King's Fund

Snakes and Ladders

Levers, Obstacles and Solutions to Putting Evidence into Practice

Second Interim Report of the
North Thames Purchaser Led Implementation Projects

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Executive Summary

Key Lessons

What works?

- Finding fertile ground where the organisation and individuals are ready
- Setting up projects which have early, tangible benefits to patients (improved patient care) or staff (professional development)
- Building on previous experience obtained through pilots, other similar projects or adapted models from elsewhere
- Getting senior level commitment of people with leadership skills within the sphere of influence
- Picking the right project worker with a non-threatening, enthusiastic approach whose skills complement the rest of the team
- Encouraging enthusiasm and involvement in the people who matter most

What should be done differently?

- Expect organisational turbulence so get people involved who are 'well anchored' in the organisation
- Try to build on what's already there rather than starting from scratch (e.g. existing mechanisms such as Audit, GP Education)
- Position projects to minimise suspicions about HA motives (e.g. in MAAG offices, local surgeries, community or acute trusts)
- Take time to learn from what you're doing and (when it can be done) try to anticipate possible problems

List of North Thames Implementation Projects

Health Authority	Project	Lead Manager
Barking & Havering	Coronary heart disease and obstetrics & gynaecology	Director of Public Health Dr. Chris Watts
Barnet	Low back pain, diabetes retinopathy, h pylori	Director of Public Health Dr. Stephen Farrow
Brent & Harrow	Protocols in A&E	Consultant in A&E Mr. A. Sivakumar
Brent & Harrow	Non-invasive cardiac assessment	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	Cardiac intervention	Senior Lecturer in Public Health Dr. Harry Hemmingway
East London & the City	Leg ulcers	Project Manager Ms. Sally Gooch
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	Dyspepsia	Principal Pharmaceutical Advisor Ms. Pauline Taylor
Kensington, Chelsea & Westminister	ECG & ACE inhibitors in chronic heart failure	Senior Registrar in Public Health Dr. Stephanie Taylor
North Essex	Cancer Services	Consultant in Public Health Dr. Shushil Jathana
Redbridge & Waltham Forest	Diabetes, asthma & hypertension	Director of Public Health Dr. Lucy Moore
South Essex	Hypertension in the Elderly	Consultant in Public Health Dr. Mike Gogarty
West Hertfordshire	Anti-coagulation	Asst Director of Public Health 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. Seventeen projects were approved, one of which was subsequently cancelled, making a total of sixteen projects in the programme.

Background to the Evaluation of this Initiative

In October 1996, the King's Fund 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 evaluation, barriers to change and sustainability. Each aspect of the evaluation will be discussed in a separate report, this being the second on levers, barriers and strategies to overcome obstacles. The first report, entitled *Putting Practitioners through the Paces,* is available from North Thames Research and Development division.

Aims of this report

There are two aims of this report. The first is to present the generalisable lessons on levers, obstacles and solutions. The second is to provide progress reports on the sixteen projects.

In meeting the first aim, we hope to give practical help to any one interested in implementing clinical effectiveness projects. One of the most encouraging aspects of our work in the past few months is that despite being beleaguered by a host of difficulties, project participants have found many creative solutions. We intend to pass their experience on so that others who meet similar obstacles can benefit.

In achieving the second, we intend to give the programme's funders, project participants and senior managers in health authorities and trusts an overview of the successes and difficulties of the initiative as a whole, as well as particular information for each project.

Work of the King's Fund

In the early months of 1998, we organised a series of four workshops for project participants. During these workshops, we discussed the role of evidence, current and past barriers to change and useful strategies for overcoming them. One project, West Hertfordshire anti-coagulation, was not represented.

At the workshops, we asked project participants to draw maps of those involved in or affected by their particular project. These people are not directly responsible for the running of the project, but do have some perspective on its success. We felt that getting information from these people was important as we needed some sort of confirmation of impressions gained at the workshops. We also wanted to provide an intermediate, anonymous feedback service to projects for any information which might be of use to them, but could not be passed on directly.

We asked for several names and then selected three to four for each project as part of a telephone survey. For further information on the methods and findings of this survey, see Appendix 3 and Part III.

Part I Levers for Change

Introduction

Although we did not specifically plan to cover levers for change, in three of the four workshops participants cited factors which were helping or could help to facilitate implementation.

Current or previous levers

- Separate funding from North Thames
- Supportive climate within department and organisation as a whole
  - passionate involvement of key senior clinician and others
  - clinicians who want guidance on best practice
  - good practice manager who will cascade train new staff
- Project management
  - regular project meeting dates to update and review progress which are sacrosanct for all project participants
  - locating the project team in the same building, preferably the same office
- Placing project office in MAAG or GP education
  - MAAG and/or education may be seen as more credible than HA
  - having the MAAG chair also as Chair of Education as line manager very good for networking and providing heavy weight support
- R&D network
  - provides links with other projects
  - way of tying clinical effectiveness into R&D agenda
- Audits
  - prospective audits are a good way to change behaviour because auditing oneself as you go along
  - latching audit work on to guidelines gives new impetus to both
  - district wide audits run by MAAG in which HA only has to know which practices are providing required data
- Outside academic advisor useful for getting detached advice
- Use marketing skills and techniques

Potential future levers

- White Paper
  - woken GPs up to the importance of IT skills
  - Primary Care Groups may be better resourced
  - easier to manage change by localities than district
  - primary care leads usually those who already in vanguard and may have more influence
  - Primary Care Groups may engender sustainability

Part II Obstacles to Change and Strategies to Overcome them

Introduction

Every project had encountered numerous difficulties, a few of which had the potential to stall the project permanently. Despite this, only one project has been cancelled (Brent & Harrow schizophrenia) and one has been postponed (Kensington, Chelsea and Westminister dyspepsia). We were immensely impressed with the tenacity and resilience of project participants to keep going, in spite of the setbacks.

