Evaluation of the PACE programme:

final report*

Dr Sue Dopson, Prof John Gabbay and Dr Louise Locock

with David Chambers

Oxford Healthcare Management Institute,
Templeton College, University of Oxford

Templeton College

Wessex Institute for Health Research and
Development, University of Southampton

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* This report has been prepared before final outcome measurement data from the project sites have been made available. Further amendments may be required in the light of these data.

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1. Executive Summary

1.1 *Aims and methods*

This evaluation report explores lessons to be drawn from the experience of the Promoting Action on Clinical Effectiveness (PACE) project. PACE was funded by the Department of Health between 1995-98 and project managed by the King's Fund, whose role included choosing the projects, allocating £30,000 per site over two years, providing a source of project support and analysing achievements. There were 16 project sites, two per region. Clinical topics were varied, as was the use of change methods.

There were two phases of the evaluation (Jan/Aug '97 and Jan/Sept. '98). The purpose was to explore, using qualitative methods, the lessons from the attempts to change clinical practice in the 16 projects and comment on the role of the King's Fund in managing the PACE work.

The methods of the evaluation included telephone interviews with: all 'core' team project members (61); 'non-core' people who could comment on the project but were not closely involved in managing it (54); the King's Fund team and representatives of the Department of Health (7). The interview schedule was semi-structured; written notes were taken of the interviews and were analysed by all four researchers. A questionnaire was also sent out to ten front-line clinical staff in each site.

1.2 *Overall progress of the 16 projects*

The aims of PACE were as much about changing attitudes and behaviour as implementing effectiveness evidence in one clinical topic. Success can thus be judged on two main axes: clinical changes and the extent to which learning has occurred. Different projects may meet some, all or none of the criteria relating to each axis:

Achievement of clinical change

- has the project been successful in changing clinical practice in the way intended? (process outcome)
- will these changes be sustained in the longer term?
- have the changes in practice achieved been successful in improving outcomes for patients? (health outcome)

Learning from the process

- has the core project team been successful at learning broader lessons from their experiences, whether positive or negative? (individual/team learning)
- has the project changed general attitudes to implementing clinical effectiveness evidence amongst clinicians? (professional learning)
- has it resulted to changes in the way the organisation as a whole approaches clinical effectiveness? (organisational learning)

On the basis of the evidence available so far, the sites fall into seven different categories:

Category	Number of sites
High levels of clinical change + **high** levels of learning from the process	4
Medium to high levels of clinical change + **medium to high** levels of learning	3
High levels of clinical change + **medium** levels of learning	1
High levels of clinical change + **low** levels of learning	1
Medium levels of clinical change + **low** levels of learning	5
Low levels of clinical change + **medium to high** levels of learning	1
Low levels of clinical change + **low** levels of learning	1

This assessment relies on information provided at interview and in their final reports by the projects themselves, and on the views of King's Fund interviewees. Objective measurements of changes in clinical practice and patient outcomes are being carried out and are being analysed by the King's Fund team as they become available. Should the results differ markedly from sources available so far, these findings will need to be revisited, although from their analysis of available data so far the King's Fund team do not anticipate major discrepancies. It should be noted that in many projects the acheivement of improved outcomes is a longer term aim, beyond the immediate timescale of the programme.

1.3 ***Factors affecting implementation***

A number of factors emerged at the interim report stage which seemed influential in achieving change in the projects: the strength of the evidence; the extent to which prior analysis of the context in which change was to take place was done, and how relevant professions were involved; the use of opinion leaders; the extent to which the organisation was committed to the project; the clarity of objectives and the strength of project management; and the adequacy of resources. The report is organised around these headings, looking at the complexity of each of the factors. Below is a summary of the key relationships between the factors and the levels of progress in different sites. This is followed by the key points about each of the factors.

