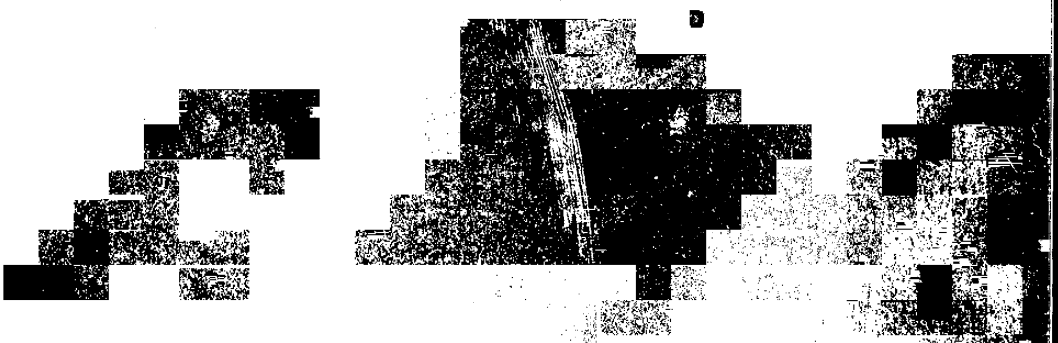
King's Fund

Putting Practitioners through the Paces

Initial Findings in our evaluation of Putting Evidence into Practice



First Interim Report of the
North Thames Purchaser Led Implementation Projects

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Key Lessons

- Funding alone does not start action.
- Attention tends to focus on the "how" of a project at the expense of the "why". A guide on taking participants through the process outlined in the *Pre-cursors to Change* box would be useful.
- Delays and lulls in momentum are to be expected.
- Objectives are a moving target.
- Original bids were often over-ambitious in terms of what could be achieved and under-resourced in terms of time and emotional commitment. Keeping projects manageable needs to be constantly re-addressed.
- Many organisations lack the evaluative skills necessary to become a "learning organisation".

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Appendices

List of Approved North Thames Implementation Projects

Health Authority	Project	Lead Manager
Barking & Havering	Coronary heart disease and obstetrics & gynaecology	Consultant in Public Health (post now vacant)
Barnet	Low back pain, diabetes retinopathy, h pylori	Director of Public Health Dr. Stephen Farrow
Brent & Harrow 1	Protocols in A&E	Consultant in A&E Mr. A. Sivakumar
Brent & Harrow 2	Schizophrenia	Director of Public Health (project now cancelled)
Brent & Harrow 3	Open Access Echocardiography	Consultant Cardiologist Mr. Mark Dancy
Camden & Islington	H pylori	Prescribing Facilitator Mr. Amalin Dutt
Ealing, Hounslow & Hammersmith	Diabetes register	Consultant in Public Health Dr. Raymond Jankowski
East London & the City 1	Cardiac intervention	Senior Lecturer in Public Health Dr. Harry Hemmingway
East London & the City 2	Leg ulcers	Project Manager Ms. Sally Gooch
East & North Hertfordshire	Pending	
Enfield & Haringey	GP learning sets	Consultant in Public Health Dr. Peter Sheridan
Hillingdon	H pylori	Consultant in Public Health Dr. John Aldous
Kensington, Chelsea & Westminister 1	Dyspepsia	Principal Pharmaceutical Advisor Ms. Pauline Taylor
Kensington, Chelsea & Westminister 2	ECG & ACE inhibitors in chronic heart failure	Senior Registrar in Public Health Dr. Stephanie Taylor
North Essex	Cancer Services	Director of Public Health Dr. Geoffrey Carroll
Redbridge & Waltham Forest	Diabetes, asthma & hypertension	Director of Public Health Dr. Lucy Moore
South Essex	Hypertension in the Elderly	Research & Development Manager Dr. Chris Joyce
West Hertfordshire	Anti-coagulation	Public Health Specialist Dr. Alison Frater

Introduction

Background to the Purchaser Led Implementation Projects Programme

In October 1995, the Implementation Group of North Thames Research and Development invited each of the 13 health authorities in North Thames to submit a bid for a project or projects seeking to put evidence into practice.

Health authorities could submit as many projects as they liked as long as the total cost of the projects was not more than £50,000, the projects were within an 18 month timescale and the research evidence was robust. They were given four months to draw up the bids.

Each bid went to one of three panels made up of members of the Implementation Group and other individuals with an interest in evidence based practice. Comments were then sent back to the bid writers who revised their bids accordingly. Seventeen projects were approved by September 1996. One bid is still pending.

Background to the Evaluation of this Initiative

In October 1996, the King's Fund Management College was commissioned to undertake an evaluation of this initiative. As close to three quarters of a million pounds had been allocated, the Implementation Group wanted to determine what benefits had been gained and, even more importantly, what could be learnt and applied to future projects of this type.

We have separated the evaluation into three parts: outcome setting and follow up, barriers to change and sustainability. Each aspect of the evaluation will be discussed in a separate report, this being the first on outcome setting.

Aim of this Report

We aim to pass on important lessons learnt so far to the funders and project participants, so they can get an idea of the overall progress of the programme. A short version of this report will be sent to Chief Executives, Directors of Public Health and operational staff within participating health authorities and trusts. We hope both documents can be used as a reference for discussion for all those interested in clinical effectiveness.

Structure of this Report

Our report is divided into five parts:

1. Work of the King's Fund evaluation to date including methods used
2. Project timescales
3. Project objectives and their evaluation
4. Evaluation of the projects in relation to the external stakeholder document *Features likely to lead to Success*
5. Progress report of the King's Fund evaluation and our learning points.

Part I Work of the King's Fund Management College

Since October 1996, we have carried out the first four steps of the external evaluation.

In the autumn of 1996, all of those known to the evaluators through the project bids were sent a letter of introduction and a copy of the King's Fund evaluation proposal.

In April of 1997, an external stakeholder group comprising a GP, a medical director, a health authority chief executive, a voluntary organisation representative and others was convened to identify features likely to lead to a successful implementation project. Their conclusions were summarised in *Features likely to lead to Success* and a copy is attached as Appendix A. A fuller discussion of this document is included later in this report.

In a third piece of work from June to July 1997, project participants were invited to one of five workshops on outcome setting and objectives. All but one very small project (Brent and Harrow Open Access Echocardiography) were represented.

Since the winter of 1997, we have been drawing up short, standardised summaries for each of the projects (see Appendix B). These summaries have helped both the King's Fund and the project participants understand the basics of each project as well as charted the changes in objectives. As the projects develop, the summaries will also change and we can continue to monitor progress.

Part II Project Timescales

Introduction

One of the most notable features of these projects so far is that initial calculations of the length of time needed to get started as well as the overall length of time to achieve objectives were seriously underestimated.

This was because many involved in the projects assumed that work on getting key individuals to see the need for change and make an emotional commitment to it had already taken place. In practice, this either had not been done or needed to be re-done as the core group of project participants formed.

Slippage of "Start" Date

Loss of momentum

Appendix C clearly shows that one of the early difficulties was getting momentum going once the bid had been approved.

Although many bid writers and others within sponsoring organisations had undertaken initial work such as forming a project group, carrying out a baseline audit and contacting key individuals, there was often a lull after the bid was accepted before a project worker was recruited. For four projects, this period of relative inactivity was about six months; for five projects it was closer to a year.

Reasons for this hiatus are not known for every health authority, but three were delayed as the original bid writer left the organisation and the project was not picked up for some time (Barnet, Barking & Havering, Enfield and Haringey) and two were affected by re-organisations (West Hertfordshire, Hillingdon).

Extension of Overall Timescale

Time consuming tasks

In addition to delays in recruiting project workers, participants commented on the tremendous amount of time it actually takes to get going once project workers have finally been appointed.

One time consuming task is finding the right people and networks both within and outside the organisation. A second hurdle is making the original bid more realistic with achievable outcomes and a solid evaluation plan. This requires a great deal of consultation and re-drafting until something practical is in place.

A third difficulty is that often an assumption is made that the evidence speaks for itself. But the findings from these projects suggests that more often than not a project worker or colleague needs to spend a great deal of time and energy persuading sceptics of the robustness of the evidence before taking even the first steps.

Once clinicians are persuaded of the validity of the evidence and are committed to making a change, workers can get on with the core of implementation work - that of showing clinicians how the evidence can and should be applied to their practice.

Projects extended to date

Because getting key participants involved and genuinely committed took much longer than expected, many project participants saw that little measurable change can be achieved in 18 months. As a result, ten of the sixteen projects have extended their overall timescale. In fact, two project workers (Barking & Havering and Barnet) made extending the period of their contracts one of their first objectives.

Five projects (Barking & Havering, Barnet, Brent & Harrow A&E and Open Access Echocardiography, Redbridge & Waltham Forest) now anticipate that it will take two or more years to achieve their objectives and so we assume (and in two cases know) that health authority or trust money will be used to cover the extensions. In terms of sustainability, this is hopeful as it indicates a degree of health authority/trust commitment.

To get an idea of when projects currently plan to "end" with a final report, see Appendix H.

Part III Objectives and Evaluation

Objectives

Introduction

One workshop participant summed up the difficulty of objectives in these type of projects by saying, "objectives are a moving target". Appendix E illustrates this clearly as the objectives for all but one of the projects (Brent & Harrow A&E) have changed since the original bids were submitted in the winter of 1996.

Degree of change

The degree of change in objectives from the original bid to the King's Fund 1997 summer workshops ranges from minimal to extensive.

Two (Camden & Islington and South Essex) have only made slight alterations in wording from their original bid. Others (Barking & Havering, Barnet, Redbridge and Waltham Forest) had no objectives in their original bid and only devised some after the project worker came into post.

Most projects lie somewhere in between. Some objectives are sharpened to become more measurable. Others are modified when a new person takes on primary responsibility for moving the project forward. And a few are dropped entirely as the project changes course.

One project (ELCHA cardiac) submitted a set of objectives in a short, pre-bid fax in December 1995. After comments from North Thames, these objectives were changed radically with the submission of their first bid and have remained constant with few changes since. This initial feedback was undoubtedly very valuable in helping the project participants understand the expectations of the funders and go through the bid evaluation process quickly.

Direction of change

One encouraging observation is that in many cases the objectives have moved much more towards facilitating the change process.

For instance, the original bids of two projects (Barking & Havering, Barnet) outlined plans to employ a project worker to synthesise evidence and provide it in a useful format for clinicians. In practice, however, neither of these project workers has undertaken this role and instead are concentrating on working with clinicians to change clinical practice.

Further examples are provided with the EHH diabetic register project and Brent & Harrow A&E. Both of the original bids focused on information technology and getting the right hardware and software. Although this is obviously important, the emphasis now is on persuading GPs and A&E doctors to actually use the systems.

Over ambitious bids

Another notable change is that objectives have become much more practical. For example, one bid (Enfield and Haringey) spoke of reaching 80% of the GPs and covering 18 topics within the 18 month timescale. These very ambitious plans have now been scaled down to something much more manageable.

More realistic objectives have also developed in projects such as Barnet and Barking & Havering, which have reduced the number of subject areas they expect to cover within the time frame. ELCHA cardiac and EHH diabetic projects have limited the number of sites involved.

Ideally, one possible way to ensure that bids are more realistic is by jointly writing the bid with the project worker who will be responsible for carrying the work forward. In practice, as later sections of this report will discuss, project workers were usually recruited outside the organisation so this is difficult.

Evaluation

Introduction

One aim of the King's Fund summer 97 workshops was to ensure that the evaluation plans relate to the measurement of the objectives and are re-assessed regularly. As objectives have become sharper, many projects have moved towards clearer evaluation plans.

In the initial bids, about half of the project plans had limited or no clear details on evaluation while seven of the bids linked evaluation directly to their objectives (see Appendix F). By the autumn of 1997, almost all of the projects had clear ideas about ways to measure change. We do not know if this clarification has come along in response to the King's Fund workshops or would have occurred anyway.

Evaluation pitfalls

Workshop participants commented that the focus of evaluation can easily shift from measuring change (e.g. number of GPs initially and subsequently participating in audit) to supporting the evidence (e.g. mortality rates).

Another potential difficulty is that some sources of data, such as PACT for *h pylori* and ACE inhibitors projects, have confounding variables and may not measure what is needed. One project participant remarked that part of the learning process is determining which indicators will give accurate measures of intended outcomes.

Approaches to evaluation

An interesting point to note is that similar projects have differing approaches on how to measure change.

For example, all three *h pylori* projects will use PACT data before and after guidelines to look at changes in prescription rates. But Hillingdon also plans to look at hospital information as they expect a decrease in hospital admissions i.e. the numbers of people with duodenal and peptic ulcers. Their approach is based on a belief that it would be easier to measure the outcome at the end rather than get into the "dark box" of monitoring changes in process.

No baseline evaluation

Unfortunately, two projects (Hillingdon and South Essex) did not carry out a baseline audit before the intervention of guidelines.

In Hillingdon's case, this is probably not a cause for concern as sources of their data (PACT and hospital information) can be accessed retrospectively. A MAAG audit covering some aspects also took place before the guidelines were launched.

The South Essex case is a bit more difficult in that they can show a *reported* change but not necessarily an *actual* change in GPs' behaviour. They are currently exploring the possibility of asking practice nurses to retrospectively audit patient notes.

Part IV Evaluation of Projects with *Features likely to lead to Success* Document

Methods

Workshop

In our proposal, we suggested that an external evaluation would be helped by pooling the experiences of others who have tried to put evidence into practice. In April 1997, we invited fifteen individuals suggested by the North Thames Implementation Facilitator to a workshop. Eight attended.

Each participant told the story of a "successful" implementation project while the others listened and wrote down key factors which led to this success. These factors were then compiled into the document entitled *Features likely to lead to Success* (see Appendix A). This draft was discussed at all of the King's Fund 1997 summer workshops and amended.

Modifications

Nine key features were identified as important. In drawing up the final draft, these remained the same, but the emphasis shifted somewhat.

In particular, the definition of "users" was broadened to mean "users of the project" as well as patients. The importance of the leadership role and re-doing groundwork was also stressed by project participants. Four elements, which had been overlooked by the external group, were added.

Uses of the document

When this document was drawn up, we were not exactly sure how it could best be applied. Since then, project participants have commented that they could regularly re-read it to check on the progress of their projects.

We plan to use it as a framework for sections of our interim reports. The document will be re-visited in the autumn of 1998 by the external group who originally drew it up. We hope to publish the final draft.

Groundwork

Introduction

In analysing the projects against the elements outlined in the "Groundwork" section of the document, several learning points are raised.

The first is that funders have a much more important role than may originally be envisaged. The second is that bids should be drawn up by at least two active and committed participants. The third is that keeping a project manageable is very difficult.

Picking an appropriate topic

Regional objectives

North Thames R&D's objectives in this programme are:

1. To enable all health authorities to get an understanding of how bids are processed and research projects undertaken
2. To identify the lessons learnt from the *process* of implementing change

In working towards these objectives, North Thames R&D has played two different roles.

Panel feedback

As funders, the Implementation Group decided which bids were realistic and so they were instrumental in topic picking. With hindsight, it seems that the three panels, which reviewed initial bids, suffered from some inconsistency.

For example, some of the bid writers were asked to submit explicit details about sustainability while others made little mention of this, but were not asked for further clarification. As only the Implementation Facilitator and Director of Research and Development attended all three panels, variations are to be expected.

Linking into regional objectives

The Implementation Facilitator has played the role of messenger from the region. Some of the messages have been confusing for project participants as they commented that "the goalposts keep moving". This is only natural in the constantly changing world of the NHS. Project participants can build flexibility into their project plans and then decide to react (or not) when new priorities emerge.

Clarity of purpose/vision/focus

Quality of original bids

Project bids varied considerably in the quality of the description of what they hoped to achieve. We have classified bids according to how easily we were able to understand them in Appendix F.

The seven clearest bids outlined objectives, evaluation measures and the steps necessary. Four other bids were understandable but needed further clarification, especially in terms of evaluation. Five bids were very confusing.

Lack of time to draw up bids

Many bids needed to be re-worked as projects exceeded the length of time suggested in the North Thames invitation or were costed at more than £50,000, despite the explicit instructions in the letter of invitation. In future, key parameters may need to be highlighted to emphasise resource limitations and other crucial criteria.

