Successful Purchasing

FROM INFORMATION TO ACTION

Case Studies in the Use of Health Related Information
for Purchasing and Commissioning

Shirley Holton
Gill Needham

Buckinghamshire Health Authority

KINGS FUND COLLEGE

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Executive Summary

These six case studies describe how purchasers, one of them a fundholding practice, bought interventions to improve the health of local populations in direct response to information which had revealed particular needs. The case studies have been published as examples of good practice because this effective and appropriate response is still a rare event. Many purchasing organisations produce information for health needs assessment, but few succeed in translating it into action and purchasing plans rarely reflect issues raised in the annual reports of Directors of Public Health.

The case studies are also about the different levers purchasers have used to achieve change. The raw power of a fundholder who can and does contract for services from named consultants contrasts with the health authority which must obtain the co-operation of an array of partners to ensure success or the health authority which threatens to withdraw custom from a major provider but has to calculate the costs of doing so.

Who takes the lead in commissioning is also an issue. In one case study, the Director of Public Health stepped outside the traditional boundaries of his role into that of commissioner. This direct route to "operationalising" public health is something which other Directors might consider if public health is to become a major influence within purchasing.

Purchasers wishing to emulate the six described in the case studies should note that the information used to identify the initial problems was relatively simple and derived from routinely collected or survey data. The factors for ensuring success which have emerged as common themes from the studies are summarised in the final section of this report.

Foreword

We are very pleased to contribute the foreword to this report, which highlights the importance of the application of information in the commissioning process and points to some of the ways in which commissioning organisations have successfully improved health as a result of using information effectively.

As the internal market develops, purchasers are becoming more sophisticated, confident and effective. At the King's Fund College, the Purchasing Innovations Project exists to help purchasing progress by spreading good practice nationally and facilitating networking between purchasing professionals. It is therefore appropriate for this inspiring, yet essentially practical report, to be distributed with the co-operation of the Purchasing Innovations Project.

The Buckinghamshire Health Authority team who compiled the report are public health and information specialists working "at the sharp end". The case studies they have made demonstrate how significant purchaser-driven improvements in the health of local communities can be achieved. Purchasing intelligence has underpinned these achievements. Purchasers have used information as a doctor uses a stethoscope - to diagnose the need for change - and then employed a variety of levers, including the information itself, to achieve their objectives.

We hope this report will, in a small way, contribute to the continued development of purchasers' abilities to improve health and health services.

Jackie Haynes
Chief Executive
Buckinghamshire HA

Peter Griffiths
Director
King's Fund College

The Project

This collection of case studies is the product of a one year Purchaser Development project funded by the NHS Executive, with additional support from DISP3. A short project report outlining the background and methodology is available from the authors on application.

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Introduction

> *"Information and intelligence are the life-blood of purchasers. Their decisions must be based on sound evidence about health needs, clinical and cost effectiveness and costs and prices"* [1]

The six case studies which follow are examples of good practice in the use of information as a trigger for action by purchasers to bring about beneficial change. We have disseminated them in the hope of encouraging others because, despite the mammoth investment in information systems and technology which accompanied and supported the introduction of the internal market, the potential of information remains largely untapped.

All Annual Reports of Directors of Public Health contain information describing their concerns about the health status of the population and suggestions for the purchase of new or better interventions to improve matters. Rarely however, do subsequent purchasing plans contain any direct response. An analysis of 1993-94 purchasing plans from 100 health authorities found that:

> *"the plans tend to be rich in information about the health status of the population being served and variations within the district, but poor in information about the services on offer and their adequacy or otherwise in addressing the health needs of the population"* [2]

Each case study describes the way purchasers responded to information about health status and service provision. In five of the six, the purchaser is a District Health Authority alone or in partnership with the corresponding Family Health Service Authority. In the sixth, the purchaser is a fundholding practice. The information was derived using either routinely collected, or special survey data. Routine sources included hospital episode statistics (HES), health service indicators (HSIs), Korner data, Office of Population Censuses and Surveys (OPCS) data and primary care audit data. The responses exemplify ways in which purchasers can bring about change. They include:

- using clinical guidelines as an aid to disinvestment
- use of purchasing power to improve service quality and value for money
- partnership with a provider to revitalise an ailing service
- creativity in purchasing interventions to reduce teenage pregnancy
- changing clinical practice and buying better services: a fundholder's experience
- purchasing primary care in response to "local voices"

We have included factors which interviewees described as enabling or acting as a barrier to success, and lessons which they felt the process had taught them.

We also found that some common themes emerged from the studies and these are summarised in the final section as ingredients in the recipe for success.

References

1 Brian Mawhinney Speech: "The Vision for Purchasing" April 1993

2 Redmayne S, Klein R, Day P. "Sharing Out Resources: Purchasing and Priority Setting in the NHS" Research Paper No.11. NAHAT: Birmingham 1993

CASE STUDY 1:

OPHTHALMOLOGY IN BOLTON

An "ailing" service failing to meet the needs of the population was identified by an extensive local needs assessment project and acknowledged as a problem by both purchaser and provider. Purchaser investment in a new unit and a service "champion" with energy and vision produced dramatic results.

Background

Bolton Health Authority commissions services for a resident population of 263,837 (OPCS 1992). Approximately 40,000 residents (15% of the total) are aged 65 and over and current projections forecast an increase of 8% by 1998 in persons aged 85 and over.

The demographic structure of the population and the known increase of visual problems with age, make ophthalmic and other related services an important health issue for the district.

In 1991, a project to assess the needs of older people with sight problems, funded by the NHSE DHA Project, was carried out by the Salford Public Health Research and Resource Centre (PHRRC) in four districts of the North West Region, including Bolton. This case study is concerned principally with the findings of that project which relate to the major provider of acute ophthalmic services to Bolton residents and with the response of the purchaser.

Problems

Hospital activity constitutes only a limited part of the services for visual impairment but consumes the greatest proportion of resources. Even before the survey was commissioned the health authority was concerned about the ophthalmology service as delivered by their main acute provider unit.

"The waiting times were regarded as unacceptable, little day surgery was carried out, the surgical techniques were old-fashioned and the unit appeared low key"

(Director of Public Health)

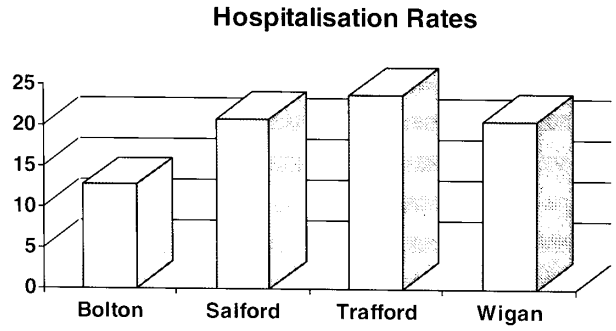
	Waiting 1 yr+		Hospitalisation	
	%	RANK	RATE	RANK
Persons Aged 65 +	25	86	13	11

TABLE 1 *Percentage on waiting list 12 months and over and hospitalisation rate for ophthalmology with national rankings: persons aged 65+: Bolton 1990*
Source: *HSIs*

The Health Service Indicators for 1990 had shown that when Bolton's acute ophthalmology service was compared with those of all other districts in England, only 14% of all other districts had a higher percentage of elderly waiting more than 1 year for an eye operation and 89% of districts had more elderly having eye operations pro rata (TABLE 1). It was obvious that some aspects of identified need were not being met.

Analysis of routine data by the PHRRC as part of the four-district survey showed that the frequency with which elderly Bolton residents were admitted to hospital for eye surgery was much lower than in the other three districts (FIGURE 1).

FIGURE 1 *Comparison of hospitalisation rate/1000 resident population 65+ for ophthalmology in the 4 districts (1990/1).*
Source: *PHRRC Survey*



The percentage of day surgery performed by the major provider for each district was also lowest in Bolton (FIGURE 2).