Types of difficulties encountered

In Table 1, the difficulties mentioned by project participants at the winter workshops are broadly grouped under five headings: technical, organisational, motivational, marketing and financial.

Table 1

Technical	Organisational	Motivational	Marketing	Financial
Information technology	Access to audit skills	Unenthusiastic clinicians	Disseminating information	Insufficient, insecure funding
Difficulties in measuring change	Restructuring	Insufficient time - clinicians' and project participants		Cost of producing and sending out guidelines
	Credibility of HA			
	Lack of career structure for non-clinical workers			

Disseminating information, information technology and insufficient time were most frequently mentioned. For further details, see Appendices 1 and 2.

Anticipated versus unanticipated difficulties

Without exception, project participants from the outset expected to meet difficulties. But what was unanticipated was their strength.

For example, one project (Camden & Islington h pylori) expected to have some difficulties in convincing GPs to carry out pilot audits, but they did not foresee that less than a third would express an initial interest of which over half would drop out leaving them with only four pilot practices when they had planned on ten.

The extent of the difficulties encountered was also unexpected. So although the East London cardiac project thought there would be some IT problems when they set up terminals in wards, they did not foresee the added problem of engineers arguing over who was responsible for laying a particular section of cable.

Identifying potential difficulties

In one project (EHH diabetes register), project participants mapped out possible problems and strategies before embarking on the project. The other projects have tended to rely on more ad hoc methods, convening strategy meetings as and when problems arise.

The greatest pre-planning seemed to go into gaining the enthusiasm and acceptance of key clinicians. Two examples are the Redbridge and Waltham Forest project which has developed a marketing approach of "tell and sell" tailored to individual GP practices and the careful planning by the East London leg ulcers team of where to open the first clinics.

Advice from project participants

Having gained valuable experience in overcoming obstacles, project participants had several general suggestions.

- Planning can only go so far. You need to be flexible and creative to find solutions to difficulties as they arise.
- Possible barriers can be avoided by plugging into existing mechanisms such as Audit, GP Education and so forth.
- Many barriers can be overcome through empowering and re-energising clinicians, especially GPs with low morale.
- Projects need a great deal of luck, especially in forecasting national and local trends.
- Projects which make progress may have failed before. It's a combination of the right moment, right climate and right people.

Obstacles and successful solutions

An encouraging finding from the workshops was the number of problems which had been satisfactorily resolved. In Appendix 1, we list obstacles and strategies which project participants found successful.

Not all problems have solutions, however. In Appendix 2, we list other obstacles which may make the work more difficult. This list is not intended to discourage those who are interested in clinical effectiveness, but to give some idea of the potential problems projects face.

Part III Progress of the Projects

Introduction

Since the last series of workshops in the summer of 1997, all but one of the projects have made progress. The exception is the Kensington, Chelsea and Westminister dyspepsia project whose project worker went on maternity leave before much work had been done.

We are also unable to evaluate the West Hertfordshire anti-coagulation project as it was not represented at the winter workshops and contact names for the telephone survey were supplied too late for them to be contacted in this round of enquiries.

Two other projects, the South Essex hypertension and the Kensington, Chelsea and Westminster cardiac project, can only be cursorily evaluated in this report, but we hope to have more information in the autumn. Although both were represented at the workshops, neither were included in the telephone survey. So our impressions of these projects are not yet independently confirmed.

Survey results

We asked project participants to supply us with several names so we could get confirmation of the strengths and weaknesses from those who are involved at a local level. For details of the methodology of the survey, see Appendix 3.

Although it was hard work to interview so many people, even by phone, we gained valuable insight into the projects. In most cases, survey findings confirmed the impressions we had received in the workshops. In several instances, we uncovered problems which had not been previously mentioned and have since fed these back to project participants.

Projects which are working well

For some, such as Brent & Harrow A&E protocols, Brent & Harrow non-invasive cardiac testing, the Camden & Islington h pylori and the East London leg ulcer projects, respondents were uniformly positive and enthusiastic. These projects have made very good progress, to the extent that one respondent (Brent & Harrow A&E) said that the entire department had now adopted an evidence based culture and could not imagine operating in any other way.

A common thread which ran through these projects was that all four were having either an immediate impact on helping professionals to improve their knowledge and practice (Brent & Harrow A&E, Camden & Islington h pylori, East London leg ulcers) and/or had tangible results in improving patient care (Brent & Harrow A&E, East London leg ulcers, Brent & Harrow non-invasive cardiac testing).

Other projects, such as the Barnet low back pain, Enfield and Haringey GP learning sets and Hillingdon dyspepsia, have made promising starts. But survey respondents felt that it was too early to predict long-term usefulness. It bears repeating that most projects will not be able to show many tangible benefits in the 18 month timescale for implementation and evaluation.

Projects with some difficulties

Several projects, including Redbridge and Waltham Forest guidelines, Barking & Havering coronary heart disease, Ealing, Hounslow and Hammersmith diabetes register, East London cardiac and North Essex cancer services have achieved success in some important aspect of their project, but are facing difficulties in another area.

Examples include getting the guidelines right but losing sight of implementation (Barking & Havering) or vice versa (Redbridge and Waltham Forest), having backing from GPs but not from hospital staff (Ealing, Hounslow and Hammersmith) or from junior doctors but not from senior consultants (East London cardiac) and not clarifying objectives with the people who matter most at an early stage (North Essex).

This survey combined with the information given by participants at the winter workshops is summarised in the individual project progress reports in Appendix 4.

Conclusion

All but three of the projects (Barking and Havering, Barnet and Kensington, Chelsea & Westminister dyspepsia) will be providing final reports by August 1998. Our next interim report on sustainability will be published in the autumn of 1998, several months after North Thames funding of the projects themselves finishes.