One reason why instructions may not have been followed is that many writers had little time to put the bid together due to other work pressures. In order to draw up a good, workable bid, managers need time to consult a wide range of colleagues to shape the bid. They also need a good chunk of uninterrupted time to write up something cohesive. If this time is not available, a great deal of energy is spent working out something later.

Skills shortage

We also noted a shortage of skills within organisations in defining evaluative projects of this type, although these skills are being attained through feedback from North Thames and the King's Fund and PACE workshops.

Most bids did not make it clear how the organisation hoped to learn from the projects. As this is one of the two definitions of success determined by the external group, project participants will have the time and space to do this in the final workshop in autumn 1998.

Departure of bid writers

Six of the original bid writers left post and are no longer involved in the projects. In most cases when a bid writer left, he or she took the energy of the proposal with them as the project had not yet been plugged into the organisation. Subsequent participants were then often unclear on how the project would work.

One possible solution is to ensure that at least two people are actively involved and committed to writing up project bids.

Ensure that project is manageable and keep it manageable

Victims of success

Two project participants mentioned that the project was in danger of becoming a victim of success.

The Barnet project worker was very pleased to be asked to work on the consultation process of the new community hospital as it gives a higher profile to her clinical effectiveness work. The disadvantage is that she will have less time for her project.

The West Hertfordshire project worker commented that the nurse led clinics were so popular that consultants are now thinking of linking with another trust and employing more staff. The health authority are happy for this to happen, but more resources are needed.

Sustainability

The Redbridge and Waltham Forest project is balancing manageability against sustainability. By getting many people involved at all levels of the health authority and within primary care, they hope to ensure sustainability. But the cost is that the Guidelines Facilitator has a very demanding workload and is severely overloaded. One aspect of keeping a project manageable is making sure that project workers are not overworked.

Ways to ensure manageability

Project participants said that revisiting the groundwork of their project regularly is helpful in keeping work at a reasonable level as they can re-examine what really needs to be done in order to achieve their objectives. Since time is the most serious resource constraint, setting realistic mini-deadlines throughout the process is also useful.

Leadership

Introduction

Leadership was rated as key to the success of a project by several project participants. Who actually qualifies as a leader was the subject of debate as some combined the co-ordination and leadership roles and others felt that they were two separate roles.

Getting good leaders

Backgrounds of project workers

Twelve of the sixteen projects have project workers responsible for moving the project forward on a day to day basis and two are about to recruit. We will be monitoring is the differences in progress between those projects with project workers and those without.

Ten project workers are non-clinical, two are clinical and two have backgrounds in professions allied to medicine. At the end of this evaluation, we would like to see if a clinical or medical project worker is at an advantage in persuading clinicians to put evidence into practice.

Lack of skilled project workers

Several lead managers spoke of the difficulties of recruiting skilled staff for the project worker post. One mentioned that capable staff are not interested in contracts of less than 18 months. Another found seconding for a part-time post difficult although a third project did manage to attract a full time secondee.

Recruitment from within the health authority

Eleven of the thirteen project workers were recruited from outside the organisation. One of the two project workers from inside (West Hertfordshire) did not find there was much advantage in having previously worked within the health authority as he was previously based in another department and did not know any of the clinicians. Another (KCW), who was in Public Health and is still there with this post, found her previous connections invaluable in getting her projects started quickly.

Role of project workers within the health authority

The position of the project workers within the organisations varied. In a few cases, project workers seem to be almost solely responsible for clinical effectiveness for the entire organisation. In others, the responsibility is shared out, although it almost exclusively remains within Public Health.

Lack of leadership

The Director of Public Health responsible for the cancelled project (Brent & Harrow schizophrenia) stated that he thought the lack of a "change agent" within the participating trust was the reason why the project did not succeed. As Director of Public Health, he did not have the time to attend to the details of the project and no one else at the trust picked it up.

Facilitation of change

Good project management skills

North Thames's role in project management

The Implementation Facilitator has, rather unexpectedly, functioned in almost a managerial capacity. Through individual meetings with project participants, he has acted as a useful external stimulus to keep projects going when they stalled.

Project management within the organisations

Three project workers (KCW, East London and the City Cardiac, West Hertfordshire) commented that they were fortunate in that they had committed senior managers who were regularly available for discussion. Having an opportunity to air concerns and gain a different perspective on the project proved invaluable for maintaining project workers' morale.

Hindrances

Structural

By far, the biggest obstacles to keeping momentum going have been major re-organisations of either the health authority or the trust. This has affected three of the projects (West Hertfordshire, Hillingdon, East London and the City leg ulcers). The appointment of a new Chief Executive or Director of Public Health can also cause disruption if the bulk of the work is based in the health authority (Hillingdon, Barnet, Enfield & Haringey).

During re-organisations or changes of senior personnel, project participants are unable to focus until they know how high a priority the project has with the new postholder.

Sustainability

Commitment of the organisation

In a workshop with project workers, we asked how committed they thought their organisations were to the projects and clinical effectiveness in general. The response from most was that it was too soon to tell.

One participant commented that his authority had adopted a position of wait-and-see and commitment would depend on the success of the project. Another mentioned that the external evaluation would be important before her organisation allocated more funding to clinical effectiveness projects.

Part V Progress of the Evaluation

Projects yet to "start"

Two projects have still not officially begun.

East and North Hertfordshire HA was recently re-created and were invited to participate approximately 15 months later than other health authorities. The timescale for the project is very short since only nine months remain before the project needs to be finished for external evaluation. This is a matter of considerable concern as lessons from other projects indicate that very little can be achieved in such a brief period.

The other project which has not officially "started" is the ELCHA leg ulcers project. The organisation (Tower Hamlets Healthcare Trust) has been in considerable upheaval and the lead manager has had tremendous problems in recruiting to the post. They hope to have someone by the end of the year as they are currently short-listing.

Although we have some concerns about its late start, one of the strengths of this project is that they have used a similar approach with the pressure sore programme and have learnt a great deal which can be applied to the leg ulcers project.

Our learning points

Communication difficulties

Introduction

Initially, we faced a great deal of frustration. If we were to undertake an evaluation like this again, we would use a variety of communication methods (telephone calls, letters, faxes or e-mail) *and* contact each person at least twice, preferably three times, over a few months.

Letters of introduction

As it was, we sent out letters with a copy of the evaluation proposal to all project participants mentioned on the original bids (about 30) in October 1996. Unfortunately, only staff from two of the thirteen health authorities received and *remembered* the letters and this is because we had worked with them on previous projects.

Other letters were lost, not passed on to new staff or read and not remembered. Feedback from the Implementation Facilitator showed that even by March 1997 most project participants did not know who we were so setting up our first workshops was difficult.

Ironically, our frustration at locating the right people within the projects and the length of time it took to do so (approximately six months) was mirrored by those within the projects who were finding similar problems.

Confusion with PACE

Confusion between ourselves as external evaluators and the PACE Programme as support also did not help. At the PACE workshops in early 1997, Mike Dunning explained that although we were both based at the King's Fund our roles were different. But a few months later we needed to clarify this again as many project participants felt they had already taken part in an evaluation exercise.

Observations on King's Fund proposal

Introduction

In future evaluations of implementation projects, we would recognise that the external evaluation is likely to change just as much as the projects themselves. Evaluation measures which are not flexible will not work.

Overly specific questions

In the proposal, we asked very specific questions (e.g. how were the outcomes determined and by which methods and processes?) which we now find are difficult to answer. This is because we approached this evaluation in "pure" research terms, expecting to be able to chart objectives over time and gain clear insights into their development.

In practice, the setting of objectives is often a murky business. It is difficult to know retrospectively who actually originally suggested an objective and how it changed. The project participants themselves often do not remember (or never knew) and in a few cases, it is almost as if the objectives sprang into life from nowhere.

Feedback from the workshops

Feedback was in the main positive, although not everyone was happy with the workshop approach adopted by PACE and ourselves. A few participants even wrote or telephoned afterwards to let us know that they had found the morning beneficial.

What next?

Plans for the rest of the evaluation

In the next two months, we will be following up site invitations from two projects. Enfield and Haringey have asked the researcher to attend one of the GP learning sets to observe. North Essex have requested that the researcher and a local health authority researcher look at the key factors that have led to the successful creation of a joint cancer directorate.

Next, winter 1998 workshops on barriers to change will take place in January and February. A second interim report will follow.

In the spring of 1998, Mike Dunning of PACE will organise a series of workshops on introducing mechanisms for sustainability. Hopefully, these will be followed with meetings between North Thames Research and Development and project lead managers so these mechanisms are put firmly in place.

Our last set of workshops will be in autumn 1998 on sustainability and overall lessons learnt. Each project participant will have a chance to define for him or herself the degree of the project's success. We will also be asking others within the organisation, who are not directly involved, to give us their opinions. A third report will follow.

The external group will be reconvened to discuss the usefulness of the document *Features likely to lead to Success* and feedback lessons learnt from the projects. A final report with key lessons from each of the three aspects of the evaluation will then be drafted and dissemination strategies discussed with North Thames Research & Development.

Ideas for further exploration

Connection between evidence, process and evaluation

In the next few months, we plan to develop our understanding of the relationship between evidence, process and evaluation (see Appendix G). So far, we have looked a great deal at process and evaluation, but have not gathered much information on evidence. In particular, we would like to learn more about how the topics were chosen, which evidence was seen as sufficiently robust, the belief in its relevance by operational staff, and so on.

Gradually, we have come to recognise that this area is much more important than we first thought. In particular, some project participants spend disproportionate energy on supporting the evidence at the expense of actually implementing change.

Pre-cursors to Making a Change

Appendix D is useful in understanding why so many projects seemed to take so long in getting started. Like North Thames and others, we overlooked a great deal of the preliminary work which project participants needs to carry out before any plans can be devised. In our case, we began our evaluation at the *rational commitment* stage when objectives are being set. This means that we need to learn much more about what happens before the planning of the "how" is undertaken.

Undoubtedly, some of the difficulties in taking clinicians through the stages of acknowledging a possibility of change, recognising the need to change and making an emotional commitment to change will come up at our next series of workshops.

The "Well Enough" Theory

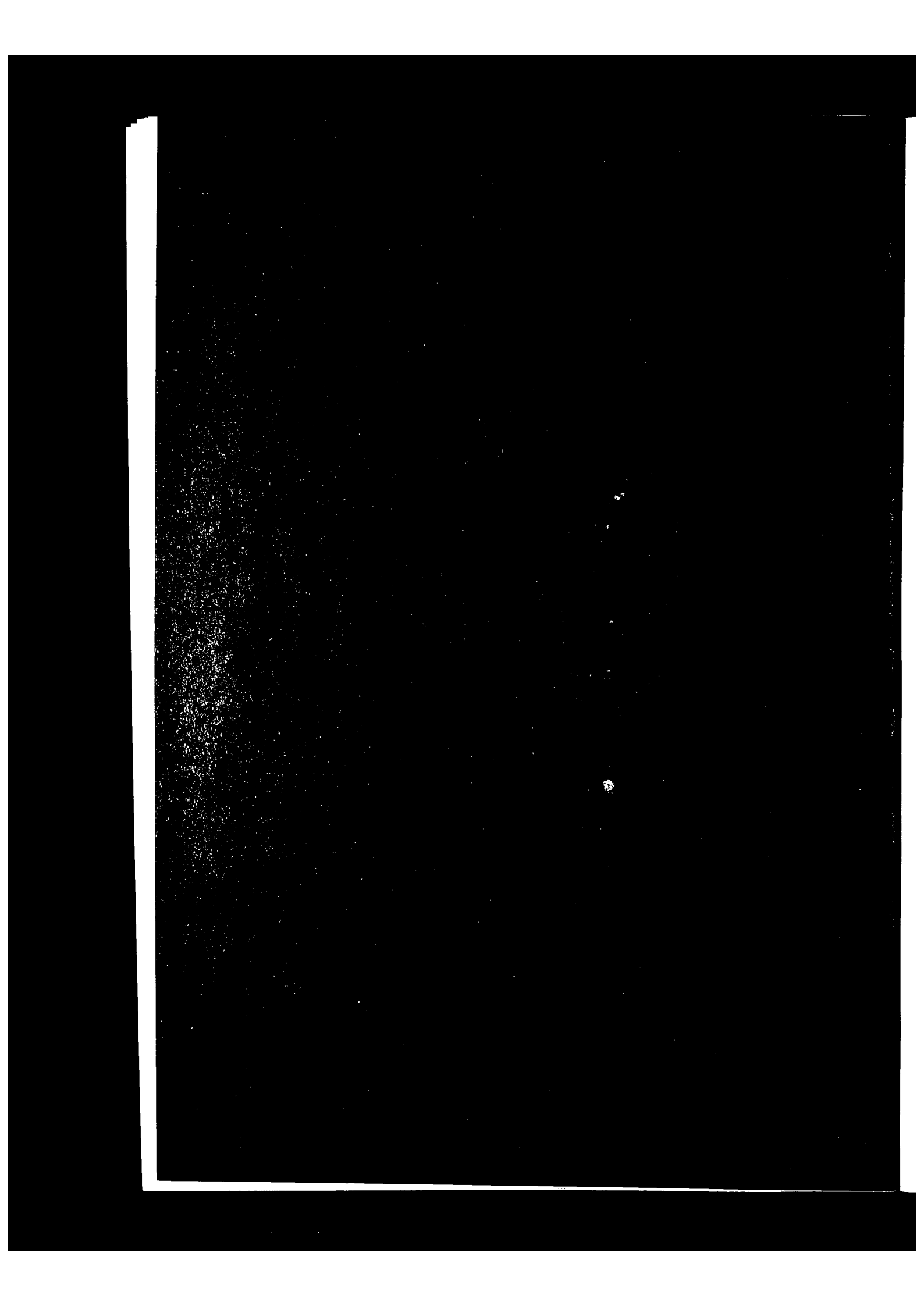
Initial findings suggest that for change to occur many aspects need to come together and happen "well enough". What we need to learn more about is which aspects are key to making change happen.

Conclusion

After the King's Fund summer 1997 workshops, we were pleased that so many of the projects were progressing after the slow start previously reported. The majority of the projects are about a third to halfway through.

We are looking forward to the winter workshops to see just how much further along projects are. In the meantime, we hope that this first interim report will provide project participants and funders with points for discussion.

Appendicies



Appendix A

North Thames Purchaser Led Implementation Projects

Features likely to lead to Success as suggested by an External Stakeholder Group

Methods

In April 1997, an external stakeholder group was convened from regionally and nationally known professionals with an interest in clinical effectiveness. Of the fifteen people whose names were put forward, eight were able to attend a workshop run by John McClenahan, Fellow at the King's Fund Management College.

A wide variety of professional viewpoints were presented including those of a medical director, GP, voluntary organisation director, health authority chief executive, senior nursing lecturer, academic, a representative from CRD and the funders, North Thames Implementation Group.

Participants were asked to tell the story of a "successful" implementation project in which they had been involved while the others in their group took notes on the key points. These key points were then grouped by the workshop leader and a researcher and fedback to participants. Further discussion took place.

The following is a synthesis of those elements which the external stakeholder group believed would be incorporated into a successful change project. The draft document was presented at workshops in the summer of 1997 to project participants in order to get their opinions. This final draft includes their suggested modifications.