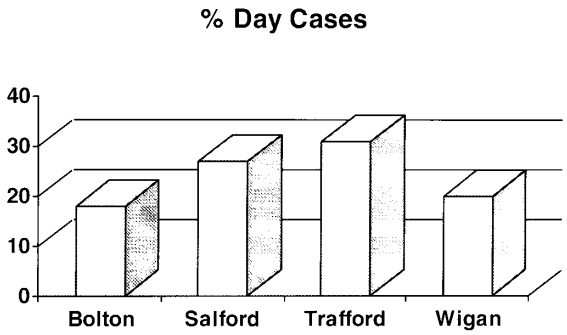


FIGURE 2 *Percentage ophthalmology day surgery by major provider for each of the 4 survey districts: 1990-91*
Source: *PHRRC Survey*

A comparatively low rate of new ophthalmology outpatient attendances was also identified for Bolton by a 2 month survey (FIGURE 3).

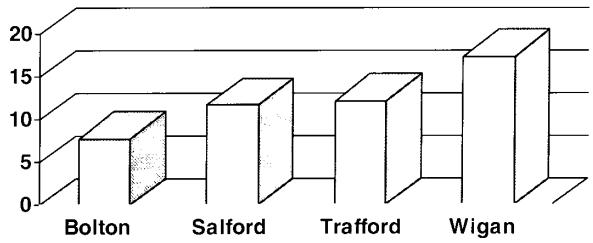


FIGURE 3 *New outpatient attendance rates per 10,000 total population by district of residence: results of a 2 month survey 1990-91*
Source: *PHRRC Survey*

A survey of self reported visual impairment in a sample of persons over 65 in each of the four districts to estimate local prevalence found the highest proportion (16%) in Bolton. This seems broadly to accord with the data illustrated in the figures above, although the relationship is likely to be a complex one.

Purchasers and providers both agreed that these variations revealed significant problems. A picture was emerging of unmet need in the elderly population, poor access to services and poor quality. It was also acknowledged that for a number of reasons, including long term sickness, the ophthalmology service lacked leadership and advocacy, that this was a key factor, and that revitalisation was required.

Solutions

Acute Services

The purchasers funded the appointment of another ophthalmic consultant to increase the department's activity and also to act as service champion and advocate. When the new consultant came into post in 1992, he proceeded to galvanise purchasers and providers into action to improve the service and raise its profile. He discovered that the facilities for ophthalmology, particularly the theatres, were such that the provision of a modern service was all but impossible.

To make this a priority for action, he organised an external assessment of the staffing and facilities, first obtaining the agreement of general management and the medical executive.

The subsequent report by a professor of ophthalmology and the chairman of the Regional Speciality Sub-committee had the desired effect. Centralisation of all acute services onto one major hospital site was currently under way and the providers were persuaded that ophthalmology should be moved first. In addition, purchasers agreed to fund the renovation of two former geriatric wards on the new site from capital and waiting list money to form a dedicated ophthalmology unit. This became operational in early 1994.

Activity increased dramatically. TABLE 2 shows the increases in throughput of inpatients and outpatients and the rise in day case surgery.

	1990 - 91	**1993 - 94**
OP Sessions	459	544
New OP Attendances	2222	3675
% Day Cases	19	54
IP Episodes	620	1077

TABLE 2 *Outpatient (OP) and inpatient (IP) ophthalmology activity: Bolton 1990-91 and 1993-94*
Source: *KH09 and HES*

The new consultant was soon joined by another young and energetic colleague and by the end of September 1994, the "long waiters" had disappeared. No-one had been waiting for admission as an inpatient or as a day case for a period of 12 months or longer.

Quality improvements in the service as described by the consultants include:

- intraocular lens implantation programme: 98% patients with cataract have this routinely compared with 5% in 1990-91
- retinopathy clinic
- use of diagnostic ultrasound
- age related maculopathy service
- botulinin toxin treatment for squint

Other Issues

Both purchaser and provider acknowledge that these improvements have not resolved all the problems uncovered by the Visual Impairment Needs Assessment Study. Others are being addressed through a multi-agency working party representing DHA, FHSA, GPs, providers, Social Services, optometrists and the local voluntary sector. This group has examined two major conclusions of the study, namely that access to appropriate ophthalmology services is seriously hampered by:

- a lack of information for clients about the services and facilities available
- poor communication between different agencies.

Solutions developed to date are a directory of local and other services for the visually impaired funded by the purchaser and the use of shared care patient notes.

In addition, the consultants have set up a teaching programme for local GPs and optometrists, supported by the FHSA and the Postgraduate Medical Education Department who have jointly purchased a specialised piece of video equipment for filming eye operations. The consultants are keen to expand their teaching role. They believe that inappropriate referrals could be reduced by increasing GPs' confidence and expertise in this area.

Enabling Factors for Change

The main factors identified were:

- common acceptance by both purchaser and provider "based on good data and sound evidence" that there was a problem
- purchaser commitment to improve the service
- a "good appointment": the energy and vision of the consultant whose appointment led to most of the development.
- general agreement about the importance of ophthalmology as a health issue for the district
- an external assessment of the poor facilities by acknowledged experts:

"Their report was the key to making this an urgent problem which had to be dealt with"
(Consultant Ophthalmologist)

Barriers to Change

- the reactions of other specialities: *"vested interests"*
  (Director of Commissioning)
- the provider's problems of developing the department and increasing staffing levels with short term funding:

"use of the waiting list initiative for short-term fixes"

(Consultant Ophthalmologist)

Lessons Learned

Lessons learned for the future were:

- purchaser and provider together need to assign problem status to an issue, agree on desired objectives and also the means of achieving them within a timescale acceptable to both parties

- local partnerships facilitated by purchasers are important in achieving change:

"An important purchasing role is to bring people together creatively to find and develop solutions. Projects can help to bring people out of isolation and move them forward collectively"

(Director of Public Health)

- the stimulus provided by creative and charismatic individuals:

"We need entrepreneurs. Ophthalmology previously received less revenue because clinicians were not coming up with exciting schemes"

(Director of Public Health)

- the importance of local ownership of a service:

"We have to have Bolton ownership: the local GPs feel they have achieved something with the unit, they can be proud of it"

(Consultant Ophthalmologist)

- information derived from routinely collected data and from local surveys by professional researchers external to both purchaser and provider may be perceived more objectively and carry greater weight than work undertaken internally

- external assessment by acknowledged experts of the resources available to a service may be perceived more objectively by purchasers and by provider managers

This account is based on interviews with the Director of Public Health, the Director of Commissioning, two Consultant Ophthalmologists and telephone discussions with staff at the PHRRC.

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Weston South, gives particular cause for concern. Weston South ward, with a population of approximately 8,000, has a Jarman score of +29.6, indicating an area which has the potential to generate a heavy workload for primary care. It includes three older style council estates, one of which, Bournville, houses 5,500 (69%) of the ward's population. Bournville also has two hostels for the homeless which provide shelter mainly for very young, single mothers and their infants. When these families are rehoused, it is usually on the estate. The whole ward is geographically situated within a triangle formed by the main railway lines:

"These railway lines serve to emphasise the area's isolation"
(Locality Profile: Weston South Ward)

For a range of health indicators, including premature death, the population of this ward has rates which are significantly worse than the district average.

The use of hospital services including A&E attendances by people from Weston South ward is also significantly higher than the district average (TABLE 1).

	Number	SAR	95% CI*
Emergency Admissions			
Medical	234	**160**	**140-181**
General Surgery	119	**241**	**199-287**
First Attendances			
A&E	3,786	**371**	**362-381**

* *95% Confidence Intervals*

TABLE 1 *Standardised admission/attendance ratios for emergency admissions to and first A&E attendances at Weston General Hospital : Weston South Ward Residents 1992/3 [Bristol & District = 100]*
Source: *Locality Profile, Weston South Ward*

Primary Care

The Director of Public Health questioned this disproportionate use of emergency care as symptomatic of a problem with access to primary care:

"The use of hospital services to this extent may be appropriate but a primary care response may be more desirable ..... primary care alternatives should be explored"
(Report of the Director of Public Health, April 1993)

More direct evidence that Weston South ward residents needed, and wanted, better access to primary care services came from:

- a ward profile by a local health visitor (1991):

"In general, GPs are reluctant to take on patients in Weston South because they are perceived as high need ..... high demand ..... poor attenders for item of service procedures"

- a local survey of Bournville estate residents, initiated by community workers, to elicit opinions of local primary care provision, which at that time consisted of one branch surgery of one of the three practices serving the area:

"While the performance of the GPs was very good, there were problems associated with the process of going to see the doctor. 'The doctor is brilliant! But you have to wait two weeks for an appointment.' Most people (72%) had complaints about the service.....the most common was the time waiting for an appointment. Other problems included time waiting in the surgery and..... 'it's never open for long'. Significant numbers also found travel to the surgery difficult. 'There is no bus service...', while many 'cannot get on the doctor's list at the Bournville surgery'. There is a clear demand for a full service primary care facility on the estate."