Appendix 1
Obstacles with successful solutions

Difficulties with clinicians	Solutions
Non-clinical background of the project worker ("Are you one of us?")	Develop relationships with practice nurses or practice manager who may be more receptive Adopt a non-threatening, professional approach "we're here to develop what you've already done" Identify which aspects of the work need to be carried out by clinical colleagues and which can be done by non-clinical team members Get people with status on your side e.g. cover letter for guidelines from respected source Point out expertise in non-clinical areas which may be of benefit such as auditing or 'marketing' skills
Clinicians interested until they realise degree of work	Break up the work into manageable chunks Make the first few steps feasible Tailor approaches to what the individual needs/wants If possible, offer to pay a small amount for audit or to free up staff time
Unenthusiastic clinicians	Understand the constraints of those involved - it's only one of a hundred things for them "Sell" services of HA e.g. help with audit or IT skills PGEA accreditation may work as an incentive if not flooded with other opportunities Focus on the enthusiastic to begin with - don't try to get everyone Find a respected colleague to persuade
Clinicians unconvinced by evidence	Get respected, knowledgeable clinical colleague to discuss doubts Choose a topic that high on national/local priorities Argue that very difficult to have perfect data but one can draw valid conclusions from "good enough" data
Clinicians feel that already doing the work	Encourage peer support by asking clinicians who are involved in the pilots to talk to about the benefits Point out that only through audit can they be sure that evidence is applied consistently
One professional group threatened by other professional group (e.g. GPs by pharmacists)	Adopt a flexible approach Genuinely sympathise with the position of the threatened group

	Find advantages for the threatened group (e.g. this will free up your time)
GPs don't want patients from other practices coming to their clinics	Start with GPs in new practices who are not so territorial and more positive
	Have the first clinic "owned" by the community trust
	Set up easier clinics first to prove that idea viable before tackling more resistant GPs
Negative senior clinician	Cite advantages of participation such as lots more publications for the department
	Use argument that can shift from "he" gets the right outcomes to department gets the right outcomes
	Find commercial advantage or some other incentive (e.g. IT)
	Ask obstructer to write something to be published on the pros and cons of evidence based practice
	Show obstructer that already practising according to the evidence
	Argue "what will happen when you're gone?"
	Find way to make obstructer centre of attention (e.g. appoint as head of project, chair of forum or lead speaker on evidence based medicine debate)
	Accept that sometimes best you can hope for is a neutral position
	Wait until obstructer retires
Clinicians initially motivated to participate by financial incentives and funding running out	Find other resource that value such as responsibility, time or professional education
	Find financial resources from other consortiums
	Find ways to empower clinicians so they want to carry on
Levels of knowledge vary amongst GPs, Public Health consultants and hospital doctors	Set up meetings or open debates between the different groups so they can bounce ideas off of each other
	Recognise which conditions GPs want information on - pick your topic carefully
Competing guidelines - experts and consultants do not agree	Present guidance as supportive rather than prescriptive
Ethical	**Solutions**
Patient confidentiality	Talk to clinicians rather than audit notes directly (NB will only get idea of reported not actual change)

	Ask practice staff to audit notes and pass on in anonymous form (payment may be required)
	Get patient consent
Dissemination	**Solutions**
Dissemination of guidance and other information	Plug into existing mechanisms such as 'locality forums' and quarterly GP educational meetings
	Use multiple routes for getting the message across
	Don't expect the cascade method to work - it often doesn't
	Use a graphic designer to make flow charts and so on more eye catching
	Make information snappy with a clear message
Costs of publishing and sending out guidelines	Get outside company to publish through an educational grant
Ownership	**Solution**
Project owned too much by HA even if HA wants to pass it on	HA sorts out most of the problems then tender out as a package to a trust, way to ensure sustainability

Appendix 2
Other Difficulties

Technical

Information technology

- GP practice skills limited in getting out non-routine data
- Too many different software packages amongst GPs
- GPs don't want to pay for more IT training for their staff
- READ codes difficult
- Inaccurate and inconsistent data within individual practice as well as between different practices - data not good enough for audit
- Difficult to link hospital and GP systems or GP and HA systems
- Malfunctions in hospital systems so data can't be entered
- Clinicians may like lots of hardware, but that may not be appropriate
- Current technology may be obsolete or breakdown in 3-4 years
- HA departments not interested in working with GP systems
- Getting PACT data out is a full time job in itself

Measuring change

- Need to find way to assess both level and degree of change between those participating in project and those who are not
- PACT data for some drugs (e.g. antibiotics) will be prescribed for more than one condition, so not useful in monitoring change
- No link between PACT data and prevalence of disease (e.g. for hypertension lots of prescribing = no hypertension, lots of prescribing = lots of hypertension, no prescribing = no hypertension)
- Even if change can be sensitively measured, it may not be clear to what extent the change is due to the project or other factors
- SMRs too small for statistical significance on district wide basis
- Audit cycles short and can't go into depth that needed to make or show change

Organisational

Access to audit skills

- Poor relationship with MAAG
- Degree to which HA can influence MAAG's work and ask them to undertake audits
- Differences in opinion on how audit should develop
- MAAG don't necessarily know about drug company audits

Restructuring

- Future of trusts/HAs uncertain
- High staff turnover - loss of key staff early in the project
- Financial crises
- Freeze on external recruitment so only can get internal staff, but no-one internally suitable
- Constant restructuring of departments
- New CEOs or Directors of Public Health - project in limbo until know degree of commitment

- Changing district borders

Credibility of HA

- HAs seen as unable to contribute much
- Project simmering for a long time without action so disbelief that it will actually take off
- HA only willing to put its head above the parapet for a limited number of projects
- No long term commitment of HA to project
- HA has different agenda from PGCEs and acute trusts - HAs interested in better management, academics want to publish and hospital consultants want to funnel in more patients
- Project in danger of being "poached" by hospital

