

DELIVERING BETTER HEALTH CARE: THE PACE PROGRAMME

Demonstrating a managed approach to implementing change.

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The three papers in the series Delivering Better Health Care make several references to the work of the (PACE) Promoting Action on Clinical Effectiveness Programme. This paper provides notes about the background to that programme and a summary of the lessons from the work. The work was managed from the King's Fund between 1995 and 1998.

Full details are available in the reports published by the King's Fund. The final report describes the experiences in the sixteen projects that formed the main part of the programme and draws the main general lessons from the work. It's a good read. (Experience, Evidence and Everyday Practice, King's Fund, London, 1999. ISBN 1-857-239-6)

The background to PACE

PACE was set up to show that implementation of evidence based practice could be achieved using (then) current knowledge about managing change in the NHS and about changing clinical behaviour. Literature on managing change in the NHS was diverse but there was common consensus at the time that an integrated approach, using a number of mechanisms (such as audit and professional education) was likely to be effective. "There are no magic bullets for improving the quality of health care, but there is a wide range of interventions available, that if used appropriately, can lead to substantial improvements in the application research and, ultimately the, the effectiveness and efficiency of health care" (Oxman 1994).

The focus for PACE was on organisational development to secure the implementation of evidence for a specific clinical condition. The starting point was the Getting Research into Practice (GRiP) project (Oxford, 1993). GRiP explored how health authorities could use research evidence in their commissioning role to improve health.

What was PACE?

PACE was a national programme funded by the NHS Executive: it cost about £1.2million over three years. Its three linked objectives were to:

- ◆ Support sixteen local projects within Health Authorities and NHS Trusts in the NHS in England to demonstrate the effective implementation of evidence-based practice.
- ◆ Support a PACE Network of individuals who had interest in clinical effectiveness.
- ◆ Disseminate the lessons from the local projects.

Funding covered grants to the local projects as well as a small team based at the King's Fund. PACE was launched in autumn 1995 and work was completed in December 1998.

How was PACE set up and managed?

The launch of the programme involved:

- ◆ The creation of a Digest of Research Evidence to identify clinical topics where robust evidence was available.
- ◆ An open invitation to health authorities and NHS trusts to join the programme.
- ◆ The selection of projects to form the main element of the programme: with two in each of (the then) eight NHS regions.
- ◆ An invitation to people in the NHS to join the PACE Network.

A pro-active approach to the management of the programme was adopted from the outset. The emphasis was on action learning and involved:

- ◆ Ensuring that the individual projects were not islands through regular meetings of representatives from all the sixteen projects to enable them to work and learn together.
- ◆ Allowing people involved in similar endeavours to learn from the work as the projects rolled forward and the lessons from the work emerged - through membership of the PACE Network.
- ◆ Enabling anyone who was interested to keep in touch with the work - through the regular PACE Bulletin.

The sixteen PACE projects (in alphabetical order)

1	Barnet	Hypertension
2	Bradford	Helicobacter Pylori Eradication
3	Bromley	Helicobacter Pylori Eradication
4	Chase Farm	Pressure Sores
5	Dorset	Menorrhagia
6	Dudley	Continence
7	Gloucestershire Royal	The management of Stroke patients
8	Lambeth, Southwark and Lewisham Health Authority and Kings	Cardiac Rehabilitation
9	North Derbyshire	Congestive Cardiac Failure
10	Oxfordshire	Post-operative pain control
11	Royal Berkshire	Leg Ulcers
12	South Tyneside	Stable Angina
13	Southern Derbyshire	Low Back Pain
14	Walsall	Helicobacter Pylori Eradication
15	Wigan and Bolton	Continence
16	Wirral	Family Support in Schizophrenia.

Sixteen PACE Projects

The sixteen projects selected in the national competition to form the main part of PACE involved a range of clinical conditions and a range of NHS professions. Many of the projects required close working between primary and secondary care. Each project received a small grant (£30,000 over two years) to support the work and some of the incidental costs. Experience showed that this represented a small proportion of the costs involved. One project estimated that the grant represented about 20% of the total costs of the project.

The PACE Network

Between July 1996 and July 1998, the PACE Network provided links between people who were interested in the implementation of evidence-based practice. The organisation of the Network involved:

- ◆ Enabling members to identify colleagues in other organisations with similar experiences and/or interests.
- ◆ Learning about progress in the local PACE projects.
- ◆ Providing opportunities for discussion and debate and sharing good practice.

Between the launch of the Network in January 1996 and its closure in July 1998 the Network attracted about 500 mem-

bers from all disciplines and functions in the NHS. 50 Discussion Days were organised between July 1996 and July 1998 to enable members to meet colleagues in other organisations who have similar interests and provide opportunities for discussion and debate. The sessions were valued highly by members.

Dissemination and Publications

Publication of a regular PACE bulletin was the main vehicle for disseminating information. It was circulated to all NHS organisations in England every quarter. It was designed to give concise messages and encourage interest - rather than to provide details about the work. Articles in journals and presentations at conferences described aspects of the work in more detail (such as the work in individual projects). Descriptions of the work in the projects were also provided at the PACE Network Discussion Days.