- discussions between the Health Authority, local GPs and health workers 1992-93

- representations from the Community Health Council 1992-93:

"Health watchdogs have renewed their call for improvements.....at the Bournville surgery"
(Newspaper Report)

- the outcome of a successful community development and empowerment project, Look After Your Heart-Avon (LAYH) 1992-93, on the Bournville estate sponsored by the Health Education Authority which suggested that while better access to primary care was needed, the medical model for improving the health of residents was not entirely appropriate:

"Work done by....the project worker suggests that problems...would...benefit from a health education and community empowerment strategy combined with access to appropriate primary care"
(Proposal for Regional funding)

- an analysis of A&E attendances made by Bournville residents during April 1993, by diagnosis:

"It does...illustrate that many minor injuries and illnesses that present could be dealt with by accessible GP surgeries. It also supports...the need...to boost [residents'] confidence in dealing with some of the minor injuries themselves"

Solutions

The health authority made a successful bid for Regional primary and community care initiative money to fund a locality centre in Bournville to host any GP who has patients on the estate and form a base for other members of the primary care team.

In addition to the usual primary care facilities, the centre includes a minor treatment room, staffed by nurses with a remit to provide minor first aid, health education and, where needed, referral to the A&E department or for a GP appointment. Any resident of the estate may attend for treatment or advice. The community empowerment model is supported by a "generic" health visitor/community worker, not attached to any one practice, who will

CASE STUDY 2:

ACCESS TO PRIMARY CARE

ON THE BOURNVILLE ESTATE, WESTON-SUPER-MARE

Locality profiles assembled by gathering epidemiological information and listening to "local voices" identified a community within a large population with problems of access to primary care. The purchaser responded by securing Regional funding for an innovative primary care centre which would address the particular needs of the area.

Background

Bristol & District Health Authority was formed in 1991 from the merger of Frenchay, Southmead and Bristol & Weston health districts, and has now merged with the corresponding FHSA to form Avon Health. It is one of the largest districts in the country, with an estimated resident population of 831,350 in 1992, predicted to have increased by only 1% overall by 1998, but with a 17% increase in persons aged 85 and over in that time period. It covers a geographical area which includes the city of Bristol, Weston-super-Mare and the surrounding towns and countryside in the county of Avon.

To define local health issues for this large population, 23 localities were identified by grouping electoral wards within each of Avon's five local district council areas according to their demographic and socio-economic characteristics. Postcoded health event data (e.g. hospital admissions), local survey information about health related behaviour (e.g. smoking, alcohol consumption), information derived from birth and death registrations and other sources were then used to build a picture or profile of the health needs of each locality.

Problems

Weston South

The locality profiling exercise identified Weston South locality as an area of particular need. Weston South, one of the six localities of the Woodspring Local District Council Area, is a group of four wards in the town of Weston-super-Mare. One ward of the four, also called

continue and develop the work started by the LAYH project. Staff not employed by practices will be employed by a local health Trust.

Outcome measures for the success of this venture are

- reduction in use of the Weston General Hospital A&E department
- reduction in use of secondary services
- expressed satisfaction with services
- longer term improvement in health status

The funding secured from the Regional Primary and Community Care Initiative is for three years, to be continued by the DHA. By August 1994, the generic health visitor was in post, advertisements for treatment centre nurses had been placed and the centre, currently an extension to an existing building, was being re-built. It at the end of October 1994.

Enabling Factors

- good epidemiological information, particularly the locality profiles
- good information derived from listening to "local voices"
- the work done by, and the individual skills and energies of, the LAYH worker:

"He galvanised people to express their views by building their confidence. He raised their expectations. He was a skilled negotiator and a powerful advocate"

(Consultant in Public Health Medicine)

- successful application for funding from the Regional Health Authority
- the macroclimate concerning primary care initiatives:

"A national belief in the value of primary care at local level as the best way of delivering healthcare"

(Deputy Director of Contracting)

Barriers

Only one was identified:

- the attitude of local GPs who opposed the centre initially

The reasons given were:-

- the implied criticism of their services
- disruption of links within existing primary care teams

- *"other areas of Weston are equally deserving"*

Lessons Learned

- health problems may require solutions other than traditional health services

"You can't always solve a problem that you've identified through your own measuring tools with healthcare solutions. Housing or benefits might be much more important"
(Consultant in Public Health Medicine)

- the importance of communication with local GPs
- the importance of listening to "local voices"

This account is based on interviews with the Deputy Director of Contracting who leads the Bournville Project, a Consultant in Public Health Medicine and the Research and Development Manager.

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CASE STUDY 3:

ELECTIVE D&C IN BUCKINGHAMSHIRE

Guidelines for the management of dysfunctional uterine bleeding in younger women, developed by a group of clinicians, have enabled a purchaser to exclude D&C in women under 40 from all contracts for acute services. The guidelines were developed to standardise the management of this condition against best clinical practice, in response to local variations in admission rates.

Background

Buckinghamshire Health Authority has a population of 640,000 and was established in April 1993 by the merger of Wycombe, Aylesbury Vale and Milton Keynes health districts. For planning purposes each of the former districts has become a locality, with its district general hospital, now a Trust, as the major provider of acute hospital services to its residents.

Problem

A review of standardised admission ratios for the most common elective procedures by locality of residence in Buckinghamshire showed significant variation for dilatation of the uterine cervix and curettage of the uterus (D&C) operations in women below the age of 40.

TABLE 1 shows a marked difference in the frequency with which these operations were being done, depending on where women lived in the county, standardised admission ratios varying from 66 to 159.

YEAR	LOCALITY OF RESIDENCE					
	A		B		C	
	No.	**SAR**	**No.**	**SAR**	**No.**	**SAR**
1992 -93	89	84	124	66	221	159

TABLE 1 *Numbers of elective D&C operations and Standardised Admission Ratios in women aged 15 to 39 by locality of residence in Buckinghamshire: 1992-93 [Bucks = 100]*

Source: *HES*

The most common reason for elective D&C in this age group is dysfunctional uterine bleeding (DUB), heavy periods with no abnormal cause for the bleeding. This condition may be so severe that it interferes with the quality of life and many women seek medical help. The operation is an aid to diagnosis, curettage providing a sample of the endometrium or lining of the uterus for microscopic examination. There is no evidence that the procedure, in itself, is of therapeutic benefit.

While this work was in progress in Buckinghamshire, the British Medical Journal published a paper by Angela Coulter and her colleagues[1] evaluating the appropriateness of diagnostic D&C. The authors reviewed studies from a number of places, notably America where D&C rates have fallen to very low levels, and concluded that routine endometrial sampling by D&C for women under 40 who were at minimal risk of endometrial cancer, was not appropriate.

Not only is the procedure now acknowledged to have no therapeutic value for women with dysfunctional uterine bleeding, but it is in any event, outmoded as a method of endometrial sampling. If required, there are newer and less invasive techniques which can be done, some without anaesthetic in outpatient clinics. The implication was that many women had a costly stay in hospital and were subjected to the risk of an anaesthetic for an unnecessary procedure.

Solutions

Using Information

The work on standardised admission ratios had been carried out as an exercise in routine surveillance by a Consultant in Public Health Medicine who now saw that this and the evidence in Coulter's paper presented an opportunity to standardise the management of DUB in younger women across the county to best clinical practice.

"I had to take this information forward into the purchasing arena where it would be used. Too often information just circulates round a department and no-one does anything with it"
(Consultant in Public Health Medicine)

The channel for communication in this case was Buckinghamshire's Acute Focus Group, a forum for discussion of matters relating to the purchase of acute services. It was chaired by the Director of Planning and members included representatives from all departments in the health authority, as well as from primary care.

The information and the suggestion that it could be put to positive use, giving the health authority an opportunity to disinvest in an inappropriate intervention, was received with enthusiasm by all members. A small working group was set up consisting of two public health physicians and, most importantly, a GP who was a fundholder, a member of the Local Medical Committee (LMC), and an opinion leader.