Lack of career structure for non-clinical project workers

- Project worker leaves before project completed because nothing else available
- Skills loss because project worker learns lots but leaves before that learning can be of benefit to the organisation
- Good project workers vulnerable to "poaching" by other organisations

Motivational

Unenthusiastic clinicians

- Research done outside the UK is often not accepted by British clinicians unless study repeated with UK populations
- Research in languages other than English not read and not seen as credible
- Variations in clinical judgement e.g. missing 2 out of 100 may be acceptable to one clinician and not to another
- May have lots of evidence on clinical processes but not much on how to implement change in practice
- Culture of Academia - teaching hospitals interested in the few unusual cases not necessarily in doing the routine things well
- Clinician has one bad experience in acting according to the evidence so reluctant to try again
- Litigation - clinicians rarely sued for being overly cautious, even if it does not comply with the evidence
- Fear of doing harm to the few that won't benefit
- Low GP morale - GPs tend to see things as "evils out there" and can't see how they can change things
- Clinicians reluctant to adopt updated guidelines as they have already made a change and are suspicious about doing it again
- GPs and consultants do not see the importance of nurses, practice managers and other staff
- Accessing single handed GPs

Insufficient time

- GPs, HA decision makers, consultants and project workers don't have enough
- Opportunity cost of those involved in a part time or sessional basis
- If more than one project going on at the same time, projects compete for project workers' time
- It takes a long time to set the project up

- 18 months too short - just get the project set up when funding runs out but too soon to show benefits

Marketing

Disseminating information

- Too much documentation to GPs and nurses from lots of clinical effectiveness projects
- Can spend so much time making sure that guidelines absolutely accurate that one overlooks implementation work
- Getting people to know and understand what the project is about

Financial

Insufficient or insecure funding

- Lots of projects fighting for extra resources to survive
- Funding needed for about 3 to 3 1/2 years to show impact
- Not enough resources to stretch to newly discovered patients
- HA trying to quantify savings too early on in project
- Difficult to convince CEOs that need lots of money first and then will reap rewards

Appendix 3
Survey details

Methods

Sample selection

Project participants supplied anywhere from three to nine names. Their selection of names depended on their own objectives for the survey. For example, the lists for Ealing, Hounslow and Hammersmith diabetes register and East London cardiac project participants included a range of positive and negative candidates.

Other projects participants were less adventurous. They complied with our request to provide a variety of names from different professional perspectives. We do not know whether they picked only those who they thought were positive. Nonetheless, even the most positive of respondents gave us some information about their concerns. (And interestingly, when speaking with two project workers at a later date, neither one could remember the names they had supplied.)

Our choice of whom to include in the survey depended a great deal on what we knew of each project. For projects with a primary and secondary care interface such as the Hillingdon dyspepsia, Brent & Harrow non-invasive cardiac and Ealing, Hounslow and Hammersmith diabetic register, we contacted both hospital staff and GPs. For projects which are totally based either in the community or acute sectors, we contacted a range of professionals such as managers, doctors, nurses and professions allied to medicine to get a variety of perspectives.

Invitations to participate

After deciding who to include, we sent out a letter to fifty five potential candidates informing them of the survey and asking them to get in touch if they did not want to participate. Twenty eight of the survey candidates did not receive the questions before hand and twenty one did. We did not find that receiving the questions beforehand made any appreciable difference in the responses as by the time we called (one to five weeks after sending the letters), participants had forgotten them. Only one person wrote back saying he did not wish to participate.

Subsequent exclusions

Two projects were excluded from the survey after the letters went out. They were the South Essex hypertension and West Hertfordshire anti-coagulation projects. We excluded the South Essex project after speaking with one of the survey candidates who agreed with the lead manager that the evaluation part of the project was at such an early stage that little useful information could be gained.

We excluded the West Hertfordshire project because we received the names several weeks after the survey started. In order to write up the results for this report, we realised that we would not have enough time to contact these individuals.

One project, Kensington, Chelsea and Westminster cardiac, was excluded at the end of the survey. This was because we were unable to get a hold of any of the four candidates after numerous attempts and messages.

Response rate

Of the fifty five candidates, six were never contacted as they were involved in the South Essex or West Hertfordshire projects. Thirteen others did not participate for a variety of reasons. Some were unavailable after numerous attempts and did not return messages (8); some did not want to participate (2); two did not think they knew enough and one was ill.

In total, 36 of the 49 candidates participated in the survey giving a response rate of 73%.

Confidence in results

Our degree of confidence in the results depended on three factors. The first was the number of people we were able to speak to for each project.

The minimum number of responses we required in order to feel confident in our findings was three. This was possible for eight projects. We contacted a fourth person for two other projects because we had received ambivalent responses and wanted an extra check (EHH and Enfield and Haringey). We would have liked to have contacted a fourth person for the East London cardiac project for the same reason, but this was not possible in the time available.

Unfortunately, we were only able to speak to two people for the Redbridge and Waltham Forest and North Essex projects. As respondents were not overly positive, we would have liked to speak to at least one other person. Since this was not possible, we are cautious in the progress reports for these projects.

A second factor in determining our level of confidence was the degree of ambivalent responses we received. If all three people were positive and enthusiastic, we were relatively certain that the project was making good progress.

A third factor was the agreement between respondents on the strengths and weaknesses. If more than one respondent commented on a particular weakness, we were fairly sure that this was a problem for the project.

Questions

All respondents were asked the following questions. In a few cases, follow up questions were asked to clarify certain points or to ask about particular concerns which had been brought up by project or survey participants.

1. What do you hope the project will achieve?
2. What do you think are its strengths?
3. What could be improved? Do you have any concerns?
4. What do you think has been learnt?
5. Will it achieve its goals?
6. Do you think it'll be around in some form or another a year from now?