Definition of a successful North Thames project

1. One which meets all of its objectives
2. One which does not meet its objectives but individuals and organisation look at why

Summarised Features Leading to Success

In total, the external stakeholders defined nine areas as important elements in creating a successful implementation project. They are:

1. Undertaking **ground work** thoroughly
2. Chosing a 'good' **leader**
3. Involving **users** - i.e. project participants as well as patients
4. Create the right **environment** within the organisation
5. **Facilitating the change** before meeting resistance
6. **Overcoming barriers** after meeting resistance
7. **Avoiding hinderances** whenever possible
8. Incorporating **evaluation**
9. Encouraging **sustainability**

Details of Features Leading to Success

Undertaking ground work

Pick an appropriate topic (applies both at regional levels and locally)

- good evidence - the stronger the better
- feasibility - go for the achievable
- Health of the Nation or local priority service area
- genuinely important to operational staff
- identify how issues at operational level link into Regional/National objectives

Clarify purpose/vision/focus

- Identify goals and outcomes
- Define and target area of intervention
- Develop good conceptual framework e.g. be clear if improving decision making and quality or just one or the other - also clarify if on an individual basis or all over organisation
- Check that objectives SMART (specific, measurable, achievable, realistic/relevant, time bound)

Do your homework

- Gather background information
- Identify resources - remember that shifting resources shifts power (where will they be at the end?)
- Plan what you want to do
- Select and recruit interested parties/sites for change
- Identify barriers
- Identify participants' real operational needs

Groundwork not just done at beginning of project but regularly revisited

Keep the project manageable

Form a group

- make it multidisciplinary for mix of skills, backgrounds and contacts
- can be used as a support for participants
- using a 'contract' between participants and a leader has been effective
- can confer self-confidence, power and status

Leadership

Identify a lead - lead may vary according to aspect of project at time

Clarification of difference between leadership and ownership

Leader and co-ordinator of project may be same person or different

Deliberately "manage" the change

Good leadership means:

- getting enthusiasm and commitment from all key players including operational staff
- motivating others to promote taking of responsibility
- fostering autonomy and control with the sharing of information
- clarifying the structure and giving feedback to build confidence and commitment
- encouraging participants to set their own objectives
- being responsive to participants' suggestions
- supporting, enabling, empowering
- demonstrating drive and energy
- offering constructive criticism with honesty of approach
- encouraging consensus

Role of Users (project participants e.g. clinicians, patients, and so on)

Involve users from the start - critical to success

Active role

- setting objectives
- sustaining performance
- consulting

Less active role

- recepients of feedback
- patient information

Care should be organised around users

Environment

Create the "right" culture

- supportive
- inquisitive - get people asking the right questions
- freedom to change
- safe, open climate for honest, constructive debate
- let people know it's OK to make mistakes
- not afraid of change
- empowering people
- bottom/up approach

Work with like minded people

Facilitatation of Change (before meeting resistance)

Ownership

- bottom up & top down can both be useful -depending on area
- sell to Region/NHSE/DH
- local involvement
- owned at all levels of the organisation
- consultation about detail

Senior Level Commitment

- get the 'correct' people enthusiastic
- recruit the great and the good
- get Board level support

Get a project mentor

- recruit a senior manager who is willing to act as a regular sounding board

Resources

- use people as resources
- use limited resources imaginatively/creatively

Strategies for running the project

- good housekeeping important
- link projects into people's own social networks - "Tupperware party" approach (e.g. "sell" project to networks that exist previously - don't create own groups from scratch)
- spread the word through conferences - promote common belief
- utilise: opinon leaders, lateral thinking, audit, change agents
- run trials/pilots
- develop training programmes, trainers, skills
- promote structured, feasible learning
- keep momentum going - think of ways to ignite enthusiasm again after first flush
- capitalise on early successes

Develop the necessary culture

Overcoming Barriers (after meeting resistance)

Use tactics of:

- consultation
- real negotiation and political skills
- persuasion/influencing
- selling
- 'soft' networking

Conflict strategies

- recognise that conflict to be expected
- 'riding the wave' rather than confrontation works best when dealing with concerted resistance
- respect the experience and perspective of the other
- harness differences of opinion creatively to further debate

- note that apparent differences in values are not always really there
- recognise that people do not always articulate their real concerns very well
- give people a chance to be heard
- find the hidden personal and professional agendas
- overcome antagonism from key players

Use incentives

- well targeted carrots rather than sticks
- mix clear controls with good incentives

Create a critical mass of core enthusiasts

Be flexible - look at alternative ways to implement the evidence

Present the alternatives - people sometimes won't do new things because they don't know the alternatives.

Encourage visibility - conferences etc to recruit others

Offering training of skills and information

Hinderances

Professionalism

- professional boundaries
- power + instransigence + control = no change

Structural

- top/down decision making creates resistance
- lack of single focal point for responsibility
- change of personnel within organisation

Process

- rote learning uninspiring
- isolation leads to disempowerment
- dubious timescale
- lack of clarity from outset

Discontinued or insufficient funding

Evaluation

More than one dimension (include users)

Define success - in whose terms?

- HA?
- Clinicians?
- Project participants?

- Patients?

Success does not necessarily mean health gain

Baseline audit

Improvement needs to be shown relative to starting point

Sustainability

Definition of sustainability - 1) project continues or 2) process learnt from and applied (with revisions) again.

Lack of structure, skill and focus can generate energy without a useful outcome

Committment of the organisation

- Strategies for sustainability need to be thought out long before project finishes so mechanisms can be put in place

Organisational change

- address the implications
- where are the resources now?

Visibility

Dissemination (spread the word)

Ripple effect of success

Factors but not sure of effect

Untrained leaders
Lack of quality control in literature
Manager and leader of project 2 different people
Fostering of critical thinking versus specific model more important?
Complex interventions versus simple ones
Relationship between vision and endpoint

Appendix B

30 October 1997

Barking and Havering

Translating Evidence into Practice: The Effectiveness Facilitator

Project Leads: Mark Ansell, Effectiveness Facilitator, Public Health Department., The Clock House, East Street, Barking IG11 8EY Tel: 0181 532 6364
Francesca Perlman, GP, Education Board, 1st floor, The Willows, St. George's Hospital, Sutton's Lane, Hornchurch Essex RM12 5SD
Sandeep Shah, GP
Timescale: Originally 2 years, now 18 months - Contract dates: 1.11.96-31.3.98 (Mark's contract to Oct 98) Final report: Sept 1998
Setting: GPs

Evidence
Evidence cited: CRD, Cochrane, medical journals
How used: Updating clinicians' knowledge on specific areas, producing "effectiveness updates".

What are they trying to do?
By using an effectiveness facilitator, they intend to work towards overcoming the barriers to acting on the evidence and thereby encourage effectiveness as a primary consideration in commissioning.

Aim: To support GPs in providing effective clinical practice in coronary heart disease and change local maternity services approach to look at evidence and review current practice explicitly and regularly.

Objectives
1. Strengthen links already established with post-graduate clinical tutors, GPs, and medical audit coordinators.
2. Encourage effectiveness issues to be discussed at GP post-graduate meetings and incorporated into teaching programme.
3. To address and overcome the barriers to acting on the evidence.

Other information
- HA accepted recommendations of report *Purchasing Effective Healthcare* which stated that effectiveness should be an important consideration when commissioning services.
- Skills needed to synthesize evidence for summaries and market EB approach noted as very different: marketing skills of postholder seen to have priority.
- Lots of ground work done on guidelines etc. before recruitment of facilitator.
- CHD work progressing, obstetrics & gynecology may not go far within contract period.
- Obstetrics work going on in parallel at maternity unit.
- HA taken on responsibility of funding the project once NT monies run out (summer 97).

Steps for CHD

1. Set up steering group with DPH/CPH, GP tutors, post-grad tutors from 3 trusts, audit coordinators.
2. Recruit effectiveness facilitator.
3. Select 3-5 areas for each specialty (e.g. aspirin, ACE inhibitors etc. for CHD)
4. Undertake baseline audit.
5. Facilitator to produce literature summary and develop detailed implementation plan.
6. Pilot use of guidelines with 4 practices of different types.
7. Extend to rest of practices.
8. Audit.
9. Repeat the process for second guideline.
10. Evaluate outcomes of the project.

Steps for obstetrics

1. Agreement with clinical/managerial staff on involvement in project.
2. Choose 3 topic areas.
3. Consider evidence of 3 areas against outcomes suggested by Changing Childbirth.
4. Survey women using service.
5. Review practice against 3 & 4.
6. Amend practice as required.

Evaluation

- Baseline audit and reaudit.
- Prescribing data from PACT
- HES data on hospital admissions.

Barnet

Implementation of effective practice (low back pain and h pylori)

Project Leads: Dr. Angela Reidy, Programme Director for Evidence Based Commissioning (wrote bid - left by May 1997)
Dr. Stephen Farrow, Director of Public Health
Jenny Morris, Effectiveness Worker, Hyde House, The Hyde, Edgeware Rd. London NW9 6QQ Tel:0181 201 4769

Timescale: 18 months - Contract dates 1.6.96 - 30.11.97 (Jenny's contract continuing beyond) Final report date: not known

Setting: GP practices

Evidence

Evidence cited:
How used:

What are they trying to do?

By using an effectiveness worker and GP fellows as opinion leaders on 3 specific projects (diabetes retinopathy, low back pain and h pylori), they intend to identify processes that work well in changing practice and thereby lead to a more evidence based approach overall within the HA.

Aim: To move towards setting up a system whereby evidence based commissioning becomes the "norm" of the HA.

Objectives

1. Encourage participation in and contribution to a cross district network to learn from a range of effectiveness work in varying stages of advancement.
2. Foster 3 way dialogue between GPs, clinicians and purchaser/provider bodies.
3. Document and review role of GP fellow and identify how best such a role could be developed at local level.

Other possible objectives

1. Facilitate consultation around new community Hospital.
2. Encourage trend towards primary care led purchasing.

Other information

- Effectiveness worker based in contracts but working under PH lead.
- Have used GP fellow approach previously with mental health and asthma.
- Interim report March 1997 - 1) diabetic retinopathy being integrated into Purchasing Plan which is out for consultation with GPs, 2) low back pain - highly motivated GP, guidelines and options being reviewed, 3) h pylori - initiating networks, undertaking baseline audit (least developed to date)
- Effectiveness previously high on political agenda, but re-organisation taking place (Spring 97)
- Commitment from HA to extend timescale past October 1997 obtained.
- PACE project on stroke within district.

- Guidelines for low back pain adapted from ELCHA and Derbyshire (?) and RCGP guidelines - some concern about local ownership, but feedback from GPs positive.

Steps

1. Identify manual and computerised systems to enable literature reference, information collection and multi-stage retrieval.
2. Collect baseline data to monitor effectiveness initiatives.
3. Develop existing staff skills in decision analysis computer based modeling.
4. Appoint GP fellows for each project (3 in total).
5. Review change programme.
6. Audit.

Evaluation

- Collect baseline data through FCE and DRG databases, GP practice and FHSA Acuity and PACT databases
- Comparision of different process between low back pain and h pylori work.
- Evaluation of low back pain -
  - GPs evaluating knowledge before guidelines and after
  - Outreach training with physios and patient prescription form
  - Chair of MAAG & Jenny to undertake review of physio services
- H pylori work - direct access endoscopy clinic - to be undertaken with senior registrar.
- Aim to retain as much patient based information as possible.

Brent & Harrow Project 1 - Evidence Based protocols in A&E

Leads: Mr. A. Sivakumar, Consultant in A&E, Central Middlesex Hospital, Acton Lane, London NW10 7NS Tel: 0181 453 2718
Amanda Layton, Head of Quality, CMH
Dr. Mark Stott, Consultant in Public Health, Grace House, Harrovian Business Village, Bessborough Road, Harrow HA1 3EX Tel: 0181 966 1048

Timescale: 18 months Contract dates 1.4.96-30.9.97 Final report: May 98

Setting: A&E Department

Evidence

Cited: Sackett et al, Ottawa Group, Turnball et al

How used: comparison of evidence based practice impact in general medicine versus A&E, estimates of reduction of numbers of x-rays and unnecessary investigations, strategies for implementing and evaluating EBP.

What are they trying to do?

By purchasing computers and entering physician agreed protocols for conditions commonly presenting in A&E, doctors will be encouraged to work to protocols and thereby leading to more appropriate tests and investigations and improving the quality of care delivered.

Aim: To improve the effectiveness and quality of care in A&E through implementing a protocol based documentation system.

Objectives

1. Develop series of evidence based protocols for management of conditions commonly presented to A&E
2. Develop system for improving adherence to those protocols.
3. Evaluate impact of introducing protocol driven care in A&E.

Other information

- Protocol driven care by nurse practitioners initiated in summer 1995. Preliminary audit suggests that x-ray requests and referrals lower→practice now needs to spread to doctors
- 19 protocols had been developed by Dec 1995
- Part funding (5 computers) and full funding (whole department) options offered→NT went for partial funding
- Members of project group attended evidence based medicine course in April 1996 and CASP workshops.
- Interim report Oct. 97 on adherence to minor protocols.
- Doctors more interested in major procedures and nurses minor → nurses 100% adherence, much lower with doctors
- Original bid to North Thames included only minor protocols, but would like to extend KF evaluation into major by summer 98.

Steps

1. Set up project team.
2. Set up system and devolvement of evidence based protocols for use by doctors.

3. Promote culture of evidence based practice by encouraging critical evaluation of the critical steps in protocols.
4. Allocate specific protocols to 9 SHOs for development.
5. Audit & evaluation
6. Disseminate

Evaluation

- Objective 1 - numbers of protocols developed, proportion of patients covered, degree to which more evidence based than consensus, setting up of process for revision
- Objective 2 - training of SHOs in EBP and Medline, removal of A&E clerk, regular review of of "new" problems and guidelines, admission rates versus outpatient rates, changes in referral and intervention rates
- Objective 3 - replacement of casualty card by A4 protocols

PROJECT CANCELLED MAY 1997

Brent & Harrow Project 2 - Development of "Systemic" Community Skills for Community Mental Health Professionals in Brent

Project Leads: Dr. Mike Gill, Director of Public Health, Grace House, Harrovian Business Village, Bessborough Road, Harrow HA1 3EX Tel: 0181 966 1046
Dr. Paul Mallett, Consultant Psychiatrist
Timescale: Two years, but funded for 20 months - Contract dates 1.10.96 - 31.5.98
Setting: Park Royal Centre for Mental Health, Acton (Brent)

Evidence

Evidence cited: Vaughan & Leff, Kuipers et al
How used: to substantiate claim that relapses will be reduced with use of family intervention therapies

What are they trying to do?

Train mental health staff in family intervention techniques to enable schizophrenic patients to stay in the community.

Aim: To enable patients to develop skills to access appropriate social networks and to manage their own symptoms (thereby leading to lower medication levels in some cases).

Objectives

1. Create critical mass of skill within the trust as part of a strategic move to change the climate of treatment.
2. Help patients to stay in the community.
3. Reduce relapse rate amongst those with serious mental illness, especially those with families with "high expressed emotion".

Other possible objectives (not explicitly stated in 'objectives section')

1. Help institutional and ward staff feel more part of community work.
2. Reduce in-patient admissions.
3. Increase psychological resources in teams, specifically those dealing with patients suffering from delusions and hallucinations.
4. Encourage staff to promote natural relationships between patients, carers and relatives.

Other information

- Course designed and run by Camden & Islington Community Health Trust.
- Director of Public Health very committed.
- Evidence only relates to schizophrenic patients.
- Letter received May 1997 that project canceled due to difficulties in funding course part of the project.

Steps

1. Train 3-6 staff in Year 1.
2. Train 3-6 staff in Year 2 (total 6-12).
3. On-going dissemination of course with other team members through termly sessions led by course participants.

4. Evaluation and clinical audit.

Evaluation

- Reduce relapse rate by 20-30 patients in Year 1.
- Number of staff interested in taking course.
- Retention of staff to Trust.
- Management of case load that reflects course teaching.

Brent & Harrow Project 3 - Open access echocardiography project

Project Lead: Dr. Mark Dancy, Consultant Cardiologist
Dr. Ha B. Xiao, Junior Registrar, Central Middlesex Hospital, Acton Lane, Park Royal, London NW10 7NS **Tel:???**

Timescale: One year project (originally) - Contract dates 1.9.96 - 28.2.98 Final report date: not known

Setting: Central Middlesex Hospital

Evidence

Evidence used: Dargie, McMurray, SOLVD Investigators, Murphy & Bossingham - Letter to the *BMJ*

How used: Estimates of morbidity, mortality, survival rates and cost to NHS due to chronic heart failure. Estimates of prevention of mortality if new service initiated.

What are they trying to do?

Set up an open access echocardiography service for GPs in the area and thereby reduce mortality and morbidity from heart failure.

Aim: To improve diagnosis and management of heart failure thereby reducing mortality and morbidity from heart failure.

Objectives

1. To improve management of heart failure by providing open access echocardiography for GPs
2. Appropriate use of diuretics
3. Increased appropriate use of ACE inhibitors
4. Audit use of service by GPs and monitor impact on out-patient waiting times

Other information

- Trust strongly committed to providing better service for GPs.
- Estimated workload 150-200 cases a year (scaled down from original estimate by GPs of 480+).
- Aims to be "truly open access" with direct contact between echo technician and GP. Consultant involvement limited to ensuring that reports from technician to GP understandable.