"I suppose we could say that after that the rest was history. He was our product champion and without him we couldn't have done it - or at least it would have been much more difficult"
(Consultant in Public Health Medicine)

Developing the Guidelines

These doctors defined their desired end product as a set of guidelines, preferably in the form of an algorithm or flow chart, which would describe the management of DUB in women under 40, beginning with the first visit to the GP. To be credible and acceptable to clinicians, the guidelines would have to be developed by clinicians, GPs working with Consultant Gynaecologists.

The public health physicians saw their role as one of facilitation. This included providing and interpreting information, doing literature searches, arranging meetings and generally acting as a secretariat to support the development process.

This idea formed the basis for a proposal to the LMC whose members were very supportive. Three LMC representatives - one GP from each locality - each met a representative of their local gynaecologists. The 'script' for their discussions was a draft flow chart which the public health physicians had prepared from a literature search to establish current best practice. Best practice, as it turned out, placed the foundation of treatment for DUB firmly within primary care, emphasising the GP's role as an effective 'gatekeeper' for secondary care. After several redrafts, a final set of guidelines was agreed by all clinicians involved and endorsed by the LMC.

Contracts

The Authority realised the opportunity to disinvest in an ineffective and inappropriate intervention by stating in all 1994/5 contracts for acute services that:

"D&C operations will not be purchased in women under 40 unless there are 'specific clinical indications' "

(Buckinghamshire Purchasing Plan: 1994-95)

Changing Clinical Practice

Guidelines are only a first step and their dissemination within the district is already in progress. The strategy for this reflects the growing literature on professional behaviour change in health care. It includes:

- the use of medical audit in primary and secondary care
- opportunistic use of postgraduate medical education programmes
- special multi-disciplinary educational events
- using GP opinion leaders in an informal way

Informing the Public

As the clinical algorithm includes the patient as a decision maker in choosing their own treatment, all potential patients must be able to make an informed choice. Furthermore, women should understand that it is legitimate to seek medical help for a physiological condition which has become unmanageable. In the longer term, pressure from informed patients is one of the subtler ways of changing clinical behaviour.

With the help of a local health information service, two leaflets have been developed to provide this information, using the experiences of women who have this condition. These were "launched" with a local media campaign in Spring 1995.

Evaluation

The ultimate measure of success will be a substantial reduction in the numbers of elective D&Cs in younger women.

Even when dissemination had hardly begun, the figures for 1993-94 showed a reduction in elective D&C in the younger age group in each locality and the proportion of all D&Cs which were done for DUB has fallen from 67% to 49% (TABLE 2).

YEAR	LOCALITY OF RESIDENCE							
	A		B		C		BUCKS	
	No.	**Rate**	**No.**	**Rate**	**No.**	**Rate**	**Rate**	**% DUB**
1992 - 93	89	3.2	124	2.6	221	6.0	3.9	67
1993 - 94	30	1.1	83	1.8	114	3.1	2.0	49

TABLE 2 *Numbers of elective D&C operations and admission rates per 1000 women aged 15 to 39 by locality of residence in Buckinghamshire: 1992-93 and 1993-94*
Source: *HES*

Evaluation will also be done through medical audit in primary and secondary care and the project has become part of the wider NHS Executive Anglia & Oxford GRiPP (Getting Research into Practice and Purchasing) project, which will be evaluated separately.

Post Script

The Buckinghamshire LMC have commissioned more work from the same team, this time to develop guidelines for the management of dyspepsia in adults.

Enabling Factors for Change

- information which described local variations and raised interest
- an organisational structure which allowed information to be communicated
- an organisational culture which used - and valued - information

- commitment and support from primary care: from individual GPs and from the Local Medical Committee

"I find it [the guidelines] an enormous help: I can explain to my patients that this way of proceeding has been developed by a group of doctors as the best practice and they understand"

(GP Fundholder)

- support from Consultant Gynaecologists:

"This is one of the better things to come out of purchasing"

(Consultant Gynaecologist)

Barriers to Change

- initial resistance from some Consultants who perceived implied criticism

"The information was the trigger, it wasn't the issue. It raised sufficient interest to get people working together on a more effective intervention, which was necessary anyway"

(Consultant in Public Health Medicine)

Lessons Learned

- the essentially slow nature of this work:

"It's all about gaining trust. This takes time and hard work"

(Consultant in Public Health Medicine)

- the importance of clinician-led development of clinical guidelines:

"We have no credibility as clinicians"

(Consultant in Public Health Medicine)

- the role of public health medicine as facilitator:

"This is important and something which displays our skills"

(Consultant in Public Health Medicine)

- the importance of local legitimisation and ownership of guidelines:

"It's not about waving big sticks, what it's really about is hearts and minds"

(Director of Public Health)

- the role of contracts as a "rubber stamp":

"When we started, we really thought that the contract was the key to changing things and that it was our only lever. We quickly realised that the contract only puts the seal on what has already been agreed. The key is working with local clinicians"

(Director of Planning)

This account is based on interviews with the Director of Public Health, Consultant in Public Health Medicine, Director of Planning, and access to transcripts of interviews with GPs and Consultants as part of the evaluation process.

Reference

1 Coulter A, Klassen A, McKenzie IZ, McPherson K. "Diagnostic Dilatation And Curettage: Is It Used Appropriately?" BMJ 1993; 306: 236-239

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CASE STUDY 4:

CASTLEFIELDS HEALTH CENTRE

USING INFORMATION IN PRIMARY CARE

This case study focuses on a "flagship" fundholding practice which has made a considerable investment in information systems. Three examples are given of the way in which the practice team has used information to identify problems, then taken action to enhance the services they offer to their patients.

Background

Castlefields is a first wave fundholding practice in Runcorn with 12,200 registered patients. It is staffed by 6 GPs, a nurse practitioner, 2 practice nurses, a district nursing team of 6, and 2.5 health visitors. Other staff include a nursery nurse, a physiotherapist, a part-time counsellor, a part-time accountant, an information manager, 3 clerical staff and 4 receptionists. In addition, a psychologist is employed for 2 days a week and midwives are attached to the practice.

The health centre is part of a new town estate in an area with high male unemployment (16% in August 1994) and substandard housing. The health centre practice serves 85% of the estate's population, but the estate only provides 60% of the caseload, the rest of which comes from the more traditional surrounding area.

The practice has gained a national reputation within the NHS as a model of fundholding because of its innovative work. The staff describe it as a community practice, dedicated to using the power of fundholding to deliver the best possible deal for the community.

"We try to work in partnership with the community"

(Practice Manager)

Practice staff are involved with a wide range of activities which are not necessarily directly health-related. These include visits to local schools and youth groups, and a food co-operative has been set up. There is even an element of "profit sharing": parents bringing their children for immunisation are rewarded with the gift of a first-aid kit:

Enabling Factors for Change

- the power of fundholding
- a practice-wide information system:

"We audit everything. The receptionists will be able to tell you how many times the phone has rung today, how many appointments have been made, how long patients have waited"
(Practice Manager)

- an information manager to develop and exploit the information
- teamwork within the practice
- commitment to quality improvement
- an organisational culture which favours rather than fears change
- good working relationships with the health authority

Barriers to Change

These were perceived by the Practice Manager to stem from the local provider:

- consultants resistant to change
- consultants unwilling to work with fundholders to develop protocols

This account is based on an interview with the practice manager, the practice's Annual Report for 1993-94 and case studies written by individual GPs

Reference

1 Royal College of Radiologists "Making the best use of a department of clinical radiology: guidelines for doctors" London: Royal College of Radiologists, 1993

CASE STUDY 5:

TEENAGE PREGNANCY IN CORNWALL

Mapping data to ward or postcode sector level can identify a problem which would otherwise have remained hidden. An unremarkable district rate may mask sub-district geographical variations of significance. Having identified a problem in this way, Cornwall and the Isles of Scilly Health Authorities adopted a creative and wide-ranging approach to reducing high teenage pregnancy rates in specific geographical areas, forming local alliances between a variety of partners, including primary care, the voluntary sector youth service, education and the local media.

Background

Cornwall and Isles of Scilly District and Family Health Services Authorities commission healthcare for an estimated resident population of 477,500 (OPCS 1992) living in widely scattered villages and small towns. Current population projections predict an increase of 5% in 1998 with an 8% increase in persons under 25 years. This compares with a projected 1% decrease in that age group nationally.