Feedback of results

A one and a half page summary was written up and sent to project participants. In order to protect the confidentiality of respondents, we did not include information on who had participated, only on total numbers of respondents. We also rang four project participants to give them further information.

Appendix 4
Progress reports

Barking & Havering

Secondary Prevention of Heart Disease and Obstetrics & Gynaecology

What are they trying to do?

Support GPs in providing effective clinical practice in coronary heart disease and encourage local maternity services to look at evidence and review current practice regularly.

Progress

CHD project guidelines were produced in March 1997 and are now at a point where the they need to be embedded. Unfortunately, the strategies for doing this are not making much of an impact.

Two survey respondents suggested that practices be paid for participating in audit, which they thought would lead to implementation. One survey respondent commented that in terms of sustainability, only pilot practices would continue using the guidelines. Another hoped their use would spread but was not sure how this could happen without involving more practices in audit. Unfortunately, there is no clear source of funding as North Thames money runs out and the health authority does not seem to be coming forward with further resources.

The two GPs who were involved in devising the guidelines have left and the project worker has limited support within the Public Health Department. We expect that the project worker will begin to look for another post, unless there is some sort of commitment made by the Health Authority.

The obstetrics & gynaecology project is about halfway through. Two new projects are starting in GP education - atrial fibrillation and angina. It will be interesting to see how they are implemented without a project worker.

Strengths

- National issue (CHD), one of the government's priorities, with great value for this locality
- Approach systematic in using and implementing the evidence - a good model
- Dedicated person to trawl through the literature, assess the evidence, discuss with Public Health colleagues, liaise with clinicians to find out what's practical and then come up with evidence based guidelines - project worker effective
- Dissemination through presentation in academic centres and personal contact powerful
- Project only one part of district wide strategy to reduce heart disease

Concerns/Improvements

- Needs more involvement of patients as without patient group interest outcomes won't change (e.g. lifestyle changes needed)
- Getting GPs to take up the guidelines - need more to actually implement the guidelines
- Using limited manpower to the best effect

What has been learnt so far

- It's easy to get overwhelmed - be careful that you are clear in what you are doing
- Simple things work well - e.g. prompting cards in patient records for aspirin use

Barnet

Low back pain, diabetes retinopathy and h pylori

What are they trying to do?

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

Progress

The outlook for this project seems good, if it is able to show enough benefits in the coming months before funding runs out for the project worker in October 1998. The strategy of devolving responsibility to GP leaders has worked well.

The project worker has worked very hard in creating networks and getting clinical effectiveness high on the agenda both within the HA and at trust level. She believes that before any project work can be carried out, clinical effectiveness must be a "high, clarified and on-going" item in the organisational agenda. This strategy, in the end, may ensure long term sustainability for a variety of clinical effectiveness initiatives - not just this project.

But the cost seems to be that project worker is overstretched and some of the project work itself is getting overlooked. The project worker is aware of this and has applied for funding from North Thames to employ an assistant.

All three survey respondents, who were only asked about the low back pain project, were enthusiastic about its potential, but mentioned that it was too early to predict its usefulness. Evaluation will probably need to be very carefully thought out to convince sceptics.

Strengths

- GP leader both interested and experienced in musculo-skeletal disease - inspires confidence, other GPs value his opinion and he doesn't tell GPs what to do
- Musculo-skeletal disease one of key strategies in HA's public health programme
- Awareness of clinical effectiveness raised amongst GPs
- Helps GPs to think about back pain
- Good relationship between GPs and HA
- Offers "one stop", independent alternative to GPs and hospital practitioners
- Shortens the medicalisation of back pain

Concerns/Improvements

- Limited impact as yet - too early to tell
- Under resourced, lots of good ideas but not enough money to do more than set things up
- Getting it "known and sold", gaining acceptance of those who need to use it
- Because it's multidisciplinary, no one wants to be responsible for the bill

What's been learnt so far

- Changing behaviour of primary care teams very challenging - it takes a long time
- Guidance (suggestions) works better than guidelines (directives) - it's better to work with GPs to find useful guidance

- Most health care professionals know the problems but don't have time or resources to sort it out

Brent & Harrow

A&E Protocols

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.

Progress

This project is working very well. The positive impressions gained at the workshops were confirmed by the people we spoke to in the survey who were all very enthusiastic.

Project participants are just beginning to audit and evaluate the project as the bulk of the work is finished. With extra funding from North Thames, they hope to get a researcher in to help with the evaluation in addition to computerising the protocols.

The A&E consultant is keen and feels confident that the project will be integrated into routine practice. Most encouragingly, one respondent said that an evidence based approach was now a part of the departmental culture - to the extent that the change had become the "norm". Possible concerns are the future of the A&E department at Central Middlesex and the eventual obsolescence or breakdown of computer equipment.

Strengths

- Bringing together lots of research in an effective way
- Non-hierarchical culture - respect between doctors and nurses, clinical staff and managers
- Commitment to clinical effectiveness from CEO and other senior managers
- Keeps SHOs "on their toes" - they get more experience than just seeing patients
- Has motivated entire department, staff like being involved
- Entire trust keen on protocols not just this department - building on a strong foundation
- A&E Consultant leading
- Protocols create agreed standard - patients less likely to fall through the safety net
- Protocols easy to use
- Staff can see how protocols can apply to their practice in immediate situations - constant professional learning
- Nurse practitioner used as a risk management tool - doctors refer to nurses and take their assessments seriously

Concerns/Improvements

- Getting and accessing the evidence more quickly (newly created research assistant post)
- Possible problems with the computers long-term
- Updating the protocols regularly so they don't become stale
- A closer tie in with audit to show that protocols have actually been implemented

What has been learnt so far

- Need someone with responsibility of pulling it together (new research assistant post)

- Set it up so it's easy and practical for staff to use
- Keep going over the ground

Brent & Harrow

Non-invasive cardiac testing (Open access)

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.