Steps

1. Meet with 30 GPs to canvass opinion. (+)
2. Devise request form for echo and audit form. (+)
3. Employ technician. (+)
4. Teach GPs from first meeting on aspects of echo service.
5. Pilot with GPs from first meeting.
6. Extend service to all GPs in Brent.
7. Disseminate.

NB (+) means task completed as of June 1996.

Evaluation

- Prevention of 13 premature deaths per year.
- Referral rates of 30-40 patients to service a month.
- Reduction in out-patient referral to cardiology department.
- Quantitative data on prescription patterns (ACE inhibitors, diuretics and others) and impact on outpatient waiting time (reduction from 15 weeks).

Camden & Islington

Helicobacter pylori eradication in Camden & Islington

Project Leads: Amalin Dutt, Prescribing Adviser
Julie Ferguson, Audit Facilitator, 110 Hampstead Road, London NW1 2LJ
Tel: 0171 383 4888 x5576
Timescale: 18 months - Contract dates 1.10.96 - 31.3.98 (Audit facilitator in post until 31.8.98) Final report: Aug 98
Setting: GP practices

Evidence

Evidence used: MeReC Briefing, Shearman, Effectiveness Matters, Veldhuyzen van Zanten & Sherman

How used: Estimates of costs of dyspepsia to NHS, estimates of prevalence, support of use of eradication therapy, estimates of recurrence rates post-intervention.

What are they trying to do?

By using established research methods and facilitating self-audit amongst GP practices, they intend to increase appropriate use of eradication therapy for h pylori and encourage rational prescribing, thereby reducing C&I spending on ulcer healing drugs.

Aim: To improve uptake of appropriate eradication therapy in C&I and encourage rational GP prescribing.

Objectives

1. Disseminate strong research evidence for benefits of h pylori eradication.
2. Improve appropriate uptake of eradication therapy in C&I.
3. Ensure better value for money for expenditure on ulcer healing drugs.
4. Reduce number of patients receiving long term acid suppression.

Other information

- Distance learning pack approach used previously with antibiotic and NSAID (non-steroid anti-inflammatory drug) prescribing. Consensus of over 70% was reached with participation of over 70% of GPs. Evaluation showed subsequent 10-20% rise in appropriate prescribing.
- Distance learning pack approach consists of convening group from Prescribing Forum to determine "quality markers" and then elicit GP views in 3 cycles of Delphi technique.
- GPs to receive financial incentive for self-audit.
- Initiative will focus on high spending practices identified through PACT data and invited to be one of 10 practices. Audit facilitator will offer support to GPs for audit.
- HA wide guidelines not previously launched but provider units had own particular guidelines. (Difference with KCW and Hillingdon)
- MAAG involved in developing audit.
- Patients in follow up at 1, 6, 9 months will be on long-term acid suppresants w/in each of 10 practices. Follow up how many come back for repeat prescriptions.

Steps

1. Recruit audit facilitator.

2. Establish advisory group.
3. On-going literature review.
4. Consult local stakeholders including gastroenterologists, MAAG, C&I Purchasing & Prescribing Forum, LMC, LPC.
5. Run distance learning pack to canvass GPs' views on treatment of ulcer disease and role of h pylori eradication.
6. PACT analysis to identify high spending practices.
7. Audit pack to monitor ulcer healing drug prescribing developments.
8. Recruit initial practices and pharmacists and implement project.
9. Collect data from 1 month follow up.
10. Advisory group to discuss how to roll out project to other practices.
11. Recruit 2nd phase of practices.
12. Collect and analyse data from 1st phase practices (x2)
13. Collect and analyse data from 2nd phase practices (x2).
14. Write up final report
15. Disseminate and publish.

Evaluation

- Outcomes to be measured in terms of h pylori incidence in target population, h pylori eradication rates, follow up at 1 (Aug 97), 6 (Feb 98) & 9 (May 98) months to determine prevention of reoccurrence, effects on ulcer healing prescribing patterns and costs.

Ealing, Hounslow & Hammersmith

Implementation of diabetes information system

Leads: Dr. Raymond Jankowski, Consultant in Public Health, 1 Armstrong Way, Southall, Middlesex UB2 4SA Tel: 0181 893 0303
Suzanne Smith, Commissioning Manager, Tel: 0181 893 0267
Timescale: One year Contract dates 1.10.96 - 31.3.98 Final report date: June 1998
Setting: 15 GPs

Evidence
Cited: local diabetes survey, Diabetes Control & Complications Trial, St. Vincent's Declaration, CSAG and British Diabetic Association
How used: prevalence of diabetes within population, support for premise that intensive treatment of diabetes reduces complications and slows development, targets to improve diabetic care, need for local registers

What are they trying to do?
By setting up a diabetic register to be piloted in 15 GP sites, they intend to work towards improving quality of care and realign and rationalise services.

Aim: To improve the quality of care of diabetics by setting up a register.

Objectives
1. To accurately record the number of known diagnosed diabetics for which services have to provided.
2. To check that these patients have a minimum of an Annual Review.
3. To enable practices to take part in more sophisticated clinical audit.
4. To try to record diabetic complication rates and monitor the progress of their reduction.
5. To provide a reliable recall and review of all people with diabetes in EHH.
6. To improve communication between all health professionals caring for people with diabetes.

Longer term objectives (not within lifetime of evaluation)
1. To ensure that multi-disciplanary input is provided to diabetics, especially at the time of annual review.

Other information
- 80% of GPs involved in Chronic Disease Management initiative (~14,800 diagnosed diabetic patients).
- User information will be collected as part of larger project (excellent - how? What?)
- Larger project which pre-dates this one already engaged all key providers and they had hand in developing this one.
- Nicky Gibson, Service Manger, on maternity leave.
- Carole Cairns, Diabetic Project Manger, left March 1997→point at which system out to tender and needing to be integrated into purchasing.
- Competitive tender out before Xmas 1996.
- Piloted in East London.
- Patient confidentiality issue - basically circumvented by asking patients to sign form that gives permission for them to be on the Register. Form taken from East London draft.

- Practices with highest prevalence of diabetes targeted.
- Other projects on stroke, hypertension, depression?
- Parallel projects going on with acute trusts, but not part of North Thames project.
- Criteria for GP practices included in scheme include: having over 100 known diabetic patients, approved to run the Chronic Disease Management Programmes for Diabetes, using EMIS computer system (~25) or a non computerised practice which the HA is planning to computerise (~3).

Steps

1. Appoint facilitator.
2. Agree specification with purchaser, provider and IT.
3. View systems
4. Set up working party.
5. Tender.
6. Agree system.
7. Identify 15 GP sites.
8. Facilitator to train and support professionals.
9. Audit
10. Evaluate.

Evaluation

- Audit to include before and after data for each practice on: number of diabetics, proportion of patients from ethnic groups, perecentage of diabetics with records of smoking, BMI, HBA1c, annual reports, fundoscopy, total number of patients who've had an annual review either at practice or hospital.
- Audit form 1 page with MDS
- More qualitative work with GPs/practice nurses thru workshops and questionnaires on extra time needed for this work (could be selling point or detractor), barriers to change, questions such as has it been worthwhile?
- Don't want evaluation to turn into punative measures for those GPs doing few annual reviews.

East London and the City

Evidence Based Cardiac Intervention

Project Lead: Harry Hemmingway, Consultant in Public Health (now at KCW)
Shrilla Banerjee, Registrar, Cardiac Research Office, London Chest Hospital
Bonner Road, Victoria Park, E2 9JX Tel: 0181 983 2213
Timescale: One year - Contract dates 1.12.96 - 30.11.97 Final report: April 98
Setting: London Chest Hospital and St. Barts

Evidence

Evidence used: Pocock et al, Davis et al, Hutchinson et al., Grol, Gray et al, Kravitz et al
How used: outcomes of revascularisation and angiography, influenced the planning of strategies for successful implementation, estimates of inappropriate interventions and survival rates.

What are they trying to do?

Having established an "evidence resource" database and set up an expert panel to rate indications for angiography, angioplasty or bypass grafting using the Delphi technique, a registrar has been employed to persuade colleagues to follow recommended practices, thereby leading to a reduction in unnecessary revascularisation and investigation as well as a reduction in variations in rates amongst the 2 sites.

Aim: To ensure that coronary investigation and revascularisation is carried out appropriately, nobody is inappropriately investigated and revascularised and the variations in revascularisation is reduced between the two sites.

Objectives

1. Initiate and sustain evidence based practice within cardiac directorate.
2. Develop and disseminate "evidence resource" (literature review and reference database).
3. Develop guidelines for coronary revascularisation and angiography.
4. Evaluate.

Other information

- Harry Hemmingway no longer at ELCHA (KCW).
- Implementation part of much wider project which grew from initial work with expert panel funded by 5 HAs which refer to Royal London.
- Proposal states that evidence based practice being used as an organising principle (umbrella) within directorate.

Steps

1. "Reference manager" ("evidence resource") database on angiography, angioplasty and bypass grafting set up with original abstracts (1500+ references) (+)
2. 9 member expert panel set up to evaluate appropriateness of all indications for angiography, angioplasty and bypass grafting. (+)
3. Prospective study designed to measure use of angiography, angioplasty and bypass grafting amongst 5 HAs. (+)
4. Recruit and train registrar in evidence based medicine.

5. Registrar to pass on skills in evidence based medicine to colleagues. ("Change agent").
6. Develop "reference manager" database into "evidence resource" and disseminate through CATs (Critically Appraised Topics) (i.e. take topic of local interest and write up info with reference to database for discussion).
7. Introduce "evidence resource" into library.
8. Develop and disseminate guidelines on revascularisation and investigation.
9. Establish links with existing guidelines on coronary care at primary and secondary level.
10. Explore ways to including GPs in developing new guidelines.
11. Evaluate.
12. Disseminate locally and nationally. N.B. (+) means carried out before Feb. 96

Evaluation

Evaluation on two levels - appropriateness and evidence based cardiology site

- Appropriateness - comparison of revascularisations before and after expert panel
- Evidence based cardiology site - quantifiable data in numbers of users of "evidence resource", attending evidence based medicine sessions, times computer used and grade of staff using, number of times *evidence based medicine* or *CAT* of guidelines referred to in notes or other clinical documents.
- Qualitative data - impact of project assessed through interviews with junior and senior colleagues. Tavistock doing pre and post interviews after EB sessions completed. Have done first round. Sessions finish July so coming back in August/September.

East London & City

Programme for Implementation of Evidence Based Practice in Leg Ulcers

Project Leads: Sally Gooch, Project Director,
Alison Hopkins, Tissue Viability Specialist Nurse, Tower Hamlets Healthcare Trust, Elizabeth Fry House, Mile End Hospital, 275 Bancroft Road, London E1 4DG Tel: 0171 377 7924

Timetable: 1 year - Contract dates 1.4.96-31.3.97 Final report: Aug 98

Setting: Tower Hamlets Healthcare

Evidence

Evidence used: Guidelines and audit tools developed by University of Liverpool, NHS Executive guidelines (NHSE Consensus Strategy for Major Clinical Guidelines - The Management of Leg Ulcers 1995), literature search

How used: adapted and consulted while developing local guidelines known as *Tower Hamlets Healthcare Trust - Pressure Sore Care Programme* (January 1997) and *Leg Ulcer Care Programme* (Autumn 1997)

What are they trying to do?

By employing a tissue viability specialist nurse as an opinion leader, they intend to develop, implement and audit their local guidelines on leg ulcer management as well as set up primary care led leg ulcer clinics thereby reducing variability of clinical practice and outcomes across the trust's services.

Aim: To improve the service and management of leg ulcers for clients of Tower Hamlets Healthcare Trust through the provision of the Leg Ulcer Care Programme and community leg ulcer clinics.

Objectives

1. To educate, train and facilitate health professionals within THHT in the care programme approach to leg ulcer management.
2. To meet the needs of the service users with support and education.
3. To develop programme with clinical audit and quality assurance framework.
4. To continue link with East London & City HA to ensure that contracting reflects good practice.
5. To reduce variability in health gain and cost benefits across the trust.
6. To set up nurse-led leg ulcer clinics with the support of GPs, district and practice nurses.
7. To reduce inappropriate referrals to the complex wound clinic.

Other objectives (not explicitly stated)

1. To roll out to other community trusts in East London.
2. To apply approach to other topics.

Other information

- Pressure sore care programme preceeded this - helped to sort out some of the problems
- Tissue Viability nurse remit went trustwide July 1997.
- Plan to produce same format for continence.
- Project manager (Alison) brought in May 1997.

Steps

1. Recruit replacement project worker as secondee.
2. Complete development phase of guidelines development (July 1997).
3. Launch/publish care programme (September 1997).
4. Provide implementation programme (October 1997).
5. Support staff using care programme (clinical nurse specialist) (Oct 97 on)
6. Develop and conduct audit programme to support care programme (July 1997-Mar 98)
7. Establish primary care based leg ulcer clinics (Sept 97-March 98)
8. Develop link practitioner network to support care programme (Sept 97-March 98)
9. Write report (Aug 1998)

Evaluation

Evaluation based on structure, process and outcomes model

- Structure - Getting clinics established and getting nurses to see patients of "other" GPs, rota of practice nurses, identify pilot site
- Process - audit by March 98 of use of leg ulcer care programme
- Outcome - audit, specifically healing rates from assessment.
- Also can compare with data from national programme of the National Chronic Wound Project and East London wide audit on leg ulcers
- Before and after data on costs, measured outcomes of care, extent of divestment from traditional clinical practice.
- Effectiveness of programme to be measured by Clinical Audit Facilitator.

Enfield and Haringey

Self Directed Learning Sets

Project Leads: Dr. Peter Sheridan, Consultant in Public Health, Alexander Place, Lower Park Road, Southgate N11 1ST Tel: 0181 361 7272
(bid drawn up by Allison McCallum who moved to E&N Herts)
Douglas Guest, Project Officer, 85 Tanner's End Lane, Edmonton N18 1SB, Tel: 0181 803 1444

Timescale: Originally 20 months - Contract dates April 97 - May 98 (Douglas's contract June 98) Final report: June 98

Setting: GPs

Evidence

Evidence cited: Budd (not NTRHA), Sackett, Ayres and others

How used: Applied their findings in constructing a viable framework for introducing EBP.

What are they trying to do?

By using a self-directed learning approach with existing GP fora and extending it to previously uninvolved GPs, they intend to establish mechanisms whereby evidence can be accessed, appraised and acted on as part of routine practice.

Aim: to create a culture in which GPs synthesize and implement new evidence quickly and effectively and demonstrate behavioural change.

Objectives

1. Increase ability of local clinicians to implement EB care.
2. Develop sustainable skills in critical appraisal.
3. Improve access to evidence.
4. Develop programme of EB self-directed learning at locality level.
5. Improve clinicians' ability to identify and act on summaries of high quality evidence (e.g. *Bandolier*, *Effectiveness Matters* etc.).
6. Communicate and disseminate lessons to other GPs, purchasers and providers.
7. Consolidate links between EBP, clinical audit and continuing education.
8. Ascertain study areas chosen and reasons for topic choice.
9. Demonstrate improvement in performance in topic area.

Other information

- Self-directed learning approach consists of groups of GPs working together to identify a topic, review summaries of evidence, audit existing practice, discuss possible changes and make recommendations.
- GPs themselves choose topics of interest and how plan to learn. Project worker available to sythesize evidence, organise meeting facilities and observe group interactions.
- Previously run in LIZEI areas, but not all of HA covered.
- Pilot topic - aspirin in cardiovascular disease.
- Allison McCallum left and project dropped for a while until picked up by Asst Dir of PH.
- HA to fund 4-6 meetings only. Sustainability measure - do these groups continue to meet after the funding stops?

Steps

1. Pre-pilot study in one of GP fora to experiment with method.
2. Recruit project worker to search for and prepare summaries of evidence and develop GP learning sets.
3. Set up learning sets to review evidence, audit existing practice, discuss changes in practice, make recommendations and close audit loop.
4. Audit of implementation and recommendations made.
5. First year report.

Evaluation

- Overall - evaluation to get a sense of how much group processes facilitate behavioural change in individuals.
- Analysis of materials used and produced.