For planning purposes the two Authorities have created localities by mapping postcode sectors to general practice populations on a 'best fit' basis, creating groups of practices throughout the county. Prioritisation for resource allocation is then aided by mapping health event data relating to residents of each locality for a variety of health issues to highlight geographical variation.

Identifying a Problem

One such issue is a Health Of the Nation key area: conception rates in girls under 16 years. Cornwall's conception or pregnancy rates in age groups under 20 are lower than the national rate and not significantly different from Regional rates. In addition, these rates have fallen each year between 1990 and 1992 (TABLE 1).

"They are helping us to meet our targets. We get paid for that: we should share that payment"

(Practice Manager)

Public health issues including the development of local networks and partnerships are considered to be the business of all members of the team and there is a close working relationship, including information sharing, with the North Cheshire HA Department of Public Health Medicine.

A sophisticated practice wide information system run by a full time information manager allows the primary care team to audit every aspect of its work and performance. Three examples of the use of this information to identify a problem and the subsequent interventions are described below.

Gastrointestinal Endoscopy

A practice audit of surgical referrals revealed that the waiting time for open access gastrointestinal endoscopy had grown to 3 months. This was considered unacceptable.

The audit also showed a lack of any consistent approach to follow up after the investigation. Patients with similar conditions were either discharged to their GP or given follow-up appointments with the surgeon or referred for repeat gastroscopy.

Although there is now considerable evidence to show that infection with Helicobacter pylori has an important role in peptic ulcer disease, no testing for infection with the organism was carried out, thus losing opportunities for eradication.

The GPs were also unhappy about the consultant's choice of drug therapy which did not appear to reflect generally accepted guidelines. The drug used, Omeprazole, was expensive, not offered as part of an eradication course and perceived as unnecessarily powerful in the majority of cases, where less expensive H2 receptor antagonists would have been adequate.

The GPs wrote to the consultant telling him the result of the audit and asking the following questions:

- **what criteria are used to decide further action after gastrointestinal endoscopy?**
- **how often are samples taken for Helicobacter pylori?**
- **would it help relieve the burden on outpatients and on the endoscopy waiting list by allowing GPs to follow up more often?**

"The specialist's reply stimulated a discussion amongst the GPs, who decided to explore the literature and other specialists' opinions to determine the current best practice"

(Practice Annual Report)

A review of the literature convinced the GPs that eradication therapy should be an option for patients with proven peptic ulcer. They drew up and agreed, in conjunction with a

Consultant Gastroenterologist, two protocols: one for dyspepsia and one for gastro-oesophageal reflux disease.

"The practice now purchases these protocols by stipulating in the contract with the provider that all open access gastroscopies are to be carried out under this named consultant's care"
(Annual Report)

	1990/91	1993
TOTAL	% 100 (n = 98)	% 100 (n = 61)
NORMAL	29	48
Discharged	20	46
Reviewed OPD	9	2
ABNORMAL	71	52
Discharged to GP	10	48
Reviewed OPD	29	4
Rescoped	31	0
H pylori +	None tested	25
Successfully eradicated	NA	16

TABLE 1 *Effects of protocol for assessment during and follow-up after GI endoscopy: percentage of patients by findings and disposal: 1991/92 and 1993*
Source: *Practice Annual Report*

TABLE 1 shows that in the year following the introduction of the protocol, one quarter of patients endoscoped were found to have H pylori and 16% were successfully treated with eradication therapy.

A revision of the protocol is planned to include the use of breath-tests to detect the presence of H pylori after eradication.

This was an important learning experience for the practice. The doctors are now working with providers and the Department of Public Health Medicine to produce protocols for tonsillitis, grommets, angina, heart failure, peri-operative pain relief, peri-operative anti-coagulation, treatment of simple fractures, joint replacement, breast lumps and back pain.

The positive effect of the first protocols are described as follows:

"The GPs are delighted with the effect of purchasing protocols. They are more confident about dealing with these diseases. They are in a better position to explain to patients what to expect and how to proceed. They are able to offer some of them the potential of a cure. Instead of the depressing prospect of people being told they have to stay on medication for life and go through an unpleasant investigation on a regular basis, the GPs have more control over the treatment and are in a better position to respond to individual needs. Costs have fallen, even though new referrals have increased. Contrary to expectations, the protocols have, in fact, increased the clinical freedom of the GPs"
(Practice Annual Report)

Diabetes

In 1993, the records of the 235 diabetics on the practice's register were reviewed and details of the frequency of surveillance obtained for the 50 whose glycated haemoglobin blood levels indicated the poorest control of the disease. As 30 of the 50 (60%) were not attending either the health centre or a hospital clinic regularly, fifty questionnaires were sent to a random sample of the 235 diabetics to establish preferences for the way services are delivered.

Of the 24 patients who responded, 20 said they liked the idea of a diabetic clinic at the health centre. When asked where they would prefer to be seen, 15 said they would prefer the health centre, 6 the hospital, 2 at home, and 1 not at all. In the previous 6 months, these patients had made 11 visits to the hospital and 14 to the health centre.

The local diabetologist had previously always rejected the idea of holding specialist clinics in a primary care setting. The results of the survey however, convinced him, and there is now a fortnightly clinic at the health centre staffed by his registrar, a diabetic nurse, a chiropodist and an optician paid for by the FHSA. In the first 8 weeks, 28 of the original 30 people with poor disease control were seen. A retinopathy protocol is now being developed.

X Rays

In early 1992, the practice carried out a three month audit of all X-rays requested. The audit was done to establish baseline information before introducing guidelines for keeping X-rays to a minimum in order to reduce waiting times and costs and to avoid unnecessary exposure to radiation. The following guidelines were developed after the first audit cycle:

- **Have confidence in clinical acumen**
- **Be specific about the part to be X-rayed**
- **Spinal views rarely help with management**
- **Treat chests and review to consider X-ray**
- **It is unusual for a fracture to present to general practice**
- **Reassurance is not a valid reason for blasting people with radiation**
- **Follow Royal College Guidelines**[1]

The GPs set themselves the targets of reducing X-ray requests by 10% in the next year using these guidelines.

FIGURE 1 shows a 29% reduction overall in the use of X-rays between two time periods compared, before and after the introduction of the guidelines.

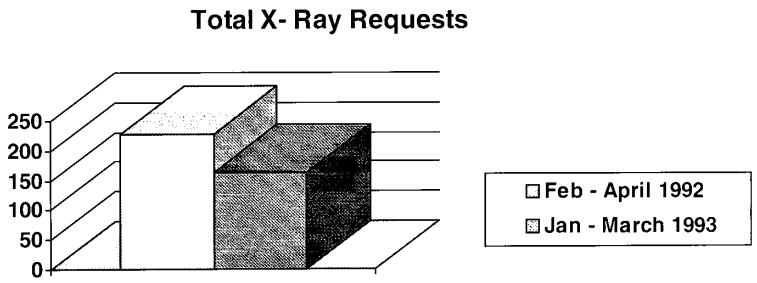

FIGURE 1 *Number of X-ray requests. Two time periods compared: before and after guidelines*

Increases had occurred however in ultrasound examinations, due to open access becoming available during the time period under review, and the "other" category which included mammograms, barium studies and intra-venous pyelograms (IVPs).

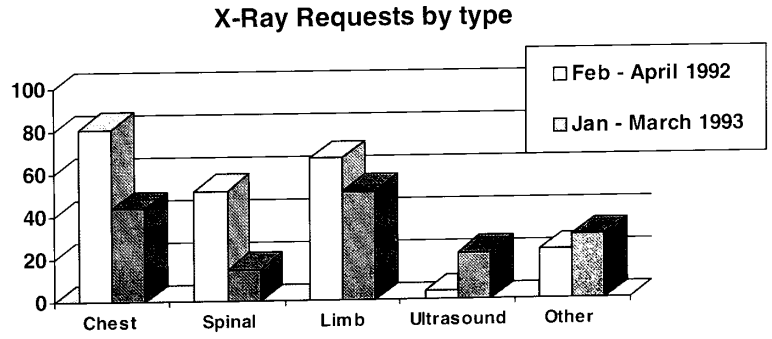

FIGURE 2 *Number of X-ray requests by type compared before and after guidelines*

Source: *Practice Annual Report*

The proportion of X-rays with results which actually aided diagnosis (10%) was unchanged, while the ultrasound investigations in 1993 showed the largest proportion of these results (33%).