Progress

This project seems to be working very well. The service has now been set up and all the steps completed except writing up of a final report.

Survey respondents were all positive about the benefits both to GPs and in the longer term to patients. Two respondents mentioned that there is a learning component to the service as GPs need accreditation in order to use it. One commented that the service is very popular.

Main concerns were getting more GPs to use the service, the limited time the project worker has for this work and including "harder" outcomes in the audit to show impact. Another difficulty is that the project worker alone runs the service and if he is absent for any reason, the service stops.

The project worker commented that the service is not being actively promoted, but all GPs are welcome to use it. This seems to indicate that a proactive approach to implementation is missing. Perhaps with the promised further funding, a more active effort to reach all GPs in Brent will ensue.

Strengths

- It works!
- Subject to on-going audit
- Updates GP skills as they need to go through accreditation (education as well as service)
- Fairly structured system
- Good way in which presented to GPs
- Reduced waiting times for patients
- Encourages involvement of primary care in cardio-vascular assessment
- Earlier treatment of patients

Concerns/Improvements

- Improve time between GP referral and test completion
- Demonstrate impact through monitoring of mortality and morbidity rates in the area - patient satisfaction outcomes too soft
- Could disseminate and attract wider GP audience if worker had more time
- Could look at harder outcomes if worker had more time
- Audit limited to what GPs sending back - not sure of degree of bias

What learnt so far

- Not a lot of money is needed to improve service and roll it out to other areas
- If you give the GPs power to give tests then they become better doctors

Camden & Islington

H Pylori

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.

Progress

There are many positive aspects to this project. All of the survey respondents commented that the guidelines, flowchart and audit pack were excellent and very usable. The GPs seemed to value the expertise and experience of the hospital consultant and he in turn was pleased that the hospital could offer better services to GPs.

Improved GP knowledge and discovering that the majority of patients are being prescribed appropriately have been two factors in encouraging GPs' enthusiasm. The only concern seemed to be convincing GPs who do not feel they have the time or resources to give the audit pack a try.

Right now, it is hard to tell how sustainable this project is or the extent to which it will spread to non-pilot GP practices. It is not clear to how far clinical effectiveness work can or is being plugged into routine practice. This may be clearer post-audit.

Strengths

- Good audit pack - not too lengthy, user friendly, very well organised and presented
- Guidelines all on one page, well researched and suggestive rather than directive - reflects lack of consensus
- Flow chart very good - well designed
- Audit not massive in terms of patient numbers
- Can take audit in stages - take subsections and apply in a systematic way, do as much or as little as you want
- Community rather than hospital based - too many projects in hospitals where consultants know what they should be doing and get good results but not many with GPs
- Have changed data collection sheet so less paper and easier to pick out patients that want
- GPs encouraged to say what they want and the hospital is responding (open access to non-invasive testing)

Concerns/Improvements

- Getting GPs to sign up to it because they see the audit as too much work
- Need to help practices with everything to do with audit - lack of time and skills

What has been learnt so far

- Lack of education amongst GPs in one of commonest causes of patient referral to GPs
- (Having done audit) few patients inappropriately treated but about 60% need more investigation - would have expected to find more patients to take off treatment
- GPs very keen to learn

Ealing, Hounslow & Hammersmith

Diabetes Register

What are they trying to do?

By setting up a diabetic register to be piloted in 18 GP sites, they intend to work towards improving quality of care and realign and rationalise services for diabetics.

Progress

The Public Health Consultant for this project is very keen and the project team is well-led and managed. They are very impressive in terms of the degree of planning and forethought, regularly re-checking objectives, obstacles and strategies. They have been able to employ a GP Facilitator until December 1998 and so we will not be able to comment on the sustainability aspect of this project in the next report.

Survey response was mixed. One respondent was positive and felt that the register could do much to help his patients; two others were somewhat sceptical but felt there was some potential; and a fourth was negative as he thought patients with the greatest need are already known and there are not enough resources to treat any more who come forward. As the project participants gave us a wide range of names to contact, including obstructers, this mixed response is perhaps to be expected.

Main concerns that this could rapidly turn into a data collection exercise with little impact on patient care and that the Health Authority is not genuinely committed to resourcing extra patients who surface as a result of the register. One respondent said that the project had not yet achieved much. This lack of "early wins" means that there is some scepticism.

The team's strategy is to work out all the kinks with the GP Facilitator in post and then open up the diabetes register for tender at a local hospital. In this way, the project team feels sustainability will be maintained as ownership of the project is passed from the HA to a trust.

Strengths

- Good partnership between HA and GPs
- Planning of health care provision based on data that collected on a daily basis
- Know which practices have more diabetic patients
- Relieves GPs of some of the difficulties of call and recall

Concerns/Improvements

- Only one side of district included (not covering Hounslow and Fulham)
- Lack of resources for potential number of new patients coming forward
- What will happen to the data once they are collected?
- No evidence to show that diabetic register improves patient care
- Project started the "wrong way", should have started at the hospital and moved out
- Can't see any strategy or direction - project only seems to be about data collection (1 respondent only)
- What happens to non-computerised GP practices?

What has been learnt so far

- Collecting data difficult because of all the technical problems
- Patient confidentiality issues important

East London and the City

Cardiac Intervention

What are they trying to do?

Having established a database and set up an expert panel to rate indications for angiography, angioplasty or bypass grafting, 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 two sites.

Progress

Further funding for two years has recently been received. As a result, many of the planned steps, such as developing and disseminating guidelines, have been extended. In terms of this evaluation, the project will end with the introduction of the database into the library. The quantitative aspect of the evaluation has been dropped. But a report on the in-depth evaluation carried out by the Tavistock will be available within the next few weeks.

The biggest obstacle throughout the project has been the resistance of a senior cardiologist who is not partial to EBP. Without his support, the project worker is limited in the impact she can make with senior colleagues. However, junior colleagues are reported to be interested.

