The Nursing Specialist Group

The INFOmed Touch Series

Volume 1 - Sharing Information: Key issue for the nursing professions

First published March 1997 - ISSN 0901865 72 9
Edited by Denise E Barnett
Prepared for the web by Rod Ward

Sharing information with patients in a general practice

David Colin-Thome while GP Fundholder, Castlefields practice, Runcorn, Cheshire and Fellow in Health Service Management, Manchester University

I wish to use as a case-study our Practice. In about the mid-eighties we became infected by management, we had a time-out session with a facilitator. That facilitator asked us what we were in general practice for - we just sat there thinking, as we had not thought through our philosophy. One of the values we identified at this workshop was to be a resource for our community. The community being our registered practice population. Such a population is peculiar to British general practice, it is the envy of many GPs in other parts of the world such as New Zealand and Canada.

There are those on the libertarian right, if that is not a contradiction in terms, who say "Why can't we expose general practice to the marketplace because when you go shopping why can't you pop in and see any GP not just the ones you are registered with?" and there is a certain superficial validity for that unless we GPs demonstrate that we can use the registered practice population for the benefit of our patients.

What we decided to do was to have a needs assessment. One of the problems with needs assessment is that if you ask some of the public health people they often come up with pseudo-scientific 'argon. So we decided to develop our own scientifically validated test for needs assessment. We came up with the two-pint test. When you go to the pub and have at least a couple of pints, honesty and clarity of thought break out. When you subject public health people to this test, two things happen: they always drink more than two pints, and they are less than clear about what really constitutes local needs assessment. We had a two year project with a public health nurse working with us, funded by the then Mersey Region.

The idea was to try and develop a new model of health visiting. I belong to the national sport of finding new jobs for health visitors. Mandy Wearne's work was to try and define the needs of our population using various techniques:

- to look at the morbidity information we had, which was poor,
- to do some community development work such as facilitating groups.

We now have the 'Nifty Fifties' exercise co-operative running in our area, another is 'What's Cooking' in Castlefields. One of the things we discovered was who needs doctors and nurses? They are very expensive. Health is much better and more important than just talking about medical care delivery. From this work we also identified other needs such as those of the young who were not well served in our area. As a result of Mandy's work we defined the needs of the young by using focus
groups etc. We have called together a group of people to meet these needs by being the co-ordinators of this sort of approach. One of the roles the primary care team can have; apart from being a provider, or as a fundholder, being a purchaser: can be as a micro-commissioner with the registered population. Not only purchasing but influencing what happens to the local patient community.

One of the areas we have looked at with the youth project is to release resources from fundholding into providing some of that resource. We are now exploring, with some of our health visitors and the schools, developing pre-school education packages including parental skills. Now some of my GP colleagues, who are obsessed by the biomedical model, think this is all just messing about, until I point out to them the work emanating from America about pre-school education. The outcomes of such programmes as 'Head Start' are much better than most things we could ever achieve in the medical world. Therefore if we are going to look at health in the round, can we in the primary care team be facilitative in looking at health needs in a wider sense.

Sharing general information

So some of the work that Mandy had done was in defining these needs. The other thing that she did was to identify a group of people that became a health forum. As a result they meet the practice on a monthly basis. They bring all sorts of issues to the practice including complaints, sometimes from people who are too nervous to do this themselves. They make suggestions about developing the practice. We have developed the idea of this as a focus group to look at health issues, how their bodies function and things like that. We have also used them as a sounding board for our changing of contracts in fundholding, so these people bring a rich feedback from the community.

We also, separately, meet our local political councillors. We did explore patient participation groups in the 1970s, but as often happens in working class communities these are not sustained because people do not have the confidence or skills to sustain them. Where they have been successful they often turn out to be doctor's fan clubs and not really good, objective feedback. So we have developed this community feedback to help us provide a better service.