Objective 1 Pre-audit of care for each topic to be undertaken.
Objective 2 Measurable?
Objective 3 Access to and use of facilities examined before, during and after project.
Objective 4 Documented evidence of such a programme.
Objective 5 Use of EB summaries examined before, during and after initiative (possibly).
Objective 6 Examine effectiveness of dissemination process and uptake of recommended changes in practice.
Objective 7 Documented evidence of links between EBP, clinical audit and continuing education.

- Evaluation of group processes around change - for those who participate look at knowledge, attitude changes and skills of enabling change in clinical practices (hopefully leading on to behavioural change). Also look at effect on GPs who do not participate - do practice changes go beyond the participants to affect others not directly involved?
- Simple measures can include composition and attendance at groups

North Essex

Improving Cancer Care in N Essex: putting evidence into practice

Leads: Dr G Carroll, DPH & Clinical Policy, North Essex HA
Sushil Jathanna, North Essex HA, Turner Road, Colchester Essex CO4 5JR
Tel: 01206 851257
B. Sizer, Consultant Clinical Onocologist
Andy Horsley, Radiographer

Timescale: 18 months - Contract dates 1.10.96-31.3.98 (Andy's contract ends June 98)
Final report: Spring 1998

Setting: Essex Rivers Healthcare and Mid Essex Trusts

Evidence

Evidence cited: Eccles, Grimshaw, Russell et al, and University of Leeds evidence

How used: effective methods of developing guidelines, benefits to cancer patients of enrolment in clinical trials – 3 studies from 1985-1994. Clinical evidence upon which to base proposed treatment guidelines is to be assembled and reviewed as part of the project

[Later in response to N Thames comments: cited BASO reports, Clinical Outcomes Group report in draft, local evidence of variation in number of operations per surgeon per year. Referred to EL(96) 15 and Calman Cancer report. Cited Colorectal Cancer study (John Guy, Carl Martin) highlighting absence of explicit guidelines and GPs and consultants awareness of need for them.]

What are they trying to do?

By appointing a CSDO, developing guidelines and conducting clinical trials, they intend to work towards fostering teamwork and standardising treatment across two trusts; thereby leading to improved survival rates in patients with breast and colorectal cancers and establishing mechanisms for further collaboration on other types of cancers.

Aim: Improve consistency of treatment, and hence survival, of patients with breast cancer and colorectal cancer, in two collaborating trusts in N Essex.

Objectives

1. Develop and implement evidence based guidelines for the management of breast cancer and colorectal cancer.
2. Identify clinical trials to which patients should be offered entry, and facilitate entry process.
3. Actively promote joint clinical management to medical and surgical colleagues
4. Provide a basis from which to seek opportunities to work on comprehensive clinical guidelines for common cancers, with hospital colleagues, primary care staff, and patients & their carers.

Other objectives implied or mentioned elsewhere in text

1. Foster multidisciplinary teamwork (which evidence suggests improves five-year outcomes)

2. Ensure that each patient receives consistent information and coordinated treatment from all those involved in their care.

Steps

1. Recruit Cancer Services Development Officer (CSDO).
2. Surgeons and oncologists with support from public health physician meet to evaluate the evidence systematically.
3. Establish Cancer Guideline Development Group.
4. Disseminate guidelines to relevant clinicians and GPs, allied with educational meetings for hospital and community staff.
5. CSDO review current activity in clinical trials across oncological specialties, and identify potential numbers of patients who might benefit from inclusion in trials.
6. Develop specifications for information systems.
7. Seek examples of good practice elsewhere.
8. Consolidate guidelines into purchasing contract specifications.

Evaluation

Based on structure, process, outcome model

- Structure - cancer partnership in place between 2 trusts, identify team, roles and responsibilities (KF and Jackie Ord to evaluate together?)
- Process - involvement of users (clinicians and patients), development and dissemination of guidelines, setting up quality standards to progress towards information system, recruitment of patients into clinical trials
- Outcomes - knowledge and awareness of guidelines amongst clinicians, audit practice against guidelines before and after (colorectal audit originally done 95-96, re-do on referral time from GP to clinician), appropriate referrals, referral f secondary problems eg not just breast cancer but complications

South Essex

SEEP (South Essex Evidence into Practice) - Hypertension in the Elderly

Project Lead: Dr. Mike Gogarty, Consultant in Public Health, Arcadia House, Warley Hill Business Park, The Drive, Great Warley, Brentwood Essex CM13 3BE
Tel: 01277 755200
Dr. Chris Joyce, R&D Manager
Lizzie Shires, Public Health Consultant - liaises with Primary Care Education

Timescale: 18 months - Contract dates 1.10.96 - 31.3.98 Final report date: not known

Setting: GPs and practice nurses

Keywords: guidelines, change agents, GP tutors, coronary heart disease, stroke management, trickle down, larger project, baseline data

Evidence

Evidence cited: Collins et al, Dickerson et al

How used: support for position that GPs begin treatment of hypertension at higher blood pressure levels than those recommended

What are they trying to do?

By using guidelines and GP Education, they intend to persuade GPs to abandon the over 75 checks and start treating hypertensive patients earlier.

Aim: To persuade GPs to diagnose and treat hypertension in line with British Hypertension Society Guidelines, thereby reducing strokes, myocardial infarction and other vascular events.

Objectives

1. Assess current treatments of 60-79 year olds.
2. Agree best way to manage hypertension for this group.
3. Develop implementation plan to introduce management plan.
4. Assess framework for implementing change.

Other information

- One third of GP practices have signed up (~50) [at time of bid]. 165 practices by Spring 1997.
- South Essex have employed this method previously with success (i.e. developed guidelines by using single lead with background in GP education and with full support of relevant local expertise).
- Part of larger project known as Stroke Strategy.
- Work will continue beyond 18 months.
- Primary Care Education came into existence in December 1996.
- Sought support for abandonment of over 75 checks from HA, LMC, local consultants, CHCs and local pensioners' action groups.

Steps

1. Questionnaire to all GPs on their management of stroke. (October 1995)
2. Develop guidelines with GPs, consultants, GP tutors and "known product champions".

3. Carry out training seminars, lectures and small group initiatives with GPs and nurses.
4. Support with high profile initiative around over 75 checks.
5. Repeat questionnaire survey of GP knowledge and expressed behviour and problems encountered in practice (October 1996).
6. Evaluation on practice basis.

Evaluation

- Difficulty in that no baseline data collected before launch of guidelines. Reported change taking place but need to measure actual change.
- Evaluate actual change through employing researchers to define management change in a group of involved practices (e.g. through retrospective survey of case notes)

West Hertfordshire

Implementation of research evidence of anticoagulation therapy in primary and secondary prevention of stroke

Leads: Dr Alison Frater, Assistant Director of Public Health
Cam Lugton, Public Health Officer, Charter House, Parkway, Welwyn Gdn City, AL8 6JL. Tel: 01707-390855. Fax: 01707-390864
Jenny Voke, Consultant Hematologist East Hertfordshire Trust, QE11 Hospital, Howlands, Welwyn Garden City, AL8 6JL Tel: 01707 328111

Timescale: 18 months (revised up from 12 months). Contract dates 1.7.96-31.12.97
Final report: June 98

Setting: Hospital and community clinics

Keywords: anticoagulation, atrial fibrillation, non-clinical worker, seminars, demonstration project, mechanism, audit

Evidence

Evidence cited: EAFT trial, pilot, Regional Audit of Anticoagulation Therapy (prepared by HAEMAC), St. Albans & Hemel Hempstead NHS Trust assessment of nurse led anticoagulation service

How used: supports position that anticoagulation therapy with warfarin highly effective in relative risk reduction, estimates of numbers of events prevented, developing strategy for implementation, organisation and management of clinics

What are they trying to do?

By appointing a Public Health Officer to lead, they intend to improve anticoagulation treatment through the implementation of service change and set up mechanisms for integrating EBP more widely by evaluating the change process.

Aim: To see that anticoagulation is done consistently well across the county and secure evidence based practice through implementing and monitoring clinical efficiency and the cost benefits of nurse led clinic/domicillary anticoagulation service.

Objectives

1. Assess present and future demand for care.
2. Undertake prevalence study to estimate anticoagulation across the county.
3. Assess current models of care in use.
4. Introduce and evaluate nurse led clinics in East Herts
5. Evaluate extension of nurse led clinics in North West Herts.

Other objectives implied or mentioned elsewhere in text

1. Reduce mortality and disability from stroke (major priority within the agency's clinical effectiveness programme).
2. Improve quality and efficiency of the service provided.
3. Avoid long outpatient waits for elderly people.
4. Shift service towards providing ambulatory care.
5. Engage local managers' support for implementation of 'optimal' policies.
6. Understand overall cost implications.

7. Identify via patient and carer groups desirable improvements in perceived patient satisfaction and quality of care and in relevant information available to patient.
8. Support agenda for EBP in general by such a 'compelling example' based on strong evidence.
9. Secure change using educational networks, influence of peers' dissemination of pilot work and contracting/purchasing mechanisms.

Other information

- 2 p/t nurses already leading anticoagulation service at St. Albans City Hospital
- Plan to run clinic out of Harpenden
- On-going development of phlebotomist service supported by computer dosing and first time/difficult to manage patients seen by consultant at Watford General. Service can be compared with nurse led service at St. Albans City Hospital.

Steps

1. Appoint public health officer to lead project, working to assistant director of public health.
2. Establish steering and project management arrangements, agree objectives.
3. Literature search and review.
4. Undertake prevalence study - atrial fibrillation and other conditions requiring anticoagulation. Apply best recent reported methods to Herts population.
5. Assess use of warfarin in Herts through consultant interviews, prescribing data and GP questionnaire.
6. Assess GP point of view and impact on GP workload.
7. Understand care pathways available across Herts through investigation of hospital records, consultant interviews and GP questionnaire.
8. Implement/extend nurse practitioner led service in E Herts and NW Herts
9. Develop sound organisation and management to cope with likely increased demand.
10. Final report - June 1998
11. Evaluation throughout project to monitor progress according to goals and milestones.
12. Disseminate findings through educational networks, devise quality criteria for use by primary care practitioners and establish service specification and contract monitoring for agreement with trusts.

Evaluation

- Local concerns and barriers to implementation
- Project audit through patient safety, patient compliance, complications, patient satisfaction and GP/referrer satisfaction measures
- Costs and benefits of non-nurse led paths of care for anticoagulation
- Training needs for staff in primary care and OP nurse specialist
- Monitoring of prevalence of atrial fibrillation locally, compared to national estimates of need
- Impact on GPs of service changes and increasing prevalence of conditions treated by anticoagulation
- Use of consultant time made available through the introduction of nurse led clinics
- Documentation of project, and discussion through local educational networks
- Documentation of quality criteria for use in contracting.

Hillingdon

The Eradication of Helicobater pylori and the Management of Dyspepsia

Project leads: John Aldous, Consultant in Public Health
Chris Deeming, Project Worker, Kirk House, 97-109 High Street, Yiewsley Middlesex UB7 7HJ Tel: 01895 452051
Timescale: Originally 2 years - reduced to 18 months - contract dates 1.12.96 - 31.5.98 (Chris's contract until Aug 98) Final report: Aug 98
Setting: primary and secondary

Evidence
Evidence cited: Effectiveness Matters, *Evidence based candidates for audit and purchasing agenda* (North Thames R&D)
How used: support of eradication therapy in curing ulcers and decreasing relapses

What are they trying to do?
By concentrating on the topic of h pylori and through the use of a facilitator, they intend to develop a mechanism for establishing a more overall evidence based approach within clinical practice and the HA itself.

Aim: To improve the effectiveness of local clinical practice in the management of dyspepsia and h. Pylori infection.

Objectives
1. To critically review existing local guidance and dissemination on the effective management of dyspepsia.
2. To establish the impact of this guidence.
3. To identify the main issues and impediments to the adherence of clinically effective practice.
4. To develop a strategy for improving the uptake of clinically effective practice.
5. To implement and evaluate this strategy.

Other information
- H pylori priority area for development in 96/97 purchasing plan.
- Hillingdon Hospital to develop gastroenterology services with new consultant appointment and new gastro liaison nurse.
- GP led projects in CHD and leg ulcers also going on in parallel.
- MAAG representative on dyspepsia group undertook preliminary audit on interface between primary and secondary care Will be repeated in autumn of 98.
- Guidelines from dyspepsia group went out in autumn 96. Project Worker taken on 8 months later and first task to evaluate how well guidelines received.
- Project Worker developed own plan of work (Stage 1, 2 etc document).

Steps
1. Establish dyspepsia group.
2. Appoint facilitator.
3. Establish scientific credibility of the guidance.
4. Review process of obtaining guidance and dissemination strategy.

5. Establish the impact and adherence to guidance through the integration of clinical audit and other appropriate indicators.
6. Reconvene dyspepsia group.
7. Review evaluation.
8. Develop and implement strategy.
9. Re-evaluate.
10. final report

Evaluation

- Establish a baseline with data trends using PACT, Hospital Prescribing, FCEs, operations and procedures
- Use of endoscopy/gastroenterology service
- Primary and secondary care audits and near patient testing (NPT)
- Use of h pylori testing (serology) and breath testing service
- Assessment of clinician (GP) awareness and attitudes towards guidance
- Challenge of this project is in substituting one effective treatment for another effective one → change is that patient no longer needs to take drugs for the rest of his/her life

Kensington, Chelsea and Westminister

Project 1 - Management of Dyspepsia

Project Leads: Pauline Taylor, Principal Pharmaceutical Advisor
Helen Dunford, Clinical Audit Advisor
Sonja Hood, Research Project Worker, Public Health Department, 50 Eastbourne Terrace, London W2 6LX Tel 0171 725 3251
Timescale: 18 months - Contract dates 1.12.96 - 31.5.98 Final report date: not known
Setting: GP practices

Evidence

Evidence cited: Effectiveness Matters, Feldman & Burton, Howden, DeBoer & Tytgate, Arens & Dent, MeReC Briefing, Drug Intelligence Group North Thames
How used: support for use of cimetidine as first line treatment, estimates of percentages of people infected with h pylori, potential savings

What are they trying to do?

Discover the extent to which 1992 KCW guidelines (re-launched in 1995) on management of dyspepsia are being implemented by auditing GP notes and interviewing GPs, and then formulate a strategy to implement revised guidelines, taking into account the problem areas and barriers to change identified previously.

Aim: To identify barriers to change in a) prescribing cimetidine rather than cimetidine and b) managing h pylori and GORD more appropriately.

Objectives

1. Identify barriers to change through GP interviews and surveys.
2. Audit management of dyspepsia in selected practices.
3. Use PACT data to determine the prescribing habits of different practices.
4. Convene a small working group to re-work the guidelines in light of findings from the audit, interviews and PACT data.
5. Re-launch the guidelines.
6. Determine the success of the new guidelines through re-audit, monitoring of prescribing data and interviews with GPs and other relevant health professionals.

Other information

- 1992 - only 3% move towards prescribing cimetidine rather than raniditine after issuing of guidelines - little change since then.
- Use of omeprazole increasing - would expect an associated decrease in ranitodine & cimetadine
- anecdotal - GPs saying pts still suffering symptoms of dyspepsia after eradication
- Guidelines first drafted by pharmacists and clinicians at Chelsea & Westminister.

Steps

1. Review guidelines and identify potential problem areas. Develop audit questions, survey and interview schedule.
2. Collect and analyse relevant PACT data.
3. Recruit 10 practices with EMIC to audit. Ideally, practices will be drawn from different levels of prescribing.
4. Undertake audit.
5. Send a brief survey to all GPs on dyspepsia management.
6. Conduct in-depth interviews with select GPs around dyspepsia management.
7. Analyse information from audit, PACT data, survey and interviews.
8. Revise guidelines accordingly, consulting with relevant health professionals (GPs, consultants, pharmacists). Develop a strategy to re-launch guidelines.
9. Plan and conduct re-audit 6 months after re-launch of guidelines.
10. Analyse and disseminate results.

Evaluation

- Audit to include before and after data on number of patients on H2 blockers, proton pump inhibitors and diagnosis of dyspepsia, peptic ulcer and GORD, who initiated prescribing, frequency of review of patients
- Bulk of data collection from GPs not secondary centres.
- Qualitative data from GPs gathered through interviews and surveys (e.g. do you know we have guidelines on ...?)