Two of the three survey respondents were fairly to very negative about this project. The other felt there were some technical problems, but the project had potential. There could be several reasons why respondents were so negative.

We only talked to senior consultants who, we were told, have been much more resistant to the project than junior doctors. The Tavistock researcher said that she thought the negativity was partly due to "evaluation fatigue". The project worker wanted both positive and negative feedback and so supplied the names of some people who she knew would be negative.

Strengths

- Good idea in principle
- Possibility of applying evidence based practice in day to day running of wards
- Provides high quality information
- Provides impetus and encouragement for people to make use of information facilities
- Has made some cardiologists more aware of the evidence

Concerns/Improvements

- Evidence based medicine should also include negative studies so database incomplete
- Computer network still not in place at Victoria Park, operating on stand alone
- Under resourcing of academic support services such as IT
- Just sticking a terminal in a ward is not enough
- Project has shown that this approach does not work
- Project somewhat "over-hyped"

What has been learnt so far

- Pilots and preliminary studies are needed first to see what works in implementation, but these pilots should not be misinterpreted as testing the viability of EBP itself
- Difficult to get the attention of cardiologists
- Installing computer hardware needs thought and planning

East London and the City

Leg Ulcers

What are they trying to do?

They intend to develop, implement and audit local guidelines on leg ulcer management as well as set up primary care based leg ulcer clinics, thereby reducing variability of clinical practice and improving patient and economic outcomes.

Progress

This project is working well. As they have learnt a great deal from the pressure sore programme, the chances of success are quite high. Interestingly, the issue around sustainability is that they may be *too keen* on clinical effectiveness work and overwhelm GPs and district nurses with guidelines and new clinics.

The survey confirmed positive impressions of the project. Although the first clinic had only been opened for a week, enthusiasm was high. In particular, respondents felt that the clinical nurse specialists were providing an excellent service in terms of professional development of community nurses and GPs and support in getting the clinics off the ground. One respondent suggested that the survey be repeated in the autumn when more will be known about long-term sustainability of the clinics.

We are also impressed with the persistence of Alison Hopkins in maintaining a commitment to this project despite tremendous organisational turbulence and the initial lack of appropriate staff to take the work forward.

Strengths

- Documents widely circulated and lots of consultation with those who will use it
- Very supportive clinical nurse specialists
- More access to training
- Patients happier
- Easier and more direct access to clinical nurse specialists (fast track method)
- Access to more specialist equipment such as camera and pump
- Rational approach to a problem

Concerns/Improvements

- Documentation not computer friendly - at some point will need to go on computer template
- Need to find long term mechanisms for protocols so that staff continue to use e.g. develop preferred prescribing protocol for GPs and nurses

What has been learnt so far

- Staff haven't been providing the quality of care that they should have been

Enfield and Haringey

GP Learning Sets

What are they trying to do?

By using a self-directed learning approach with existing GP forums 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.

Progress

Even though this project had a number of false starts and was dropped for nearly 18 months before getting going again, the project participants are keen and focused on the issue of sustainability.

All of the survey respondents were enthusiastic. The GPs seem to like working in groups and enjoy learning in this way.

There were several concerns. One is the continuance of the groups once the project worker's contract ends (lack of support) and funding for attendance runs out. Another is the difficulty in making or showing an impact on clinical practice. A third is that other professionals besides GPs need to be involved.

Ultimately, the key factor may be that the project will only have run for 12 out of the potential 18 months. They will certainly not have enough time to embed the learning sets into routine practice and GPs may not be sufficiently convinced to want to continue without the £75 payment they have hitherto received. The project may be much more pilot based than was intended.

Strengths

- Lots of people participating on a voluntary basis
- Group works well with everyone interested in achieving targets
- Led largely by GPs themselves
- Good administrative and other support
- HA and post graduate centres interested so potential to take it forward

Concerns/Improvements

- How easy would this be to do with an unmotivated group?
- Role of project worker difficult in both observing the process and imposing audit
- Tension between evolution of group and auditing "hard outcomes" - different timetables
- Self-directed learning groups usually steered by one or two key people
- GPs need more training in appraising the evidence and applying to their own practice
- Time difficulties - 2-3 hours taken away from GPs' own time
- Need funding and support from clerical staff to do the searches as GPs don't have the time
- Not enough time to train group leaders
- What will happen when GPs no longer paid to attend?
- Needs to go wider than just GPs to primary care teams

What has been learnt so far

- Separate out evaluator from facilitator roles
- Look at existing models rather than trying to achieve something totally alien
- Backing of HA makes it more likely to happen, previous locality projects very grassroots and stopped when funding ran out

Hillingdon

Dyspepsia

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.

Progress

This project has made progress in getting some GPs to look more closely at their prescription of ulcer healing drugs. Survey respondents commented on a number of positive factors such as the role of the project worker in improving communication and the good mix of interests and disciplines in the steering group. A principal concern was getting more GPs on board.

Indictors such as hospital prescribing data, FCEs, operations and procedures and so forth have been collected. They are currently trying to negotiate audit with MAAG. The MAAG feel they should be paid extra for this audit and the HA wants it included in their routine work.

Leg ulcer and cardiac projects are also underway, although they are not within the scope of our evaluation.

In terms of sustainability, the project worker felt that there are enough people interested in this work, and were even before he was employed, to ensure that the h pylori project goes on. The initiation of two other projects is also a good sign that the HA is committed to clinical effectiveness.