The GPs concluded that they had made considerable progress in reducing X-rays, and a further target to reduce by 10% in the following year, particularly in the "other" category, was set. Open access to ultrasound was welcomed but it was felt that protocols were required to ensure appropriate use.

Age group	Cornwall 1990	Cornwall 1991	Cornwall 1992	South Western Region 1992	England & Wales 1992
11 -15	3.2	3.1	1.9	2.3	2.9
16 -19	56.9	55.5	49.0	47.7	60.0

TABLE 1 *Pregnancy rates (births plus legal terminations) by age group under 20: Cornwall compared with Regional and national rates*
Source: *DPH Annual Report 1993*

To disaggregate this information and define the age groups under 20 with the greatest need for interventions, the percentage which terminations (defined as legal terminations plus spontaneous abortions treated as hospital inpatients) formed of all conceptions was used as an indicator of unwanted pregnancy for each year of age under 20. Using this method, ages 15 to 18 were selected (TABLE 2).

Age	Terminations	Births	% Terminations
15	39	28	58%
16	70	85	45%
17	143	209	41%
18	129	345	27%
19	125	521	19%

TABLE 2. *Terminations (legal terminations of pregnancy plus spontaneous abortions treated as inpatients), births and terminations as percent of all conceptions: Cornwall 1990-93*
Source: *DPH Annual Report 1993*

When conception rates for this age group were mapped by locality, considerable variations were revealed, with particularly high rates in Camborne, central Falmouth and the large rural area north of Bodmin (FIGURE 1).

Because OPCS figures for terminations are not available at ward or postcode sector level, these data were obtained from all providers, including the private sector.

"The highest conception rate for 15-18 year olds are in area PL30.3 (St Kew etc.) TR11.2 (central Falmouth) and TR14.8 and 15.3 (Pool and Tuckingmill). In these three patches at least seven girls aged 15-18 in every hundred are becoming pregnant each year. Thus, in the four year period between their 15th and 19th birthdays, they have at least a 25% chance of pregnancy. This risk must be reduced."

(Director of Public Health, Annual Report 1993)

Number of terminations and births in those aged 15-18

shown as an annual rate/1000 15-18 year olds

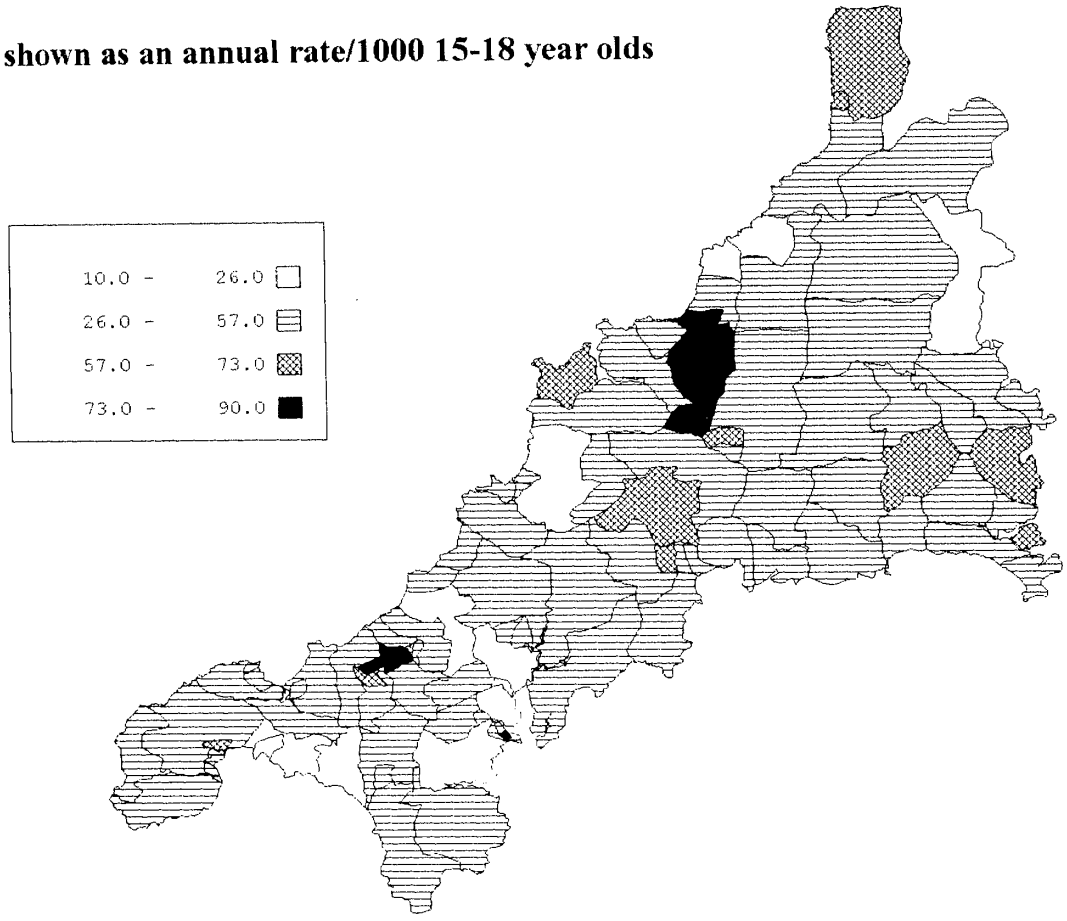

FIGURE 1: April 1990 to March 1993 (NB. private terminations are included)
Source: Department of Public Health Medicine, Cornwall and Isles of Scilly District and FHSA

Solutions

The health authorities' response was to supplement existing health promotion work in schools with three initiatives:

Commissioning a Brook Clinic

Using the AIDS budget, the Director of Public Health agreed to fund a Brook Clinic for young people to serve the Camborne and Redruth area, which had been identified as having one of the highest rates of teenage pregnancy. He and a Senior Health Promotion Officer together assembled a group of people to develop and launch the service. This group included representatives from the youth service, health authority, social services, Relate, the Church, and further education. A bank manager, a businesswoman /local councillor and a psychosexual therapist were also members.

Inevitably, publicity during the planning stage led to some well organised local opposition. At a conference in Camborne to mobilise support against the service, however, a non-Executive member of the health authority spoke about the importance of Health of the Nation targets to such good effect that the event served to publicise the venture. When the clinic opened, the pickets which had been feared did not materialise.

The clinic opened in April 1994 in temporary accommodation on an industrial estate in Pool. The publicity describes the clinic as offering:

"A free confidential service for young men and women under 25. Contraception including condoms. Pregnancy tests with immediate results. Emergency contraception. Help with problems. Under 16s welcome."

(Poster)

The service is soon to move into permanent accommodation situated close to a popular leisure centre, a college of further education and a market frequented by teenagers.

The steering group continues to play a major role in the service and mediates between it and the community, working locally to gain support and allay anxiety.

Making condoms available to primary health care teams

A project to ascertain the value of making condoms available to primary health care teams to use in their work with young people is being led by a former GP and medical director of an FHSA, now a Registrar in Public Health Medicine.

Six practices were chosen for the pilot project, representing a range of different settings from urban to rural. Each practice team selected which of its members would be involved in the study but practice nurses played a major role in each case. The practices were only allowed to give out condoms in the context of a health promotion/advice session. This would consist of an exploration of the young person's knowledge regarding the protective effect of condoms in preventing sexually transmitted disease and advice on contraception. The health professional was asked to ensure that the subject knew how to use a condom correctly.

The study ran from 1 July 1993 to 31 December 1993 and led to increased numbers of young people receiving advice on sexual health and contraception. Within the six practices there was a 61% overall increase in the proportion of young women registering for continuing contraceptive care. As a result, it was strongly recommended that free condoms be made available to all practices in Cornwall to use in their work with young people under the age of 19 and for this to be evaluated on a continuing basis. The projected costs of extending the scheme to all practices in Cornwall for one year are:

Cost of condoms	£14,470
GP item of service payments	£17,490
TOTAL	£31,960

"I do hope the scheme will be extended - we wouldn't be able to give out the condoms if the FHSA weren't able to pay. We think it is so important to have the direct contact with the teenagers"

(GP in pilot practice)

Funding "Young Women and Change"

"Young People Cornwall" is the largest non-uniformed youth organisation in the county. Through their discussions with young people, the youth workers were increasingly concerned about unsafe sexual practices and high rates of teenage pregnancy. The organisation contacted the health authority and suggested a collaborative project aimed specifically at reducing teenage pregnancy.