Kensington, Chelsea & Westminister

KCW Project 2 - Management of heart failure in primary care and open access echocardiography

Project Leads: Stephanie Taylor, Registrar in Public Health
Sonja Hood, Research Project Worker, Public Health Department, 50 Eastbourne Terrace, London W2 6LX Tel: 0171 725 3251
Timescale: 18 months - Contract dates 1.12.96 - 31.5.98 Final report date: not known
Setting: Victoria locality and Chelsea and Westminister Hospital

Evidence

Evidence cited: CONSENSUS trial, SOLVD trial, Colquhoun et al, Wheeldon
How used: support for using ACE inhibitors, estimates of hospital reductions, estimates of cost of NHS of heart failure, mortality & morbidity figures

What are they trying to do?

After auditing the current management of heart failure in primary care, guidelines will be developed and implemented for improving the treatment of chronic heart failure leading to the development of a new, open access echocardiography service.

Aim: To improve diagnosis and treatment of cardiac failure in primary care and assess the effectiveness of implementing local guidelines through clinical audit and other more qualitative evaluation.

Objectives

1. Conduct retrospective audit of heart failure diagnosis and management.
2. Develop guidelines for good management of heart failure including echocardiography and ACE inhibitors.
3. Disseminate guidelines developed by GPs.
4. Pilot open access echocardiography.
5. Audit use of open access echo in terms of uptake, appropriateness of referrals and changes in management.
6. Re-audit practices to establish how well guidelines have been implemented.
7. Evaluate primary care teams' perceptions of guidelines.

Other information

- Lots of support for the project from Primary Care.
- GPs to develop guidelines and thereby encourage a more bottom-up process.

Steps

1. Establish steering group.
2. Recruit 9 practices in Victoria locality.
3. Retrospective audit of patients with chronic heart failure in 9 practices (~200-500 case notes).
4. Review current prescribing level of ACE inhibitors and diuretics for each practice.
5. Semi-structured interviews with GPs and practice nurses to look at ways to implement and maintain change.

6. Develop local guidelines by steering group.
7. Implement guidelines through seminars and outreach work by GP and Project Worker.
8. Feedback audit results to practices including comparison of practice with aggregated data.
9. Pilot open access with 9 practices.
10. Follow up non-participants to identify barriers to change.
11. Re-audit management of patients with heart failure and analyse prescribing data and referral rates for echo.
12. Feedback audit.
13. Evaluate project.
14. Disseminate

Evaluation

- Quantifiable data in prescribing rates, referral rates and data from case notes.
- Three specific evaluation points: number of patients referred to echo, considered for ACE inhibitors and managed in primary care.
- Qualitative information from semi-structured interviews at start of project and once again 6-18 months after project starts. Aim - to get GP, echo technician and others' feedback on usefulness of GP developed guidelines.
- Evaluation aim specifically to look at how appropriately echo service used and how information is fed back to subsequent management of the patient.
- In part, evaluation will also let KCW know how well they are doing.

Redbridge and Waltham Forest

Go For It - Development of guidelines on diabetes, asthma and hypertension

Project Leads: Lucy Moore, Director of Public Health
Peter Elliott, Medical Advisor
Pratibha Datta, Consultant in Public Health, MAAG Chair
Sue Collett, Guidelines Facilitator, MAAG Office, James Fawcett Centre, King George Hospital, Barley Lane, Goodmayes Essex IG3 8XB Tel: 0181 970 8250

Timescale: 2 years originally - Contract dates 1.6.96 - 30.11.97 (Sue's contract to April 98) Final report: April 98

Setting: GP practices

Evidence

Evidence cited: Diabetes Control and Complications Trial, UK Prospective Diabetes Study, WHO criteria for diabetes, British Diabetic Association (diabetes), British Thoracic Society (asthma), British Hypertension Society guidelines (hypertension)
How used: support that control vital in the prevention of complications from diabetes and screening and diagnosis evidence (diabetes), adapted majority or aspects of guidelines (asthma and hypertension)

What are they trying to do?

Implement locally developed and adapted national (and international) guidelines by 1) using a facilitator (and GP tutors and locality team leaders) to discuss the guidelines with the GPs and develop ways of auditing them and 2) using computer prompt diabetic guidelines.

Aim: To set up a mechanism whereby locally adapted guidelines can be disseminated as well as assimilated and applied by practitioners as they are developed.

Objectives

1. Integrate primary care into mainstream services with clarification of the referral criteria for GPs and specialists.
2. Develop the commissioning of services from perspectives of diseases and care groups.
3. Improve standards in primary care and monitor them.
4. Reduce unplanned admissions for selected conditions.
5. Reduce the disease complications (long-term objective not within life-time of this project).

Other information

- District wide guidelines steering group, chaired by GP, established to steer both the development and implementation of guidelines. Implementation subgroup concentrates on getting guidelines already produced into practice. Development subgroup looks at the criteria for guidelines topic selection.
- Supplying 22 practices with computers which they can keep after the project finishes (creative incentive!).

- Computerised diabetic guidelines will also be available in a more traditional booklet.
- Important lesson from diabetes guidelines - keep it simple plus a "trial" for evidence.
- Diabetes guidelines launched in May 97; antibiotics revised and relaunched in April 97 (originally launched in Spring 96); asthma, hypertension and CHD under development.
- Asthma guidance launch scheduled for autumn 97; hypertension guidelines being piloted (summer 97) - very successful and popular with GPs.
- Implementation includes active launch for each guideline with workshops (hope for attendance of about 80 GPs at launch) and practice visits.
- Long-term → paediatric guidelines planned.
- HA have devised formal criteria for selecting topics for guidelines & implementation process.

Steps

1. Adapt national and international guidelines - PHC & specialists. (+)
2. Recruit senior nurse researcher to promote guidelines (actually recruited someone with marketing skills). (+)
3. Presentation of guidelines at CME meetings. (+)
4. Distribution of guidelines to all GPs via mailout. (+)
5. Visit of facilitator to at least half of the GP practices to discuss any queries (~88). (+)
6. Piloting of computerised diabetes guidelines.
7. Questionnaire to GPs.
8. Piloting of asthma and hypertension guidelines.
9. Visit of facilitator to A&E departments to query referral patterns (x2).
10. Review of guidelines (in conjunction with audit of process with MAAG).
11. Report.

NB (+) means achieved by 6.97

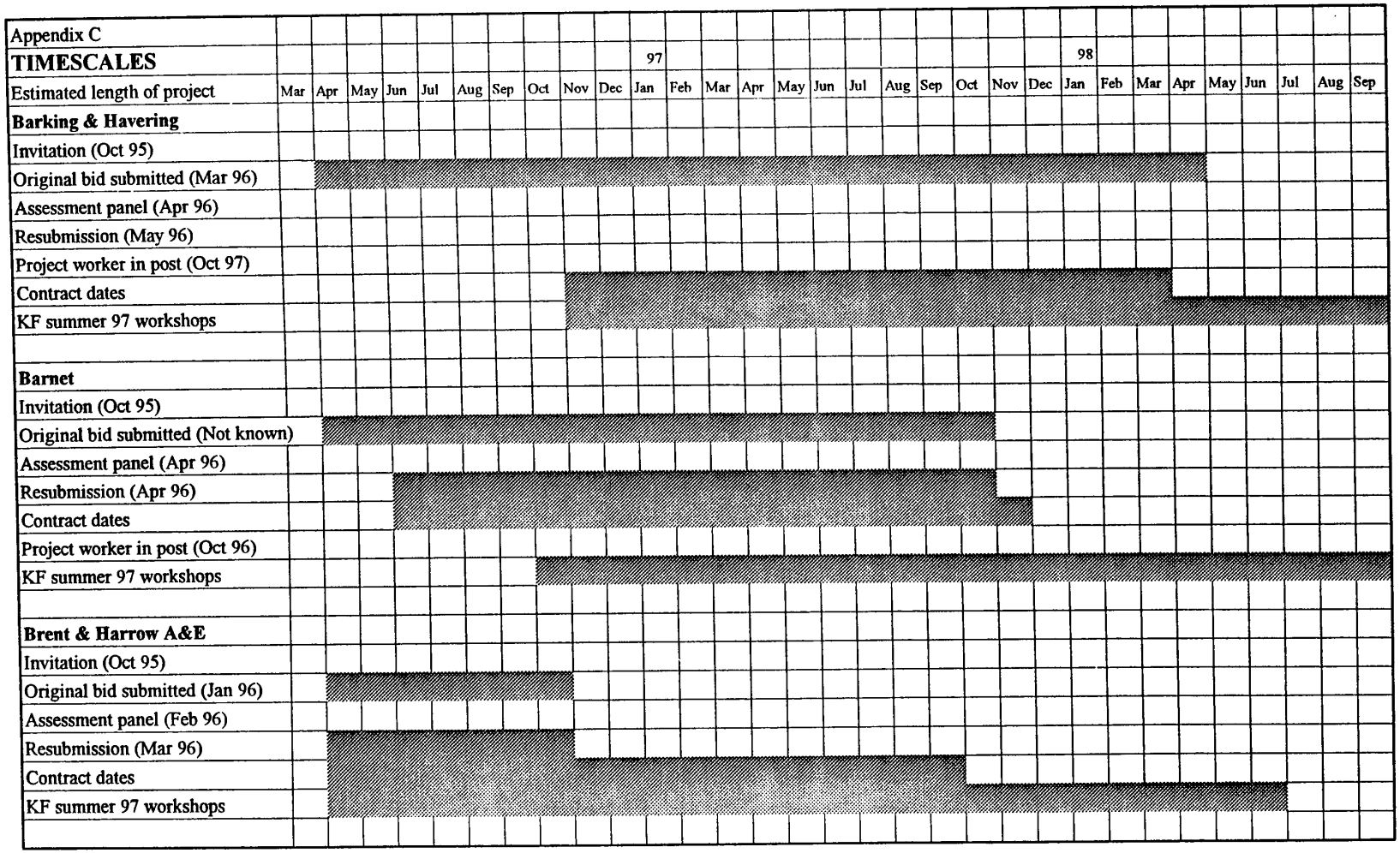
Evaluation

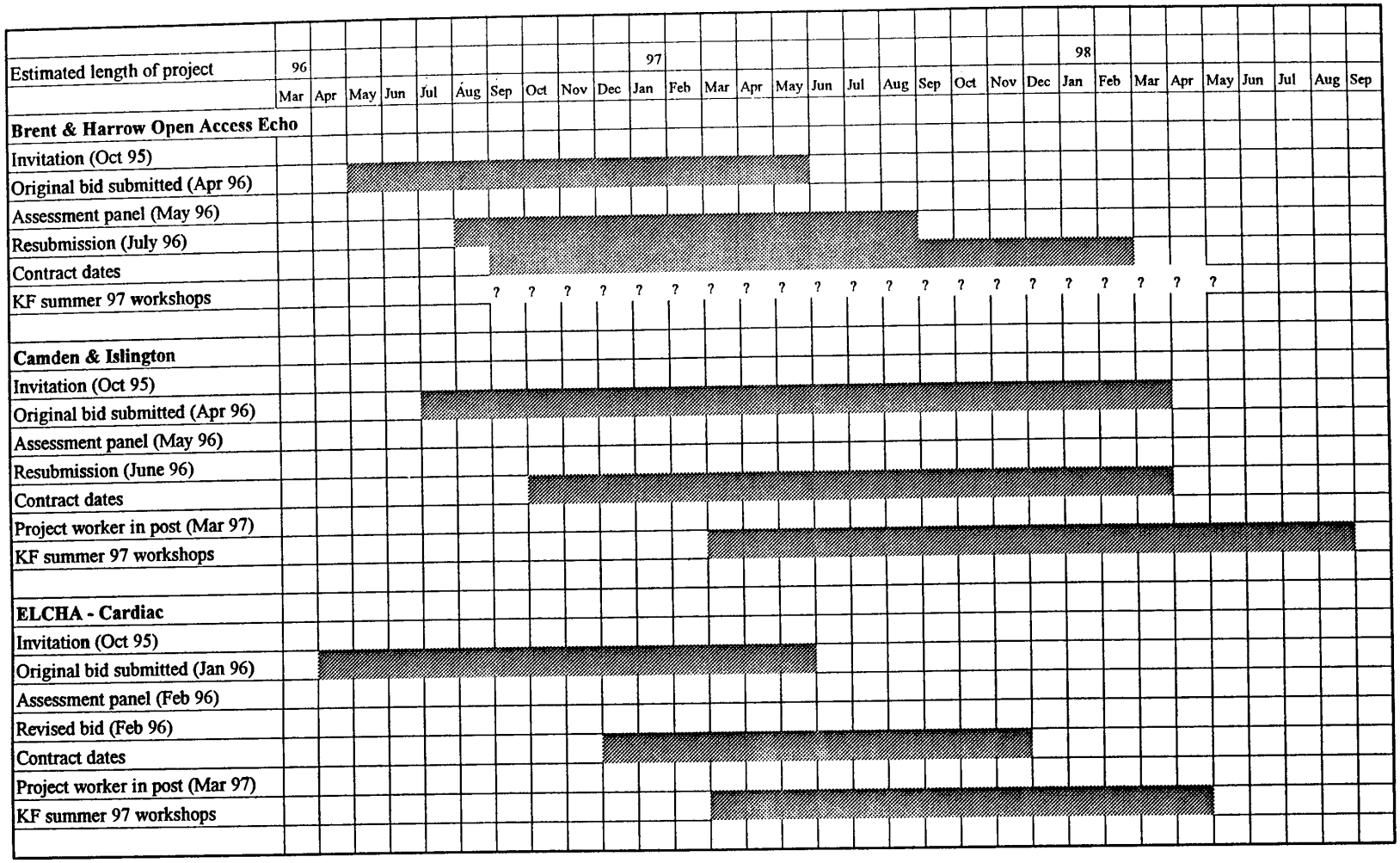
For each guideline, collect data on:

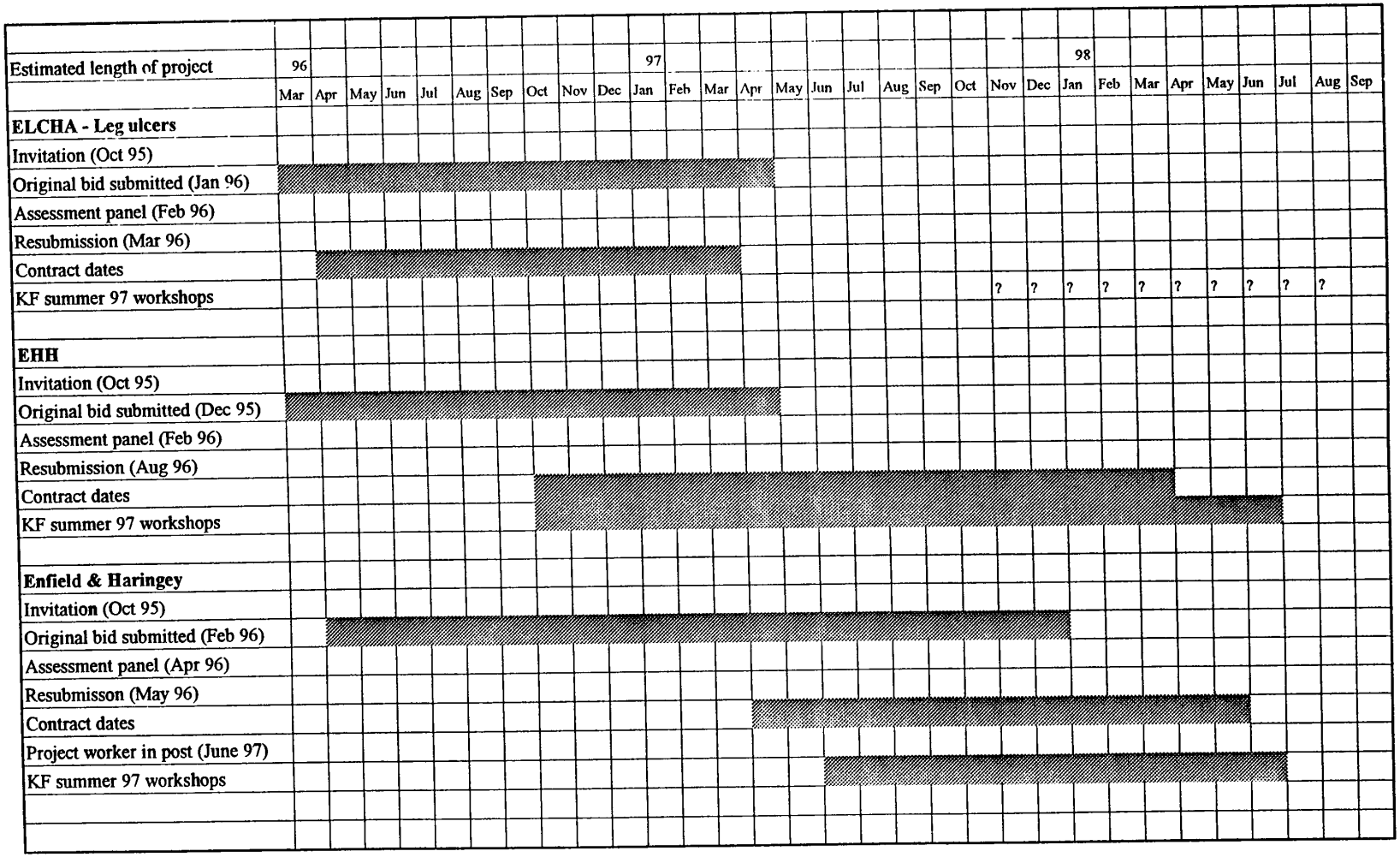
- Changes in referral patterns.
- Changes in A&E attendance/emergency attendances.
- Comparison of usage of guidelines between computerised GPs, booklet GPs and those with neither (control).
  Changes in disease parameters - prescribing, laboratory tests (HbA1cs for diabetes).
- Also want to include qualitative measure for change in GPs - plan to link into GP networks already in existence. Possible items: number of visits, membership/attendance of groups/telephone survey of GPs' adoption of guidelines?