1.3.1 Relationship between the factors and levels of progress

- Strong evidence, supportive opinion leaders and integration within a committed organisation appear to be the primary drivers, without which projects have little chance of success. Evidence and opinion leaders are particularly important for immediate implementation of clinical change, whilst organisational commitment is more strongly associated with wider learning from the experience

- On occasion a perceived need for change can provide momentum where evidence of effectiveness is weak, although this will by definition limit the project's value as a demonstration of evidence-based practice. It may also limit how much can be achieved even within the clinical area concerned

- Although organisational integration and commitment is associated with organisational learning, there is insufficient evidence to assess how far this learning is the result of PACE alone. To some extent the relationship between PACE and other clinical effectiveness initiatives is circular - the more effectiveness work there is going on locally, and the more it has the interest and support of senior people, the better the PACE project seems to do and the more the organisation can learn

- The remaining factors (context analysis, professional involvement, clear objectives and project management, and level of resourcing) seem to be secondary, supporting processes; their presence might be an additional help, but on their own they would not be enough to initiate change. Their absence does not necessarily prevent success, although a serious problem with any of them - for instance alienating professional groups or catastrophic project management - can have a strong adverse impact. There was strong agreement about the value of having a dedicated project worker

- Interviewees generally felt extra resources were helpful, and were most likely to judge the level of resources to be sufficient in projects which had done well in achieving clinical change. There is insufficient evidence to conclude that success was dependent on resources, however. It is possible that the level of resourcing was itself dependent on the level of organisational commitment

- The nature of the clinical topic has a bearing on success - projects with a narrowly defined topic may make good progress in achieving clinical change, but at the expense of wider relevance and profile in the rest of the organisation. 'Unfashionable' topics may find it difficult to engage enthusiasm for implementing clinical changes, let alone for dissemination

1.3.2 The strength and importance of the evidence

- The presence of 'rock solid evidence' greatly improves the chances of persuading doctors and other health professionals to change

- Many interviewees, even in projects which had struggled to achieve change, felt PACE had helped change attitudes amongst the professionals directly involved towards effectiveness, evidence and research

- One of the original criteria for selecting the 16 project sites was that the work proposed should be based on 'robust evidence'. In practice, perceptions of the strength of the evidence varied both between projects and sometimes between members of the same team

- There are different forms of evidence differentially accepted by different individuals and occupational groups

- The tension between evidence and clinical experience was a recurring theme. Evidence is more powerful where it chimes with experiential knowledge

- The failure to get a consistent message across primary and secondary care was seen as a substantial obstacle to persuading GPs that there was a need to change

- Whilst doctors might sometimes rely more on experience than evidence, they might also be critical of other professions for doing the same

- A number of interviewees reported that in their experience nurses have a more receptive culture to clinical effectiveness, even though there is less research evidence about nursing

- The perception of the need to change can create its own momentum independent of evidence

- Although the absence of evidence could present major problems, good evidence of effectiveness was felt by many interviewees to be a 'necessary but not sufficient' condition for achieving change

- The point that a perception of a need to change can make up for a lack of strong effectiveness evidence raises an important qualification: strong evidence may not even be necessary, if a strong enough alternative justification can be found

- A number of projects reported focusing selectively on aspects of the condition where the evidence was agreed to be strong

- The idea was widespread that for evidence to be accepted some process of local adaptation and ownership was needed, but that this should be based wherever possible on existing guidelines

1.3.3 The importance of prior contextual analysis and the identification and involvement of relevant professional groups

- Understanding the political and cultural context, the relationships between key stakeholders and resource issues was a helpful factor in achieving change, but is not itself a primary determinant of progress. Less successful contextual analysis is not necessarily a major obstacle

- Many interviewees noted some weaknesses in their approach. These included not involving all the right people, not involving them at the right stage, not anticipating the strength of likely reactions, or failing to identify some practical resource requirements

- It is important to identify informal as well as formal sources of influence

- Although context analysis was generally seen as helpful, many interviewees commented on its 'politically sensitive' nature and felt there were dangers in formalising it, as it could lead to unhelpful labelling of 'difficult' individuals

- Knowing what the blocks might be was not enough on its own - this knowledge then had to inform strategies for overcoming obstacles or harnessing potential support