We also explored consumer surveys. The biggest one about four years ago went out to eight percent of our practice, asking the usual questions about receptionists, home visits and so on. Because the questions were set by someone outside the practice, questions were included such as 'Did the doctor appear to be listening to you during the consultation?' another was 'Did the doctor address the problem you came with?' and some ungrateful patients said "No"! As a result we have changed our behaviour: longer surgery times, we use our counsellor to help us in our video-feedback of our consultations because she can comment on our verbal and non-verbal communications or lack of them.

So we have had a go at looking at the public health needs of our practice community through the public health nurse, and we have done the consumer approach. We have also decided to look at social care. We have a social care management project, which we are also partially funding out of fundholding, where we have a care manager for the 60 plus age group. This includes doing some needs assessment including use of the criticised over 75s home visits. These are much criticised by GPs who are biomedically obsessed, who like to do blood pressures on 90 year olds, rather than
looking at what their social care needs might be. We also have a dementia and depression screen in our protocol, where who ever goes out can make an assessment. What we have tried to do is start looking at the wider aspect of a practice population, with a public health focus and also a social care focus.

Now the final part of this needs assessment has been our use of information technology. When Mandy Wearne was doing her public health work and wanted to look at some morbidity data we had precious little. We are computerised. At the moment eighty per cent of GPs are computerised. They are the most computerised part of the clinical NHS and we ought to be asking what benefit the NHS gets for all this investment. I went to visit one practice recently where the computer was still in its polythene case.

It seems we have decided to have computerisation without any thought about what it can be used for. This was certainly true of our practice. We were putting rubbish on the computers. For the last eighteen months we have gone paperless. Therefore the doctors, the nurses, the physiotherapists, the counsellor, all put their clinical contacts onto the computer. This means not only do we have a superb morbidity database, we also have a super tool for audit. We no longer have to stagger home with all those notes, as someone clever can press a few buttons and provide all the 'stuff'. This means our annual report is our health information report of the practice giving details of contacts, referrals, audit and so on. We had this needs assessment. This was very important when we went fundholding.

We need to look beyond fundholding as just purchasing hospital care. While this might be very expensive, it is a marginal and peripheral activity in general practice. The main job is to be looking after patients in the primary care setting. The attraction to us of fundholding was to have a budget, not for purchasing but for looking after our patients and the discipline that would induce in the GPs as well. From that approach we have decided to look at the needs assessment, which had been started before fundholding, but also then we can start looking at if we do make any underspends can we be spending resources in things such as information management, social care and pre-school education by supplementary health visiting time. So that was the package that we developed. During this time we had the contact with patients from the health forum and from our local councillors. That is where we were.

Looking to the future

One of the other things general practice needs to do is manage the clinical resource. GPs who are purchasers and providers are also clinicians and in fundholding manage the resources. All GPs need to be involved in this. As a result of having a budget it gave us a 'kick up the backside' to do more, for instance with audit. We can demonstrate, for example with asthmatic care that 23 per cent of the asthmatics have a peak expiratory flow rate of less than 80% of expected. We can tell you that 20 per cent of our diabetics have a glycosylated haemoglobin of more than 10 per cent and so on. As a result of this we have decided to set ourselves targets to improve outcomes. Having got interested in our own work we wanted to look at the primary and secondary care interface. We decided to look at the physiotherapy service. We decided to contract for a musculo-skeletal physiotherapist on the grounds that there were a lot of musculo-skeletal things about. Within three months this physiotherapist had a waiting list which had gone from nothing to three months long. It was the M25 effect - you provide a service and people go and use it!
So we did some audit. The physiotherapist said the doctors were sometimes inappropriately referring. We looked. She was right. So we have used her to train us in things like examining backs, she calls this 'skilling', we call it 're-skilling' but that is just a play on words. But as a result of this work with the physiotherapist our orthopaedic referral rates have fallen by 20 per cent. So now when we are setting clinical contracts we are saying, that with a better skill-mix and use of resources, we have the information to start changing contracting patterns.

We have similarly started auditing X-rays, using the Royal College of Radiologists guidelines, we have cut our X-ray referrals by nearly 30 per cent and spinal X-rays by 70 per cent because we had got into mechanistic thinking. When we look at a needs assessment we ought not to assume that what is currently spent on the health service is due to need. With much more detailed audit you may want to think again.