The proposal was for a "peer learning project" in which a worker would be employed to train young women how to pass on information about sexual health to their peer group. The model is supported by research from the Institute of Population Studies[1] which suggests that:

"With respect to the sexual lifestyles of young people in modern western society, the major social influence is generally held to be the peer group and especially close friends"

The project which the health authorities agreed to fund aims to:

"increase/advance the health and well being of young women in the 13 to 17 year age range by a health education programme designed to prevent unwanted teenage pregnancy"

This project is now in its second year. It targets young women not reached through conventional educational means and whose learning may take place "on the street". In the first year, groups were set up in Falmouth and Truro, meeting weekly, involving 22 young women in all. In their outreach work, these young women contacted 90 more, and new groups have now been set up in Falmouth, Truro, Redruth and Camborne some of which meet weekly, some less frequently.

Although detailed evaluation of the work is planned, the young women themselves already regard the project as successful in terms of their own knowledge and confidence:

"I know more and understand lots of topics. I can give knowledge to others. I feel better about myself as a young woman. I also feel more strongly about young women's rights and also angry that we don't have many. I made new friends and I know I have got support if I'm in trouble."

Measures of success

Trends in births and terminations to girls under 19 will give some indication whether the health authorities' overall strategy is successful, although confounding factors including the impact of national initiatives, make it difficult to isolate the effects of the three interventions. The monitoring of individual contacts with young people in each setting will also be important.

Enabling Factors for Change

Key factors were:

- a committed team of public health, health promotion and primary care professionals
- keen support from some sections of the community
- good information and the use of mapping techniques to show variations clearly:

"This allowed us to "sell" the problem more easily to DHA/FHSA members and the local media"

(Director of Public Health)

- Health of the Nation targets:

"These give us powerful ammunition. Who, apart from the local "anti-sex lobby" can argue against government policy?"

(Director of Public Health)

- support from the local media:

"The local radio is mainly staffed by young women who have been very interested, so have the two major local papers. The DHA/FHSA has an excellent relationship with local media now. We seem to put out press releases on everything we do"

(Consultant in Public Health Medicine)

- availability of short term funds
- people prepared to experiment with different ways of working and take some risks

"The health authority have been very brave in working with us - our approach to working with young people is totally different from anything they have ever been involved in"

(Worker, Young People Cornwall)

Barriers To Change

Those described were:

- local opposition:

"Some traditional parents feel very threatened by this work. We are trying hard to involve them and show them what we are doing"

(Senior Health Promotion Officer)

- working in a large, difficult geographical area with poor communications:

"If this is a success, we shall need another Brook Clinic in the East of the county"

(Brook Clinic Manager)

- dealing with three separate initiatives, in terms of management and evaluation

Lessons Learned

- mapping data at small area level is powerful in terms of presentation and may reveal new information about local variations which would otherwise remain hidden.

- the DHA and FHSA working as one allows a wider perspective. The partnership of GPs, Health Promotion and Public Health staff was particularly appropriate to deal with this issue

- local partnerships with other agencies who work with young people and a creative relationship with the local media have helped to develop a community ownership of both the problem and the attempted solutions

- a combination of approaches to a problem is rewarding but makes it difficult to isolate the impact of any one initiative.

"I suppose it's the difference between research and real life. In research, you would identify the problem, introduce one intervention over a long period and try and measure the effect. In a real life situation, you see the problem and take a variety of approaches to try and achieve what you want. In the end if we reduce the teenage pregnancy rate we will be satisfied, although it may be difficult for others to learn specific lessons about these particular approaches"

(Public Health Scientific Officer)

This account is based on interviews with the Director of Public Health, Consultant in Public Health Medicine, Registrar in Public Health Medicine, Public Health Scientific Officer, Senior Health Promotion Officer, ECR Manager (all from the Cornwall & Isles of Scilly District and Family Health Services Authorities), Brook Clinic Manager, Young People Cornwall Youth Worker, GP and Practice Nurse (Saltash Health Centre).

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CASE STUDY 6:

OPHTHALMOLOLGY IN ENFIELD AND HARINGEY

Purchasing power and creative thinking were used by a DHA/FHSA partnership to address problems of cost, quality and accessibility in eye services. Service specifications and negotiation were used to effect desired changes in day surgery and waiting lists while primary care developments reduced reliance on specialist services.

Background

New River Health Authority was established on April 1st 1993 by the merger of the former Enfield and Haringey Health Authorities. It is coterminous with Enfield and Haringey FHSA and purchases health care for a population of 470,000. Although current population projections predict a fall of 4% overall by 1998, the oldest age group - 85 and over - will increase by 13%.

Haringey has always been an inner city area, with a large proportion of ethnic minority groups and elderly people, but the profile of Enfield has changed.

"Between 1981 and 1991 there have been some dramatic changes. We have deprived areas now which were previously affluent"

(Director of Commissioning, FHSA)

This case study concerns a problem which was shared by the two former district health authorities and inherited by the new authority in April 1993.

Problems

Ophthalmology has long been recognised as an important issue in Enfield and Haringey because of the increasing proportion of very elderly people and the large numbers of ethnic minority residents. A study of the incidence of glaucoma in Haringey's Afro-Caribbean population commissioned jointly by the DHA and FHSA in 1993 showed that the black population are at much greater risk of glaucoma than their white neighbours, confirming the findings of studies in the USA and elsewhere.

The two authorities were also concerned about variations in costs between their three major providers of ophthalmology services (TABLE 1).

	Providers		
	A	**B**	**C**
Inpatient	£937	£1,054	£589
Day Case	£566	£738	£367
Outpatient	£55	£50	£24

TABLE 1 *Unit cost of ophthalmology activity, by provider 1993-94*
Source: *Internal Documents: New River HA*

Provider A is an internationally recognised centre of excellence with extensive teaching and research activity. Provider B is the only locally based service and, like Provider A, offers an ophthalmic A&E service. Patients treated by provider B tend to be older and have other conditions which affect their treatment and recovery. Provider C is not easily accessible to the New River population and has no dedicated A&E service.

The variations in cost, however, did not always accord with variations in quality measures (TABLE 2).

	Providers		
	A	**B**	**C**
% waiting 1yr+	0%	10%	0%
% Day Cases	38%	0%	24%
Weeks waiting for OP appointment	6	10-51	12-20

TABLE 2 *Ophthalmology: percentage waiting more than 1 year for admission, percentage day cases and number of weeks wait for routine outpatient (OP) appointment, by provider: April 1993*
Source: *Internal Documents: New River HA*

In Spring 1993, Provider B (the most expensive for inpatients and day cases but the most accessible) had waiting times for routine outpatients appointments of between 10 and 51 weeks, while the corresponding waiting time for Provider A was only 6 weeks. In addition, Provider B did no cataract operations as day cases despite a regional target of 30%, and the department generally appeared less than dynamic:

"It would appear that consultants favour a model of traditional hospital based care"

PROVIDER	**A**	**B**	**C**
Cost	High	Highest	Lowest
Quality	Best	Poor	Good
Accessibility	Poor	Good	Poor

TABLE 3 *Cost, quality and accessibility ratings by provider*

While cost and quality presented opportunities for improvement, local accessibility in an inner-city deprived area had to be a prime concern.

The challenge for the purchaser was to balance cost, quality and accessibility of services for their population (TABLE 3). There was also a desire to reduce dependence on secondary care for assessment by better screening in primary care.

Solutions

DHA: The power of purchasing

A discussion paper setting out the problems outlined above was circulated to all three provider units in June 1993. In the same month, following discussions with provider B underlining their unsatisfactory service and the need for improvement, the DHA wrote to provider B recommending that an assessment be made of:

- unacceptable waiting times for outpatient appointments
- current outpatient work
- diabetic retinopathy screening by optometrists
- shared care glaucoma screening with local opticians
- additional primary care clinics
- staff skill mix

Provider B was also informed that the health authority would be undertaking an evaluation of all ophthalmic services currently purchased and preparing a specification prior to reconfiguration.

The Authority was also aware that at this time the local GP Fundholders' group, concerned at provider B's cataract waiting times and old fashioned procedures, was in negotiation with providers A and C to set up a cataract service.

