borough. This was much easier as the Health Authority has editorial control and we could be sure that our message would be put across in the way in which we wanted.
- Using different methods and adapting these to the particular clinical problem. For example, putting information on the continence advisory service and self help leaflets in toilets or places where patients can pick them up without being seen.
- Keeping the message simple.
- Getting advice from members of the public or service users.

- Taking care to get the language right - not too technical but without being patronising.
- Using descriptions of symptoms which the public can identify with and avoiding the word "incontinence" which is stigmatising
- Targeting "at risk" groups.
- Using material which is visually attractive.
- Humour may often help with a subject which is embarrassing but care is needed as some may be offended.
- There is a large un-met need for continence services. Care is needed when raising awareness that the services are not swamped. Without adequate personnel to assess and manage referrals, the continence service may just become an expensive pad provision service.
- There are particular problems involved in getting information translated into ethnic monority languages. It is important to get "translated " material checked by a second source. Many words or terms we use do not have an exact equivalent and care is required in the translation. Local health care staff were extremely helpful in this regard and we managed to avoid some potentially embarrassing mistakes. Humour and jokes do not often translate and so it may be necessary to change more than just the language on a publication. It is also important to be sensitive to cultural differences (which may make some subjects more taboo) and the fact that information may be read to someone by a friend or relative.

Sustaining the changes after the project has finished

Ensuring that the project will be sustainable was always given a high priority. There are a number of factors which we think will ensure that, not only will changes be sustained but that services will continue to develop.

- Staff continuity is important. The continence advisor who has coordinated the project is a permanent member of staff and will continue to work in the continence advisory service now that the project period has ended.
- Our project has involved a large number of service developments including training and awareness raising among a wide variety of professionals. This educational activity is not seen as a discrete intervention but as an on-going process. Practice nurses who have already been trained may wish to extend their skills so that feel confident to manage other types of incontinence. Some practices will require re-training because of staff turnover and training will still be offered to those who have not been involved.
- Working relationships have been built with members of staff from a variety of disciplines and these will help to sustain service developments after the life of the project.
- A new service specification for continence services has been written which contains the elements of our strategy. This will be used, through the commissioning process to ensure that service developments continue.

- Raising awareness amongst the public also puts pressure on the service to meet their expectations. It is important though that the public and patients are not given expectations which cannot be met.

Disseminating lessons from the project

Those who will benefit most from the project lessons are the people directly involved with the project because of;

- active involvement combined with reflection
- the support of the King's Fund combined with sharing experiences with other projects

Sharing experiences - progress so far

- Project lessons have been shared locally through the distribution of reports, minutes from meetings and material produced by the King's Fund. Many of the lessons are quite specific to a particular topic or local circumstances so we feel that the King's Fund has an important role in identifying common themes and lessons which may be generalised to a wider range of circumstances.
- Project lessons and progress have been presented to the Health Authority and a meeting of senior health authority executives.
- We have shared our experiences with other groups working on the same topic throughout the country. These are mostly people who have contacted us after reading King's Fund literature. This networking has been a particularly valuable role of the King's Fund.
- Lessons have also been shared among other groups in the PACE programme.

Sharing experiences - future plans

- The final report will be distributed widely.
- Those involved with the project share their experiences with colleagues on an informal basis.
- We will encourage people to attend the regional PACE conference
- We have been commissioned by the editors of *Practice Nurse* to write a paper on managing stress incontinence in primary care.

Project materials

The following education and information materials have been produced as an integral part of the project;

1. Training pack for practice nurses which includes;
   - assessment forms and care plans for patients at initial visits
   - assessment forms for follow-up visits
   - notes on assessment and causes of incontinence
   - instructions for using the perineometer
   - sample patient satisfaction questionnaires
2. *Incontinence in the elderly*, a leaflet for carers in nursing and residential homes
3. Pelvic floor exercise leaflet for women (available in 6 minority languages)
4. Poster (in minority languages) advertising women's pelvic floor exercise leaflet.
5. Display boards for pelvic floor leaflets
6. Self-help leaflet for men with post-micturition dribble / stress incontinence
7. Toilet stickers advertising the Dudley Continence Advisory Service
8. Service specification for continence services
9. Reports on GP and residential homes surveys

APPENDIX - MEMBERSHIP OF THE CONTINENCE WORKING PARTY

Membership of the Dudley Continence Working Party past and present

Name	Position
Church, Sally	Senior continence advisor
Cooke, Sue	Manager, continence advisory service
Davies, Wendy	Physiotherapist, Wordley Hospital
Dyas, Kim	Practice manager and practice nurse
Firth, John	General practitioner
Gbinigie, Andrew	Consultant, obstetrics and gynaecology
Hamilton, Alison	Director of public health
Hennessy, Amanda	Practice nurse advisor
Jones, Yvonne	Community midwife
Lawley, Linda	Practice nurse
O'Hara, Kate	**Health promotion advisor, women and mental health**
O'Mara, Liz	**Health promotion advisor, general practice**
Parry, Michelle	**Continence advisor**
Phillips, Wendy	**SpR public health medicine**
Preston, Sue	Senior manager, community trust
Rowse, Mack	Consultant, urology
Sabin, Sheila	Chief officer, community health council
Salmon, Keith	Director of nursing and quality, Dudley Health Authority
Salt, Caroline	Senior sister, urology department
Wellington, Gill	**Continence advisor**

Those outlined in bold have been part of the project planning team.