A number of PACE Discussion Papers were prepared during 1996 as short introductions to aspects of the programme. One example entitled From project to mainstream encouraged discussion about the challenge of ensuring that demonstration projects had a lasting impact of practice and services. An interim report Turning Evidence into Everyday Practice was published in November 1997 to provide an interim report of progress and identify the lessons emerging from the work. The final report was published in May 1999.

Evaluation

Three parallel activities were established to evaluate the sixteen projects within the programme:

- ◆ **The action learning approach for identifying lessons learnt - through regular dialogue between the PACE team and local projects.**
- ◆ **Support to the projects to help them measure the impact of what changed using a basket of measures which, when taken together, could reliably indicate the trend and scale of change.**
- ◆ **An external evaluation undertaken by a team based at Templeton College, Oxford to assess how the changes have been achieved by the local projects.**

The lessons from PACE

Implementing change: ten tasks

Analysis during the programme defined ten distinct - but often overlapping - tasks that require attention if success in implementing change in clinical practice is to be achieved. In effect PACE confirmed the emerging findings from research - that a multi-faceted approach using a range of techniques - can be successful. The ten essential tasks are:

1. Choosing where to start and ensuring support for the proposal.

Local criteria to guide the choice of topics for attention need to be agreed at the outset along with procedures within which decisions are made. Action is also required to assess current practice, to assemble evidence and to determine local priorities for change. Critical appraisal skills can facilitate local discussions about the relevance of research evidence.

2. Engaging clinicians and securing their support for the proposed initiative.

A broad assessment of local working relationships and processes, which avoids labelling people, was shown to be sufficient to plan implementation. This assessment can also identify local clinical leaders and provide the basis for discussions to identify and overcome barriers to change.

3. Involving patients means being clear about why patients need to be involved.

A variety of mechanisms (such as patient membership of project groups, focus groups and patients' panels) can be used to ensure that patients are involved in the work.

4. Defining local standards involves agreeing the intended standard of practice.

Local ownership of the chosen approach for the presentation of local standards (whether as guidelines, pathways or

protocols) is essential. Build on national evidence-based guidelines (or systematic reviews) rather than undertake searches etc. locally.

5. Keeping in touch with those affected as the work is taken forward.

Communications must be taken seriously. Clarity about the message and role and identity of the messenger is essential. Steps need to be taken to assure the consistency of the message. Wherever possible existing communications systems should be used, avoiding the need to organise new meetings and paperwork.

6. Securing change is the core of the work and involves a range of activities.

Consider an incremental approach, which ensures that techniques can be tested locally before they are rolled out. There is an important role for multi-disciplinary teams and steps need to be taken to support team development, for example to secure a common understanding of respective roles and the nature of research evidence.

Plans for training should take into account the pressures on clinicians and local services: practice or ward-based sessions may be particularly welcome. Clinical audit can be a practical way of encouraging clinicians to review and change their practice. Additional resources may be required to cover the costs of identifying existing patients whose care and treatment may require review.

7. Providing services to match changes the proposed changes to clinical practice.

Experience has shown that securing progress here may be as challenging as changing in clinical practice. Carefully assess the service and resource consequences of the initiative. A link with planning and budgetary timetables and the engagement of the appropriate managers in the discussions will be important.

8. Measuring impact to demonstrate achievement.

Be clear from the outset what is practical. There may be difficulties in capturing and assembling suitable data from routine data systems to measure the impact of local initiatives.

9. Sustaining change to ensure that the changes become routine practice.

Avoid the work becoming just another dead project. Take steps to guarantee the supply of new documentation after the project focus ends. Similarly, build in reminder systems as part of patient records. Provide induction training for new staff.

10. Learning lessons and managing the work as a learning experience.

Use time at project meetings for reflection to ensure lessons are learned. Take an honest approach where successes (and failures) can be openly discussed. Create links to ensure that the learning is used to influence other local initiatives and thus ensure that there is a better return on costs of initial projects work.

Managing implementation

Successful management of implementation initiatives requires a sound project management approach, with carefully developed objectives and a realistic timetable. It often takes longer than expected. Clarity is needed about who will lead the work (preferably a locally respected and knowledgeable senior clinician) and who will undertake day to day co-ordination. Effective team working is important, calling for a wide range of skills and contributions. The roles of clinicians and managers within the initiative require special consideration: implementing change in clinical practice is not solely a clinical issue. A clear link between implementation initiatives and local planning activities is essential.

In Conclusion

PACE re-affirmed that implementing change is complex and expensive. Success requires experience of managing change in the health service, a broad understanding of the range of activities involved, awareness of the emerging evidence about changing clinical behaviour and knowledge and understanding of local organisational policies, structures and working relationships.

PACE demonstrated that the effort was worthwhile and improvements to the care and treatment of patients could be achieved. Implementation projects enable people to develop new skills and create new working relationships. This cost can be seen as an investment with a steep learning curve. It can also be fun.

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