Appendix C

TIMESCALES




Estimated length of project
96
97
98
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep
Brent & Harrow Open Access Echo
Invitation (Oct 95)
Original bid submitted (Apr 96)
Assessment panel (May 96)
Resubmission (July 96)
Contract dates
KF summer 97 workshops
Camden & Islington
Invitation (Oct 95)
Original bid submitted (Apr 96)
Assessment panel (May 96)
Resubmission (June 96)
Contract dates
Project worker in post (Mar 97)
KF summer 97 workshops
ELCHA - Cardiac
Invitation (Oct 95)
Original bid submitted (Jan 96)
Assessment panel (Feb 96)
Revised bid (Feb 96)
Contract dates
Project worker in post (Mar 97)
KF summer 97 workshops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ELCHA - Leg ulcers
Invitation (Oct 95)
Original bid submitted (Jan 96)
Assessment panel (Feb 96)
Resubmission (Mar 96)
Contract dates
KF summer 97 workshops
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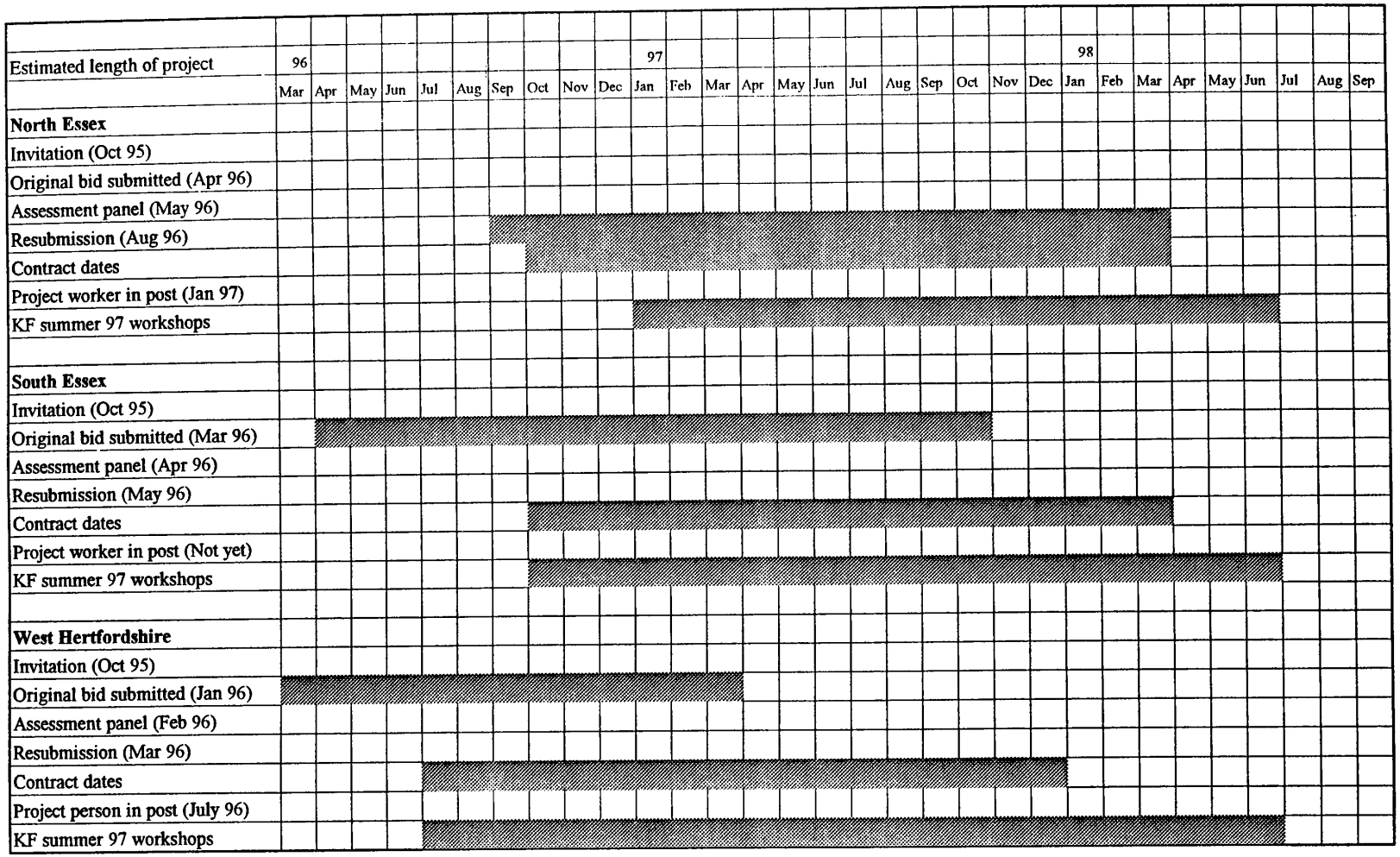
EHH
Invitation (Oct 95)
Original bid submitted (Dec 95)
Assessment panel (Feb 96)
Resubmission (Aug 96)
Contract dates
KF summer 97 workshops
Enfield & Haringey
Invitation (Oct 95)
Original bid submitted (Feb 96)
Assessment panel (Apr 96)
Resubmisson (May 96)
Contract dates
Project worker in post (June 97)
KF summer 97 workshops


Estimated length of project
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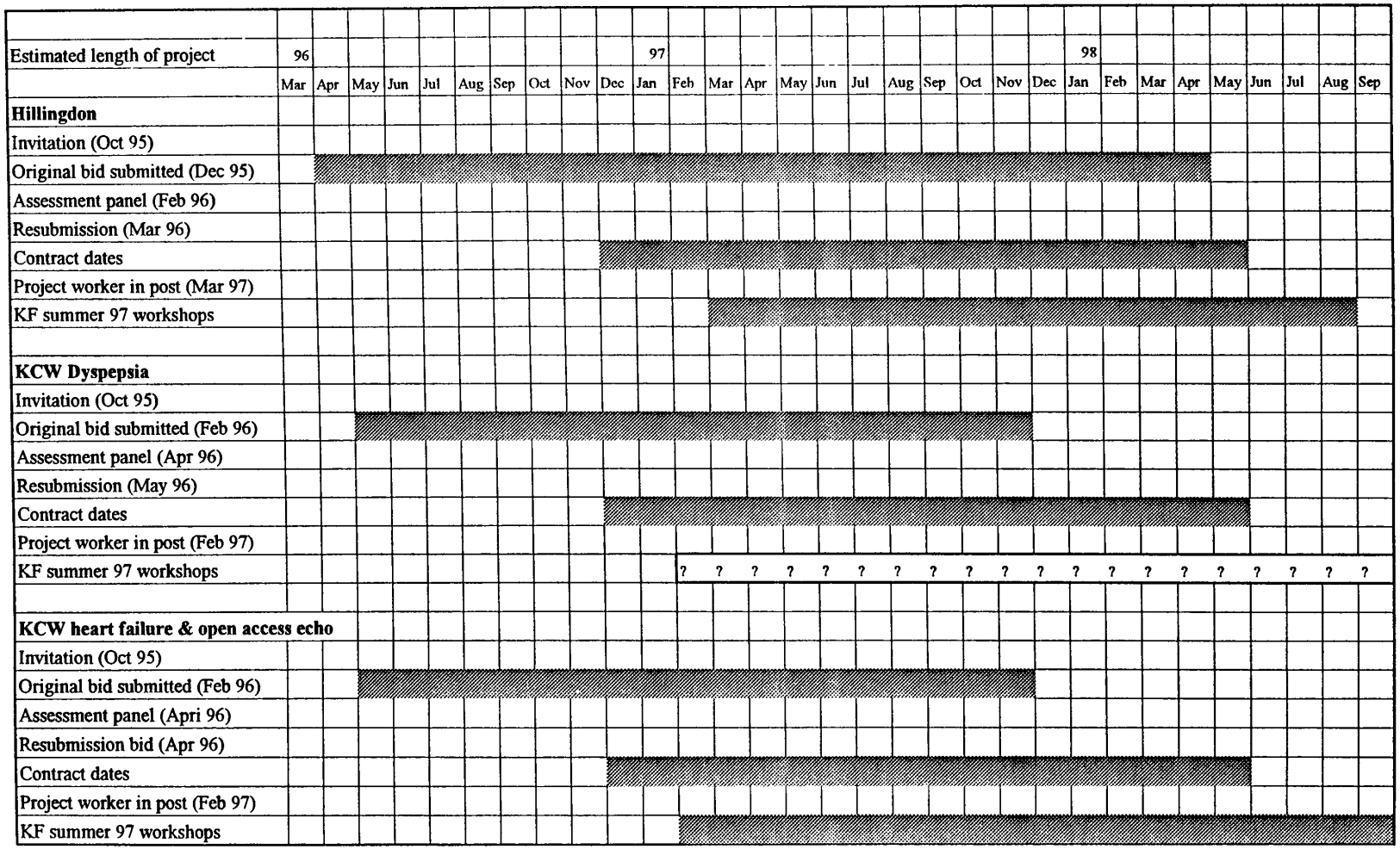
North Essex
Invitation (Oct 95)
Original bid submitted (Apr 96)
Assessment panel (May 96)
Resubmission (Aug 96)
Contract dates
Project worker in post (Jan 97)
KF summer 97 workshops
South Essex
Invitation (Oct 95)
Original bid submitted (Mar 96)
Assessment panel (Apr 96)
Resubmission (May 96)
Contract dates
Project worker in post (Not yet)
KF summer 97 workshops
West Hertfordshire
Invitation (Oct 95)
Original bid submitted (Jan 96)
Assessment panel (Feb 96)
Resubmission (Mar 96)
Contract dates
Project person in post (July 96)
KF summer 97 workshops


Estimated length of project
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97
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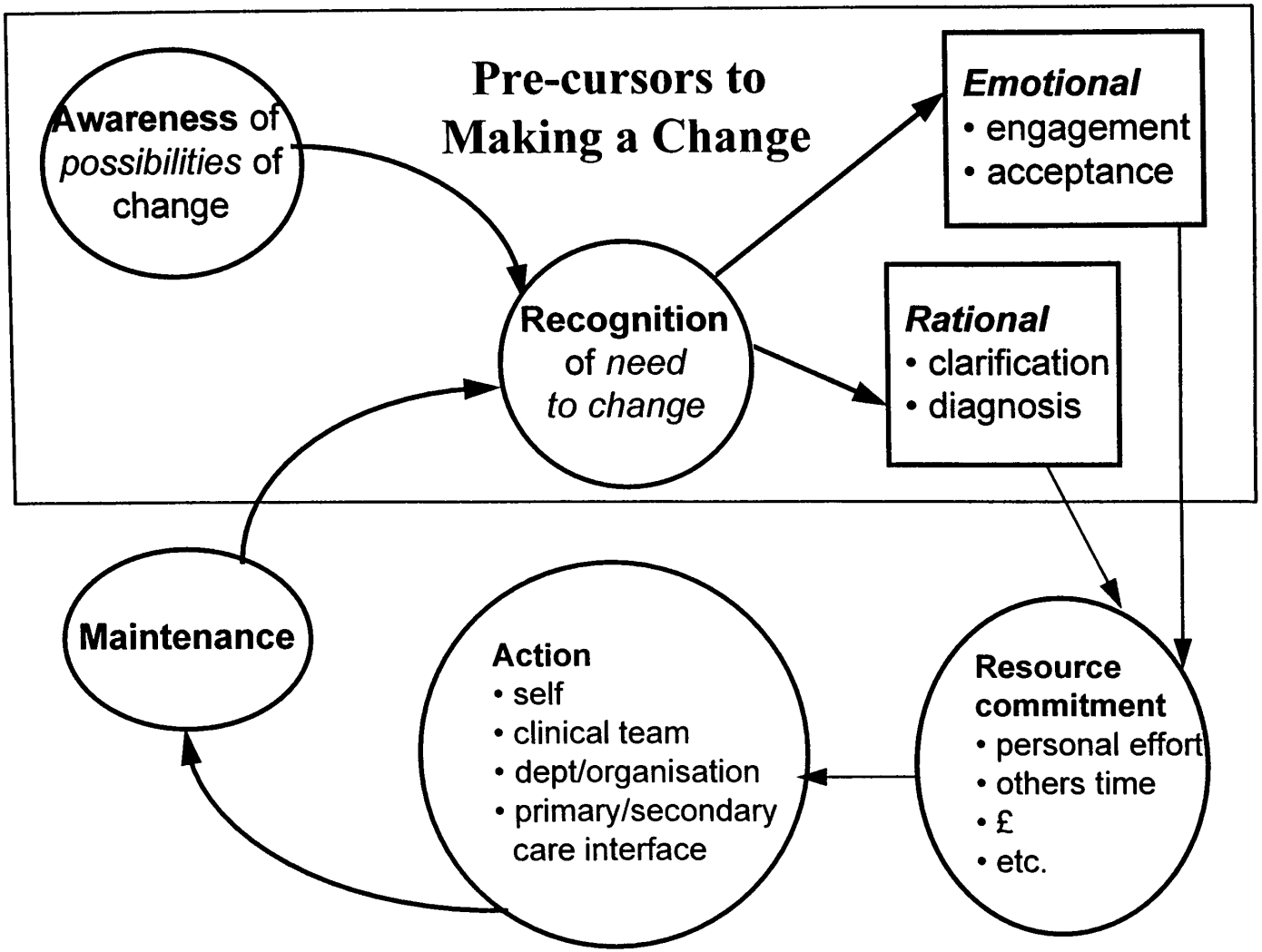
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep
Hillingdon
Invitation (Oct 95)
Original bid submitted (Dec 95)
Assessment panel (Feb 96)
Resubmission (Mar 96)
Contract dates
Project worker in post (Mar 97)
KF summer 97 workshops
KCW Dyspepsia
Invitation (Oct 95)
Original bid submitted (Feb 96)
Assessment panel (Apr 96)
Resubmission (May 96)
Contract dates
Project worker in post (Feb 97)
KF summer 97 workshops
? ?
KCW heart failure & open access echo
Invitation (Oct 95)
Original bid submitted (Feb 96)
Assessment panel (Apri 96)
Resubmission bid (Apr 96)
Contract dates
Project worker in post (Feb 97)
KF summer 97 workshops

Estimated length of project	96										97												98								
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Redbridge & Waltham Forest																															
Invitation (Oct 95)																															
Original bid submitted (Mar 96)																															
Assessment panel (Apr 96)																															
Resubmission (May 96)																															
Project worker in post (May 96)																															
Contract dates																															
KF summer 97 workshops																															

Appendix D


Pre-cursors to Making a Change
Awareness of possibilities of change
Recognition of need to change
Emotional
• engagement
• acceptance
Rational
• clarification
• diagnosis
Maintenance
Action
• self
• clinical team
• dept/organisation
• primary/secondary care interface
Resource commitment
• personal effort
• others time
• £
• etc.