- The projects differed significantly in the extent to which they enjoyed a receptive context for change

- There was a consensus about the difficulties of getting GPs involved; practice nurses were agreed to have been an invaluable route into practices

- Some projects were tempted to attribute levels of progress to awkward or helpful personalities. Whilst this may be true to a limited extent, the projects which had most successfully addressed problems of a lack of enthusiasm were those which had recognised the importance of moving beyond a purely individual level of analysis to consider wider underlying influences on behaviour, including the influence of organisational and managerial factors

- The most successful educational strategies were agreed to be those targeted at individual and practice level, which sought to root changes in clinical practice in the reality of GPs' experience and fit in with their way of working

- There was considerable agreement that GPs were more likely to respond to contact with opinion leaders from a medical background, particularly if this was offered to individual practices

- Strategies for approaching individual practices need to be based on an understanding of local circumstances. There is no simple list of ways to engage people which will be universally applicable, but many useful techniques were reported

- The same concerns about considering which groups to involve, tailoring the approach and finding alternative routes applied equally in secondary care

- Several projects reported successfully involving service users as an additional route for achieving change, for example patient education to prompt appropriate treatment plans

- Making sure all the relevant professional groups were involved in the process of overseeing the project was also a significant issue, and had implications for how well different professional groups would react to the implementation of the project

- Securing the support of leaders of groups and not just representatives of groups is an important lesson

- Involving different professional groups, like prior contextual analysis, may be helpful but its absence is not necessarily a major obstacle

1.3.4 Opinion leaders

- The term 'opinion leader' refers to people who influence the beliefs and actions of their colleagues

- Doctors inevitably feature prominently in any discussion of opinion leaders. In primary care there may be two different kinds of opinion leader influence, from fellow GPs and from hospital consultants

- The Cochrane systematic review on local opinion leaders (Thomson *et al.*, 1997) is ambivalent as to the impact of local opinion leaders. However, we found that opinion leaders were very important in influencing what happened in the projects

- There can be a mutually reinforcing relationship between evidence and expert opinion; to some extent it is the endorsement of evidence by expert opinion that makes it credible. This has implications for cases where evidence and expert opinion are at odds with each other.

- Absent or resistant opinion leaders can prove a major obstacle

- Some projects reported that they had created or discovered new opinion leaders who had helped win over people who might not otherwise have been convinced

- Strong opinion leaders can sometimes make others feel excluded or unable to keep up, and they can create hostility

- The issue of reliance on individuals is an important one. Even in cases where such individuals can be found, there are implications for the burden on them personally, and for the sustainability and dissemination of clinical effectiveness initiatives

- Opinion leaders with their own hidden agenda can be damaging

- Some interviewees interpreted the meaning of opinion leaders to encompass more than just doctors, and cited a diverse range of influential people from other professions, both clinical and managerial

- Identifying and enlisting multiple opinion leaders throughout the organisation helps to create a 'change team' with broader appeal to all the groups who need to be involved

- Where supportive managerial opinion leaders exist, they can provide crucial organisational commitment to the promotion of evidence-based practice and take practical enabling action to support change

1.3.5 Organisational integration

- Where projects were integrated with an existing clinical effectiveness strategy and there was a commitment by the wider organisation to clinical effectiveness, projects tended to do much better than those which were one-off initiatives

- Wider integration was not always necessary for clinical change to be achieved. There were several projects where clinical change was achieved without being embedded in such a strategy

- Organisational integration and commitment are necessary to ensure the initial kick-start is translated into wider, sustainable action and that the organisation as a whole benefits from the learning process of the initial project. Without that commitment, one-off projects are more likely to remain discrete initiatives with little impact beyond the immediate team and clinical staff involved

- There is some evidence that even a project which has failed to make much progress in the immediate clinical area can learn a lot from the process if there is senior commitment to it

- The evidence is ambivalent as to whether a PACE-style project can itself generate this commitment during its lifetime, so that a previously unreceptive organisation becomes committed to an evidence-based approach