Finally, as part of this approach, we decided to look at the activities that went on in secondary care. I think this is important. This sort of information needs to be distributed. At the moment there are siren voices saying that beds are shut therefore care is going to suffer. People fight for their vested interests and say it is because patients need it.

**Changing services based on information**

We asked a gastro-enterologist about his approach to dyspepsia. We liked his systematic approach so we changed our contract from consultant A to consultant B. Follow-ups have dropped, gastroscopy-follow ups have dropped and our prescribing is falling because we are treating Helicobacter pylori and are referring less gastro-oesophageal reflux because, as part of the dialogue, we have changed behaviour. We are giving such information to our health forum to explain why we have changed our purchasing. It is often the first time that some of our patients have been exposed to some of this clinical thinking which they need to inform them in the political debate. Until now it has been a very one-sided debate.

There is also a lot of information about the inappropriateness of medical activity. David Eddy in the States, who was a cardiothoracic surgeon, says that there is only 15 per cent of medical activity that has ever been scientifically validated, if using randomised, controlled trials as the gold standard. He also, as a specific instance, went back to 1906 and found no treatment of glaucoma that had ever been scientifically validated.

There is also a lot of work around, both in America and in this country about medical practice variation. For example there may be more chance of one type of an operation, than another, because surgeons 'fancy' doing it. There are the effectiveness bulletins. We decided to look at our purchasing. We picked on ENT and asked our local consultant if his present grommet activity was appropriate. We had a clinical dialogue. Basically he said he was going to carry on as before. So we asked another ENT consultant who gave an almost diametrically opposite view of what he would regard as a quality service. Given that there is so much doubt in medicine we went for the one that was going to interfere less, on the grounds that this was less intrusive to our patients body space. We have changed our contract. While we were at it we asked both consultants what grounds they would have to refer people for tonsillectomy. They gave criteria. They both agreed so we used these to analyse our last 27 tonsillectomies and none of them fulfilled the criteria. In fact four patients went along
with other things and the consultant said unhealthy tonsils - out with them. This seems a tad bit mutilative for our patients, and being a fundholder at £750 a tonsillectomy I would rather have a health visitor for that money. So what we have decided to do is purchase by protocols. We expect clinicians to set some standards on knowledge-based activity. Then audit them. We are increasingly beginning to change our contracts because of that.

That information we are now beginning to share with our patients. We had the initial medical nervousness. We think we need to share that information as part of the general health debate. Much of that offered is done in a mechanistic and medically biased way. Yet it is information that people need to make some judgements.

**Community needs assessment**

There are two other thoughts about community needs assessment.

1. We decided to subsidise our Drug Dependency Unit's prescribing costs, by paying for the prescriptions of drug addicts registered with our practice. That has become extremely expensive, but as a help we asked the patient health forum whether that was the right way forward. Of course if presented in a certain way they would have said we don't want to give these junkies all this money, we want more doctors and nurses. But we had some information from the Wirral, that the Drug Dependency Unit having been introduced there, crime had fallen by 17 per cent. In most contacts with our patients we find they are much more concerned about damp housing, poor street lighting, crime and so on than stopping smoking or drinking. It was an attempt however imperfect as a way to have some discussion on the way forward.

2. We also caused a bit of a furore this year. When we had the needs assessment performed we started drawing together a nursing specification set up by the public health nurse. We also employed a nurse practitioner in the practice, partly because health visitors said they could not take on the public health nurse work and we wanted him to do so, and partly because if you are looking at skill mix you also need to look at doctors. Do you need as many GPs? He and Mandy wrote the nursing specification and we asked our local Community Trust if they could meet it, and of course they said 'yes', because providers talk like that. They could not deliver. So this year we looked elsewhere and we have moved our community contract to a Unit ninety miles away. What we wanted to do was to keep our nursing staff, they enjoyed working with us and sack the management. Why shouldn't the market affect community services?