Appendix E

North Thames Purchaser Led Implementation Projects

OBJECTIVES

Barking & Havering
Effectiveness Facilitator

Original Bid	Revised Bid	Spring 97	Summer 97
None	None	1. Strengthen links already established with post-graduate clinical tutors, GPs & medical audit co-ordinators 2. Encourage effectiveness issues to be discussed at GP post-graduate meetings and incorporate into teaching programme 3. Address and overcome barriers to acting on the evidence	1-3

Barnet-Low Back Pain & others

Original Bid	Revised Bid	Spring 97	Summer 97
None	None	1. Develop access to computer based information on types of procedures carried out by local providers 2. Encourage participation in and contribution to a cross district network to learn from a range of effectiveness work in varying stages of advancement 3. Foster three way dialogue between GPs, clinicians, purchasers, providers 4. Document and review role of GP fellow and identify how best such a role could be developed at local level	2-4 (1 dropped)

Brent & Harrow-A&E Protocols

Original Bid	Revised Bid	Spring 97	Summer 97
1. Develop series of evidence based protocols for the management of conditions commonly presenting to A&E	1-3	1-3	1-3
2. Develop system for improving adherence			
3. Evaluate impact of introducing protocol driven care within A&E			

Brent & Harrow-Open Access Echo

Original Bid	Revised Bid	Spring 97	Summer 97
1. Improve the management of heart failure by providing open-access echo for GPs	1-4	Not known	Not known
2. Ensure appropriate use of diuretics			
3. Increase appropriate use of ACE inhibitors			
4. Audit use of service by GPs and impact on out-patient waiting times as well as use of diuretics and ACE inhibitors			

Camden & Islington-H Pylori Eradication

Original Bid	Revised Bid	Spring 97	Summer 97
1. Implement strong research evidence for benefits of h. Pylori eradication in patients with peptic ulcer disease	1-4	1. Disseminate strong...	1-4
2. Improve uptake of eradication therapy in C&I		2. Improve appropriate...	
3. Ensure better value for money for expenditure on ulcer healing drugs		3-4	

4. Reduce no. of patients receiving long term acid suppression

East London & the City-Cardiac

One page Summary	Original Bid	Revised Bid	Spring 97	Summer 97
1. Involve clinicians in developing user friendly evidence resource	1. Initiate and ensure sustainability of training in evidence based medicine within cardiac directorate	1-4	1-4	1-2, 4 (same)
2. Involve clinicians in examining relation between strength of different forms of evidence & ratings of appropriateness & agreement generated by expert panel	2. Develop and disseminate evidence resource			3. ...revascularisation and angiography
3. Involve clinicians in examining association between relation of evidence based revascularisation to audit & commissioning	3. Develop set of guidelines for revascularisation			
4. Receive formal training in evidence based medicine to benefit career	4. Evaluate intervention			

East London and the City - Leg Ulcers

One page Summary	Original Bid	Revised Bid	Spring 97	Summer 97
1. Recruit in-house opinion leader	1-5	1-5	1. Cover maternity leave	1. Dropped
2. Commission clinical training programme for 80 community nurses & 20 practice nurses			2. Educate, train & facilitate health professionals on 9 sites	2. ...programme for THHT
3. A small fund to provide service cover			3. Support & educate long term patients who depend on nurse for social interaction	3. Meet needs of service users with support & education
4. Develop audit tool & quality assurance			4. Same	4-6 (same)
5. Evaluate			5. Link with ELCHA to ensure contracting reflects good practice	7. Reduce inappropriate referrals to complex
			6. Reduce variability on health gain & cost	

EHH **Diabetes Register**

Original Bid	Revised Bid	Spring 97	Summer 97
None	1. Accurately record number of known diabetics for which services have to be provided 2. Check that these patients have the minimum of an annual review 3. Enable practices to take part in more sophisticated programmes and to help improve patient care 4. Ensure multi-disciplinary input provided to diabetic care (medium term) 5. Monitor complication rates in order to evaluate quality of diabetic care being delivered locally (long term)	1,2,4,5 (same) 3. Dropped 6. Provide data to enable GPs and primary care health teams to manage their diabetic patients	1,2 (same) 3. (reinstated with change to) ...more sophisticated clinical audit 4 & 6 Dropped 5. (Changed to) Try to record diabetic complication rates and monitor progress of their reduction. 7. Provide reliable recall and review of all people with diabetes in EHH 8. Improve communications between all health professionals caring for people with diabetes

Enfield & Haringey- GP Learning Sets

Original Bid	Revised Bid	Spring 97	Summer 97
1. Increase ability of local clinicians to implement evidence based care 2. Develop sustainable skills in critical appraisal amongst local clinicians 3. Improve access to evidence required to determine appropriate response to clinical problem 4. Develop programme of evidence based self-directed learning at locality level 5. Improve clinicians' ability to identify and act on valid but brief summaries of high quality evidence 6. Communicate and disseminate lessons learnt to other GPs, purchasers and providers 7. Consolidate links between evidence based practice, clinical audit and continuing education	1-7	1-7	1-7 8. Ascertain study areas chosen and reason for topic choice 9. Demonstrate improvement in performance in topic area

North Essex **Cancer Services**

Original Bid	Revised Bid	Spring 97	Summer 97
Not Known	1. Collaborate with colleagues to develop & implement evidence based guidelines for breast cancer and colo-rectal cancer	1-6	1,2, 4 (same)
	2. Identify clinical trials into which the entry of eligible patients should be considered		3,5&6 dropped
	3. Develop information system to allow comprehensive view of clinical treatment and trial activity and facilitate clinical audit and local outcome studies		7. Actively promote joint clinical management to medical and surgical colleagues
	4. Look for opportunities to develop guidelines with colleagues for other common cancers		
	5. Facilitate process of entry into trials by patients		
	6. Evaluate project with before and after analysis of the appropriateness of referrals and activity in clinical trials		

South Essex-Hypertension in the Elderly

Original Bid	Revised Bid	Spring 97	Summer 97
1. Assess current treatment of patients aged 65-79 with hypertension	1-4	1. ...aged 60 to 79	1-4
2. Agree, based on published literature and local consensus, the best way to manage hypertension in this group		2-4 (same)	
3. Develop an implementation programme making best use of currently available resources to introduce agreed management plan			
4. Assess framework for implementing change			

Hillingdon-Dyspepsia

Original Bid	Revised Bid	Spring 97	Summer 97
1. Develop locally based method to implement changes in medical practice based on research evidence	1-4	1. Critically review existing local guidance and dissemination on the effective management of dyspepsia	1-3 (same)
2. Pilot this method on management of upper GI ulcer disease and h. Pylori eradication		2. Identify main issues and impediments to adherence of clinically effective practice	4. ...implement and evaluate...
3. Evaluate success of pilot		3. Develop strategy for improving uptake of clinically effective practice	5. Establish impact of this guidance
4. Use this model in other areas such as ACE inhibitors in chronic heart failure and use of aspirin and beta blockers after myocardial infarction		4. Implement this strategy	

KCW-Dyspepsia

Original Bid	Revised Bid	Spring 97	Summer 98
1. Identify barriers to change by GP focus groups	1-7	1. ...change by interviews and GP surveys	1,2, 4-7
2. Audit management of dyspepsia		2 (same)	
3. Determine reasons for patient preference for particular beta blockers		3 (dropped)	
4. Analyse prescribing patterns of different ulcer healing drugs		4. (Changed to) Use PACT data to determine prescribing patterns of different practices	
5. Review guidelines for management of dyspepsia		5. (Changed to) Convene small working group to re-work guidelines	
6. Promote guidelines to primary & secondary care		6. (Changed to) Re-launch guidelines	
7. Conduct follow up audit of management of dyspepsia and comparison of prescribing of different ulcer healing drugs		7. (Changed to) Determine success of new guidelines through re-audit, monitoring of prescribing data and interviews with GPs	

KCW - Heart failure & open access echo

Original Bid	Revised Bid	Spring '97	Summer '97
1. Develop locally derived guidelines for the management of heart failure include. Open access echo and consideration of ACE inhibitors for every patient with heart failure in primary care 2. Pilot open access echo service 3. Conduct retrospective baseline audit of heart failure diagnosis and management in participating practices 4. Audit use of open access echo in terms of uptake, appropriateness of referrals and change management 5. Evaluate primary care team perceptions of guidelines 6. Disseminate guidelines throughout HA if appropriate	1-6	1-6 7. Re-audit practices to establish how well guidelines implemented	1-7 (but different order)

Redbridge & Waltham Forest- asthma, diabetes, hypertension

Original Bid	Revised Bid	Spring '97	Summer '97
None	None	1. Integrate primary care into mainstream services with clarification of the referral criteria for GPs and specialists 2. Develop the commissioning of services from perspectives of diseases and care groups 3. Improve standards in primary care ad monitor them 4. Reduce unnecessary admissions to A&E	1-3 (same) 4. (Change to) reduce <u>unplanned</u> admissions <u>for selected conditions</u> 5. In the longer term, reduce disease complications

West Hertfordshire - anticoagulation

Original Bid	Revised Bid	Spring '97	Summer '97
1. Develop and agree pan herts guidelines for primary and secondary prevention in patients with lone atrial fibrillation	1-3	1. Understand warfarin use across Hertfordshire	1. (Change to) Assess present and future demand for care
2. Ensure development and implementation of guidelines		2. Undertake prevalence study to establish anti-coagulation across county	2-5 (same)
3. Audit		3. Assess current models of care	
		4. Introduce and evaluate nurse-led clinics in East Herts	
		5. Evaluate extension of nurse-led clinics in NW Herts	

Appendix F

Quality of Description of Intended Outcomes in Orginal Bids*

Not clear [1]	Further details needed [2]	Very clear [3]
Barking & Havering	East London and the City - Leg ulcers	Brent & Harrow A&E
Barnet	South Essex	Brent & Harrow Open Access echo
EHH	West Hertfordshire	Camden & Islington
North Essex	Hillingdon	East London and the City - Cardiac
Redbridge & Waltham Forest		Enfield & Haringey
		KCW - Dyspepsia
		KCW - Heart failure & open access echo

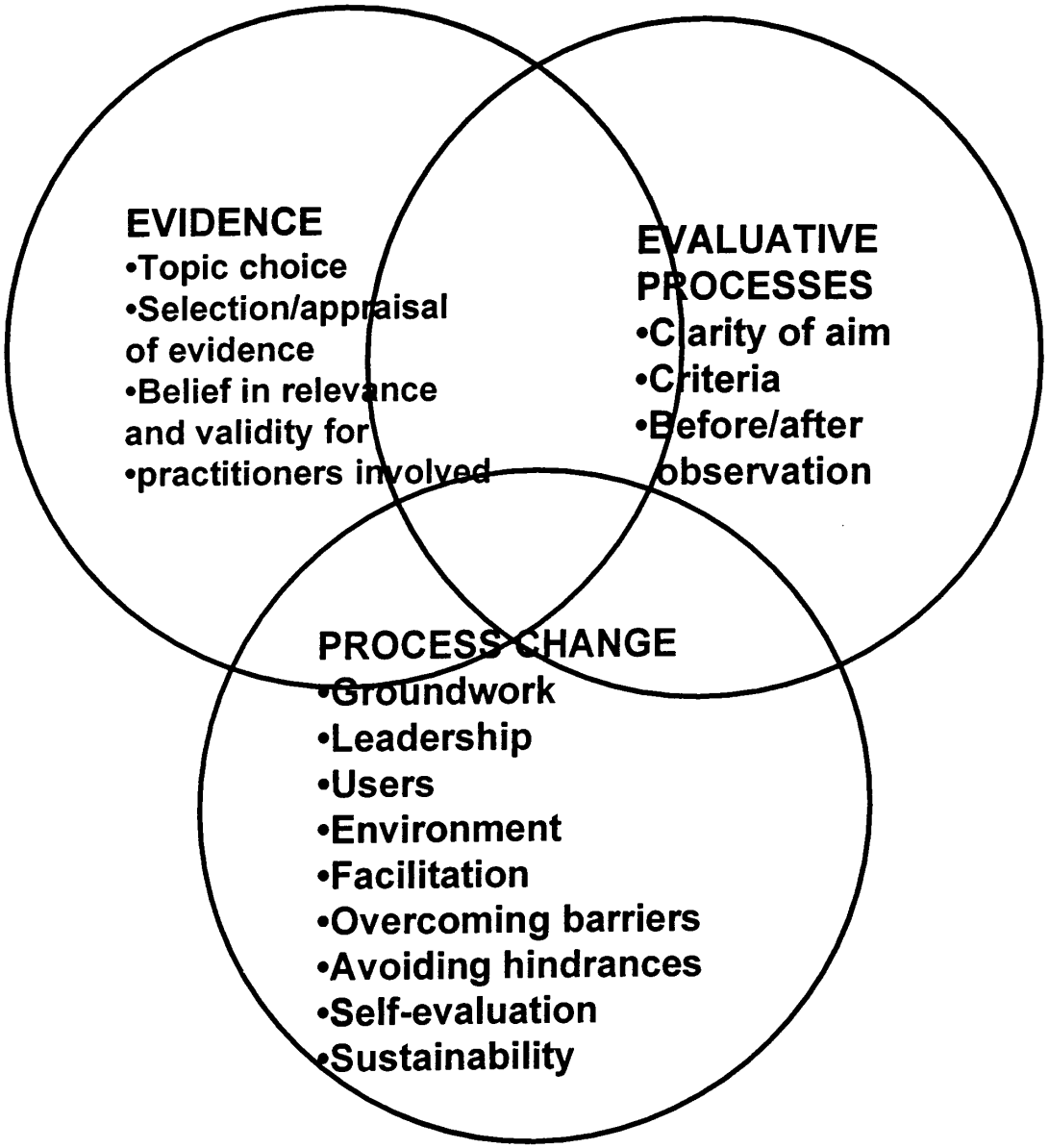
* Based on qualitative assessment of clarity of original bid as interpreted by non-participant

[1] Defined as no explicit aim, limited or no objectives, limited or no explanation of evaluation.

[2] Some explanation of aims and/or objectives but further details needed, usually of evaluation

[3] Explicitly stated aims with clear, often measurable objectives and detailed evaluation plan

Appendix G


EVIDENCE
•Topic choice
•Selection/appraisal of evidence
•Belief in relevance and validity for
•practitioners involved
EVALUATIVE PROCESSES
•Clarity of aim
•Criteria
•Before/after observation
PROCESS CHANGE
•Groundwork
•Leadership
•Users
•Environment
•Facilitation
•Overcoming barriers
•Avoiding hindrances
•Self-evaluation
•Sustainability

EVIDENCE
•Topic choice
•Selection/appraisal
of evidence
•Belief in relevance
and validity for
•practitioners
PROCESS
•Leadership
•Users
•Environment
•Facilitation
•Overcoming
•Avoiding
•Self-evaluation
•Sustainability

Appendix H

Dates of Final Reports for North Thames Purchaser Led Projects

NB all dates for 1998

April

Redbridge and Waltham Forest

East London and the City (cardiac project)

May

Brent & Harrow (A&E)

June

Ealing, Hounslow & Hammersmith

Enfield and Haringey

North Essex

West Hertfordshire

South Essex?

August

Camden & Islington

East London and the City (leg ulcers)

Hillingdon

KCW (heart failure & open access echo)

September

Barking and Havering

October

Barnet

Not known

Kensington, Chelsea & Westminister (dyspepsia)

Brent & Harrow (open access)

Appendix B

Dates of Final Reports for Month Three Pilots

All dates for 1998

April

Redbridge and Waltham Forest

East London and the City (cardiac project)

May

Brent & Harrow (ACE)

June

Ealing, Hounslow & Hammersmith

Enfield and Haringey

North Essex

West Hertfordshire

South Essex?

August

Camden & Islington

East London and the City (leg ulcers)

Hillingdon

KCW (heart failure & open access endo)

September

Barking and Havering

October

November

December

January 1999