- In practice the process seems to be more circular than linear, with mutual reinforcement and learning taking place between PACE and other activities. Where there is integration with a broader clinical effectiveness strategy, it is impossible to tell how much organisational learning or even implementation of the specific clinical topic is attributable distinctly to PACE

- In sites where the PACE project has been part of a wider initiative, interviewees generally agreed that the work would have happened anyway, although it might have been slower and done in a different way without the stimulus of PACE

- Projects with a more narrow focus may have done well in implementing change in that area, but have found it harder to use it as a broader learning experience for the whole organisation

- Whilst PACE projects clearly benefited from being part of a broader initiative, their success was also attributed to the very fact that they were something distinct and special

- There is a dilemma that discrete management and funding for a project may improve the short term progress of the work at the same time as undermining its longer term impact on the rest of the organisation

- Perceptions of the level of integration can vary dramatically within one site

- Poor integration exercised a damaging effect, particularly on levels of organisation learning

- Achieving even a small change in one area takes an enormous amount of time, energy and single-minded concentration. The chances of success are dramatically improved if the organisation as a whole gives its support and commitment to this effort; without this organisational support it is unlikely that the learning will ripple out to other areas

- Clinical governance in particular was seen by many as a way of putting evidence at the heart of decision-making, overcoming many of the obstacles faced by projects in trying to raise its profile on a local basis

- There were reservations about how effective changes such as NICE and clinical governance would be in practice; there was a feeling that organisational integration on its own would not be enough, and that lessons about the implementation process from PACE needed to be carried forward

1.3.6 *<u>Objectives, project management and resources</u>*

- There was virtual unanimity that the timescale and intensity of effort needed to undertake this kind of work had been underestimated

- Having clear objectives was generally agreed to be a useful discipline, and many projects emphasised that effective project management had been vital

- In some cases, the original objectives were generally felt to have been overambitious and it was decided subsequently to reduce their scope

- A dedicated project lead proved crucial to achieving success in the projects

- It is unclear whether the reliance on individuals and the required intensity of effort can be sustained

- Extra resources were generally felt by interviewees to have been helpful. There is insufficient evidence to conclude that success was dependent on resources, however - or at least dependent on the resources provided by PACE

- Most projects seemed confident that the clinical changes would be sustained and further projects undertaken even once the PACE funding came to an end

1.4 Role of the King's Fund

The King's Fund provided five major contributions to PACE:

1. The name and reputation raised the projects' profile locally.
2. The King's Fund team provided a valuable external resource.
3. Belonging to a national project was a source of motivation for the project teams.
4. Producing and policing timescales was perceived as valuable.
5. The networking opportunities were found to be valuable for moral support and problem solving.

Less favourable comments centred on the usefulness of the meetings in London for senior staff and the inadequate assistance in providing evidence on implementation research.

1.5 The role of demonstration projects and the New NHS

- Interviewees were divided as to the role of demonstration projects as a way forward in achieving clinical change. Some were worried about the repetitive nature of the lessons emerging from the pilots: "How many pilots does it take to fly a plane?" Some believed that PACE had been a driver but that new developments, in particular the National Institute for Clinical Excellence (NICE), the Commission for Health Improvement (CHI) and clinical governance, have so radically changed the landscape within which the implementation of evidence is set, that they found it difficult to understand how PACE can feed into the new agenda.

- Many interviewees were concerned that the lessons about the complexities of implementation, both from PACE and from other research, were being given insufficient consideration by 'the centre'. Most interviewees believed that even if national accountability mechanisms were a help, they could not be the sole solution; subtler strategies would still be needed to convince clinicians of the need to change and to act on this conviction, given the remarkably resilient nature of professional influence and practice, and the important interaction between evidence and experience.

- If these important national initiatives are to succeed, more work is needed to understand how clinicians are influenced and to understand the role of organisation and management factors. The lessons from PACE about the factors affecting successful implementation should contribute to the accumulation of learning needed to take forward the implementation of effectiveness evidence.