By October 1993, the Assistant Director of Service Development was able to present to the District Executive three options for purchasing services of the standard required by the new specification, two of which would involve tendering. If provider B tendered and was unsuccessful there was:

"the question of [Provider B] being capable of losing over £1 million per annum"

The report also comments, however:

"It is important to note that [Provider B] have clearly understood that their service is vulnerable. They have improved waiting times to around 30 weeks and started cataract day surgery [this month]"

When the DHA announced its intention to put part of the ophthalmology service out to tender, Provider B reacted immediately by threatening to close the ophthalmic A&E service. This produced a storm of protest from local GPs and prompted the DHA to negotiate a detailed action plan of improvements to the service with this provider, the option to tender being held in reserve.
By March 1994, provider B was able to report improvements in day case surgery

	% Day Cases
December 1993	38.4
January 1994	45.4
February 1994	54.3

Table 4 *Ophthalmology day cases as percentage of all admissions: Provider B, December 1993 to February 1994*
Source: *Internal Documents: New River HA*

Waiting times for out-patient appointments had reduced to 5-11 weeks. They had also set up a locally based assessment clinic for Haringey GPs and were negotiating a shared care glaucoma scheme with a local optician. In April, the following report was made to the DHA Executive:

"The regressive nature of the [Provider B] Ophthalmology Services has been halted and there is slow, steady improvement. Nevertheless, concerns remain about adherence to old methods and high costs. The tender option did focus energy to improve and if this is removed in July 1994, it must be replaced by a contract featuring the new specification. Compliance will be required or breach of contract will result in recourse to sanction, even tendering"

In June, the DHA informed GPs that they were now satisfied with provider B's performance and were recommending that the threat to tender be removed and replaced by a contract.

The successful conclusion was that negotiations between the purchaser and provider B began in November with targets for areas of the specification which could not be met immediately although some pump-priming money might be available. The specification was introduced in January 1995.

DHA and FHSA partnership: primary care based screening

An important plank of the DHA's strategy for reducing the bottleneck queues for consultant opinion has been the primary care based screening service it has now established in partnership with the FHSA.

The opportunity arose when the FHSA identified in Enfield an ophthalmic medical practitioner (OMP) - a GP with special training and experience in ophthalmology - who agreed to operate a screening service from his practice on a pilot basis. The FHSA funded the purchase of equipment from primary care development money and contracted with him for one session per week. All Enfield GPs were circulated and invited to refer patients.

The arrangements are that patients may be treated by the OMP, referred back to their own GP or put directly onto the waiting list for operation at Provider C where they will not need to see a consultant until the pre-operative visit. The OMP may eventually take over the pre-operative visits, enhancing still further the convenience to patients. In the first two months, the OMP saw 100 patients and identified 3 cataracts requiring surgery which was carried out within 2-3 months. The pilot is being evaluated.

In Haringey where no OMP is available, discussions were initiated involving GPs, postgraduate medical education, orthoptists and local optical committees about the development of a primary care centre for ophthalmology, using Tomlinson funding.

Enabling factors for change

- purchasing power: the threat of putting services out to tender

"As purchasers, we are getting more focused; it's part of the mature relationship"
(Assistant Director of Service Development)

- information which demonstrates variations between providers:

"The power of comparison"
(Assistant Director of Service Development)

- an effective partnership between DHA and FHSA:

"The FHSA Director of Commissioning has a DHA background and understands both primary and secondary services"
(Assistant Director of Service Development)

- general agreement about the importance of eye services for health gain
- timing:

"The evidence from Provider B showed so clearly that the time was right for change"
(Assistant Director of Service Development)

Barriers to change

- competition in the internal market
- lack of interest from all but one of the consultants
- bureaucratic problems in setting up the clinic in primary care:

"because of the inflexible ways in which FHSAs have to work"
(Director of Commissioning, FHSA)

Lessons learned

- a real focus and determination can eventually achieve the desired change

"It takes a lot of hard work and persuasion"

(Director of Commissioning, FHSA)

- good information is extremely powerful
- purchasing power can be used in a positive and creative way

"In the interests of healthy competition and to keep Provider B on its toes, we are still looking at schemes with other providers"

(Assistant Director of Service Development)

This account is based on interviews with the Assistant Director of Service Development (DHA) and the Director of Commissioning (FHSA) and on supporting documents, including those listed in the bibliography.

Bibliography

Wormald RPL, Basauri E, Wright LA, Evans JR. "The Afro-Caribbean eye survey: risk factors for glaucoma in a sample of African-Caribbean people living in London" 1992. Correspondence to Mr RPL Wormald, Unit of Ophthalmology Western Eye, Hospital Marylebone Road London NW1 5YE

New River HA. Service specification: eye services for residents of Enfield and Haringey, Draft 4: July 1994

SUCCESSFUL PURCHASING

Although each case study is unique and reflects local needs and circumstances, a number of common themes or ingredients for success emerge:

- *Good Information*
- *A Receptive Organisation*
- *Local Ownership*
- *Local Partnerships*
- *Strong Individuals*
- *Levers for Change*
- *Focus and Determination*

• Good Information

The information should be credible and robust. It may be derived from data which is routinely collected, supplemented by special surveys if required e.g. to obtain local perceptions of need. Presentation should be in a format which makes it easily understood by its target audience. Staff with a talent for "spotting" any opportunities for change presented by information are invaluable and should be given a voice in the organisation.

• A Receptive Organisation

The organisation must be capable of receiving and acting on the information. There must be a channel of communication for information which describes a problem requiring purchasing decisions to reach a group of receptive persons who will value it and are empowered to initiate the action required. Routine reports are not always the best way of doing this: presentation by staff with skills to explain the issue, suggest solutions and take part in discussion is better.

- **Local Ownership**

Problems or issues requiring change must have local relevance to engage support and enthusiasm. They should also be seen as amenable to intervention, to make the investment of time and effort required to achieve change seem worth while. If the topic and the need for change have been determined elsewhere (e.g. in an NHS Executive letter), obtain the information which best describes the local situation as a first step.

- **Local Partnerships**

Purchasers require a partnership strategy to gain allies for achieving change. Some partners will serve many projects, others may be short term for a particular purpose. Before any new venture however, all key agencies should be identified and involved from the earliest stage.

- **Strong Individuals**

The power of the "product champion" to drive the project and motivate others cannot be underestimated. Outside the organisation, opinion leaders are a particular category of persons who should be courted for this role. People within the organisation who show a talent for this should be sought out and encouraged.

- **Levers for Change**

Contracts between purchasers and providers are not, by themselves, the instruments of change. Contracts set the final seal on the outcome of the change process, during which purchasers may use leverage to achieve their objective. Leverage is the exercise of power as the system allows and creativity in discovering new levers is an asset.

Levers need not be restricted to threats e.g. to tender for services from other providers. Persuasive power, e.g. working with providers towards a shared objective, is also very effective. Purchasers should beware however, as the same power may operate differently in different hands. For example, GP fundholders can use leverage simply and effectively by withdrawing their custom from a particular provider in favour of their preferred option. Health authorities wishing to do this must first take care that such action does not completely annihilate the provider.

- **Focus and Determination**

The monolithic nature of health authorities and their need to gain trust and co-operation from an array of partners can make the achievement of change a long and slow process but purchasers should remain focused on clear objectives.

And finally: a key question for purchasers

Do you know how to get from information to action in your organisation?

Appendix A:

FURTHER INFORMATION

Should readers wish to follow up case studies for further details, the following people have agreed to act as contacts:

Case Study 1: Ophthalmology in Bolton

Director of Public Health
Bolton Health Authority
43 Churchgate, Bolton BL1 1JF

Case Study 2: Access to Primary Care on the Bournville Estate

Polly Davies, Deputy Director of Contracting
Avon Health
10 Dighton Street, Bristol BS2 8EE

Case Study 3: Elective D&C in Buckinghamshire

Dr Alison Hill, Director of Public Health
Buckinghamshire Health Authority
Ardenham Lane, Aylesbury HP19 3DX

Case Study 5: Teenage Pregnancy in Cornwall

Brian Guttridge, Consultant in Public Health Medicine
Cornwall & Isles of Scilly District and FHSA
John Keay House, St Austell
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Case Study 6: Ophthalmology in Enfield and Haringey

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