As a result we now have a fantastically integrated team because the management has been devolved to the practice to meet need and it is immaterial whether they are employed by the practice or under contract. The old militarist model, where you had to ask permission from a nurse-manager and then wait three months for an answer, has gone. What we want from the Community Unit is up to date advice about community service issues, not control over important members of our community service. We have managed to use the market to meet the needs. All the time we have kept our patients informed through the health forum so there was less panic when people were expressing concern.

It is important to allay their fears. When we decided to become fundholding the opponents of the reforms had done a super job in frightening our patients. So we worked very hard, meeting groups of patients, providing leaflets to allay those fears,
but they still continue. So when we have made changes to contracts we have tried to inform them as best we could.

I hope the case study is useful. For a middle-aged GP like myself, I accept Angela Coulter's suggestion that fundholding's main purpose is to address GPs mid-life crisis, but I have never been so energised, excited and emancipated and so on by the sort of work we are doing in our practice. With the information that we have now got and the contacts with the community we can truly be a resource for our community.

References


Discussion

District Nurse

I was very interested in what you said about purchasing your community nursing management from another authority. I wondered within the practice whether all your nursing services are managed by one manager: practice nurse, district nurses and so on?

Dr Colin-Thome

We call the person a co-ordinator. When we are doing these clinical protocols with consultants who were user friendly, we had a two way contract where our behaviour had to change. When we got this much more imaginative contract with the community unit they set a quality spec of us. It was a two-way deal. We had to decide who the appropriate co-ordinator of the nursing service should be, it could be either from the community staff or from our staff. We both had to agree this person had to be part of the practice management and attend partners meetings and so on. As it happened our nurse practitioner already did that and he was chosen. The idea is that there is a co-ordinator/manager. But we are quite keen on the idea that all these expensive G grades should have the skill, because of the grade, to manage themselves. What they need is facilitation which the Trust provides. We can provide some of it as part of our audit work. Being a professional in your own right, you set some standards and see if you can meet them. That is what we have tried to do rather than being a control model.

In district nursing we have decided to devolve the dressing budget to them, if they can come up with protocols and make a saving then the money can be used in district nursing development.

Caroline Ploughright, The National Case Mix Office

I was particularly interested in your forum. I have found in previous jobs that it has always been very difficult getting patient representation. I would be interested in how you did it and whether they are elected for a term of office.
Dr Colin-Thome

We did not have any difficulty. I had been a local councillor and I was obsessed with who represents the community. The work that Mandy Wearne did, her development model, taught me that a lot of this work has to be much looser. This rigid 'do they represent the community' is unreal, we used to get by at by-elections with a 15 per cent turn out. Any one can come to this group. Usually it is about a dozen people. They are various people, some of them have just heard about it from some of the other community work, its a very loose arrangement, we don't have elections, we want a much more open community approach.

Nurse Lecturer

I wondered what, in your practice, is the present state of play with the multi-disciplinary record? Do you all share the same data, or do you all hold on to your own data in different parts of the computer?

Dr Colin-Thome

Everybody uses the computer now, it is one database. We had our neuroses at first, we kept double records like a lot of people. Its a maturing process. It well may be that the nurses do the same. Basically there is one record. We have a diabetic service which the nurses run. We only get involved when there are problems, so the audit of our diabetic care is really an audit of nursing care. The computer is a common data base so the social care manager uses it too. It is a common data base for a lot of different personnel. The practice computer produces that dreadful Korner data which we ship off to the Community Trust.

Hugh Fisher NHS Information Management Centre

Speaking as a one time developer of GP systems, do you actually share the record with the patient during the consultation?

Dr Colin-Thome

The computer is slanted half-way so I can see the record and the patient can too. They often say "Hey that's not right". Its there for them to see, it is as active as we can be. One of the interesting points from our video-feedback, since the advent of using computers all the time, was whether it had altered the psychodynamics of the consultation. It has, but that was something we had to be aware of - not to become computer obsessed. But the patients comment on things like "Its about time you learnt to type".