Strengths

- Good balanced team of microbiologists, GPs, nurses, Public Health consultants, HA advisors
- District pharmacist on board
- Liaison between HA and gastroenterology department good
- Gastroenterology department has improved
- Lots of interest in dyspepsia and specifically h pylori

Concerns/Improvements

- Difficult to disseminate information
- Can explain best way but lots of GPs take things into their own hands and prescribe what they want anyway (estimate 1/3 GPs good, 1/3 approachable and 1/3 "hopeless")
- Getting guidelines owned by all of the GPs
- Keeping GPs informed about introductions and developments
- Guidelines moving targets and playing field changes all the time

What has been learnt so far

- Whatever you do it will never be enough and you have to keep doing it
- Need for increased communication between everyone
- Project worker valuable - has led to better communication

Kensington, Chelsea & Westminster

ECG & ACE inhibitors in chronic heart failure

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.

Progress

We are somewhat limited in what we can say about this project as we were unable to contact any of the local participants to get feedback.

From the workshops and two interim reports, it seems that the project worker was able to make a great deal of progress before going on maternity leave. The lead manager hopes that she will come back and finish off the audit in the summer. Unfortunately, the lead manager herself has left the organisation.

This project seems to have gone much more smoothly than anticipated. GPs were keen to get involved and the lead manager puts this down to the professional approach of the project worker. Even if someone else takes over the work, the groundwork was well laid and some change can be measured.

They have taken a discrete project based approach and so the impact of clinical effectiveness on the organisation as a whole is not known.

North Essex

Cancer Services

What are they trying to do?

By appointing a Cancer Service Development Officer (CSDO), developing guidelines and conducting clinical trials, they are working 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.

Progress

This project has a high profile within the area. It has a momentum of its own and its success is important to so many people that it is likely to keep running in some form.

Guidelines for over 12 different types of cancer have been produced, although North Thames money is earmarked for breast and colorectal cancer. Currently they are asking for £100,000 in funding from the HA to get a new information system to service the two sites.

Unfortunately, we were only able to talk to two people in the local survey and we do not know if their concerns are representative. They said lack of clear, common goals is one difficulty. A second is that neither felt they had been involved appropriately at an early enough stage to help formulate those goals. A third is that communication in general is limited.

This project is highly political with lots of different interest groups vying for their own agendas. In an area as big as North Essex, no one wants to lose local services as it would mean a great deal of inconvenience for their patients. As a result, there does not seem to be a common consensus or agreement about criteria to define the 'best possible' solution.

Although respondents had some knowledge about the breast cancer part of the project, none was clear about the progress of the colorectal part. We do not know if this is because little progress has been made or because the progress that has been made has not been well communicated.

Strengths

- Learning from experience - taking a good system and applying it elsewhere
- Providing focus for the problem

Concerns/Improvements

- Consultants almost co-opted rather than asked to get involved
- Never clear what goals are
- Input of participants of limited use because of unclear aims
- Not much information on how colorectal aspect going
- GPs not contacted until very recently
- Will be difficult to get it off the ground
- Consultants do not have enough time to steer project worker

What has been learnt so far

- We all have to talk to each other
- A highly skilled individual is required to keep up momentum
- Need lots of input from clinicians

- Project worker role has been indispensable

Redbridge & Waltham Forest

Diabetes, asthma, hypertension, antibiotics and paediatric guidelines

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.

Progress

Having devised guidelines on antibiotics, diabetes, hypertension and asthma, paediatric guidelines are about to be disseminated. The next topic may be back pain. The evaluation should show the degree of success in implementation, at least for diabetes. The project worker has recently received further funding from the Health Authority until April 1999.

Unfortunately, we were only able to contact two people in connection with this project. Without speaking to others, it is not clear whether the concerns raised are generally true for other participants.

There seem to be two main issues. The first is that the standards set by the guidelines are seen as too high by many GPs. This leads to the second difficulty - ensuring that GPs take the guidelines on board. Although the individualised, 'marketing' approach works well, the product itself is perceived (at least by one respondent) as faulty. Correcting this is a matter for the guidelines committee, but we have been told that they have come to an impasse.

Strengths

- Pace is right
- Guidelines evolved locally at a limited rate of dissemination
- GPs involved from the outset
- Good involvement of district pharmacist
- Owned and sold on an individual basis to GPs
- Good start has been made

Concerns/Improvements

- Updating and amending guidelines as new evidence comes to light
- Guidelines by committee so all inclusive
- Guidelines not practically achievable by GPs, approach has been to adopt "gold standard" rather than realistic guidelines - this has the effect of turning GPs off
- Difficulties in systematic implementation amongst both enthusiastic and non-enthusiastic GPs
- Takes too long to implement guidelines as they are
- National regulations on chronic disease management already exists, if their implementation had been effectively managed by the HA then there would be no need for this project

What has been learnt so far

- People will use things if they are involved in the production of it

South Essex

Hypertension in the Elderly

What are they trying to do?

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

Progress

This project is split into two parts. The first was the actual implementation of change which was carried out from October 1995 and throughout much of 1997. North Thames money was used at this time to fund existing mechanisms such as GP Education.

The second part is the evaluation, which has run into some difficulties. Project participants administered a questionnaire on two separate occasions, pre and post intervention, and so have an idea of *reported* behaviour. But they would like to get information on *actual* behaviour.

Their strategy is to recruit one locality in its entirety and pay practice nurses on a sessional basis to conduct a retrospective audit. In total, about one eighth of all the practices in South Essex will be included. The pilot has taken place, and they are now encouraging practices to audit. They plan to have a final report for June 1998.

After speaking to the lead manager and one local participant, this project was not included in the survey. This is because not much has happened in the evaluation and the implementation work was carried out nearly a year ago. It is somewhat worrying that there is only three months before the final report and, apart from the pilot practice, no one else has carried out the audit. The one local participant we spoke to said that a learning point had been that retrospective audits are difficult to undertake.

In terms of sustainability, their approach of hooking into existing mechanisms means that clinical effectiveness issues are likely to become much more a part of routine practice. There are also a number of project "leads" (the PH Consultant, R&D Manager, Director of Primary Care), so commitment is high.