



BALANCED VIEWS

NHS EVIDENCE: 2-3

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MAKING CONTACT



Poor communication between healthcare, social and other agencies has long been a problem with sometimes tragic consequences. Now rolling out across England, ContactPoint is an online directory that allows authorised staff rapid access to information about who is currently involved in a child's healthcare and welfare.
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FROM THE EDITOR

What's on the web

Welcome to the latest issue of *Intelligence*, the quarterly *HSJ* supplement dedicated to innovation, information and technology.

In this issue we focus on how far primary care trust websites have to go to engage communities online. A new review of PCT websites has revealed a poor standard of web communication with low levels of usability and accessibility.

PCTs should be making it easier not harder for local communities to find their way around the NHS so, to help out, Michael Guida suggests five goals for a successful site.

We also look at the benefits NHS Evidence hopes to deliver. Launched in April with over 4,000 hits in its first hour, this web based solution aims to become the main route for finding information about evidence based healthcare. With a formal accreditation system due later this year, the jury is still out on its impact.

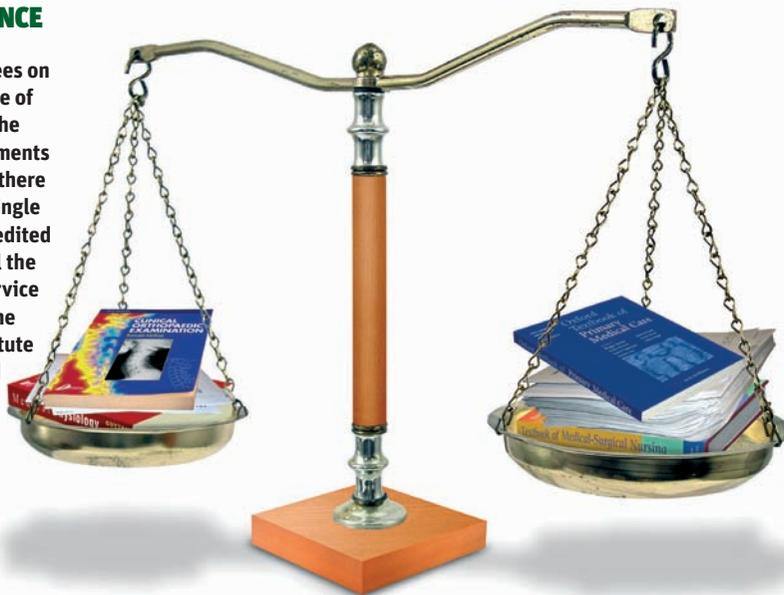
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If you have any comments or ideas for *Intelligence* email rebecca.allmark@emap.com



NHS EVIDENCE

Everyone agrees on the importance of evidence for the value of treatments but until now there has been no single portal to accredited evidence. Will the web based service provided by the National Institute for Health and Clinical Excellence have all the answers?
Pages 2-3



PCT WEBSITES



It takes just seconds to engage or lose someone's interest on the internet and yet most primary care trust websites are still poorly designed and lack the information and links a user wants to access easily. So what are the PCTs that have put together appealing and user friendly web pages doing right?
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COLUMNIST



Can quality and savings really go hand in hand, asks Alan Maynard, or is this policy making based on faith rather than financial balance?
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PORTAL POWER

NHS Evidence launched in April, designed to be a single way in to the world of health knowledge. Daloni Carlisle looks at its first few weeks

The calls for the NHS to base treatments on the best evidence are almost too numerous to mention.

Evidence based treatment finds its way into Lord Darzi's next stage review; it is at the heart of National Institute for Health and Clinical Excellence recommendations, and indeed any guidance or standard set by any medical royal college.

The problem is keeping up to date in an ever changing world. Around 3 million clinical research papers are published annually, or over 8,000 a day.

It is doubtful whether anyone could read much of this, let alone critically appraise and apply it to practice before gathering evidence of effectiveness (which is what proponents of evidence based practice would have us do). The *BMJ* recently reported that over 70 per cent of house officers read nothing about medicine; senior house officers read on average only 20 minutes a week and consultants only 45 minutes a week. There were no figures for how much health managers or commissioners read – and increasingly in the NHS they need to be on the front foot and able to debate evidence with clinicians.

There is, however, ample evidence that quite a lot of what goes on in the health service has no evidence base at all. Ben Goldacre, the doctor and "Bad Science" author who has written extensively on clinical evidence, cites papers showing that only 13 per cent of treatments used in modern healthcare have good evidence for their effectiveness and a further 21 per cent are likely to be beneficial. But, he adds, the evidence base is strongest

for some of the most common treatments so in practice 50 to 80 per cent of what the NHS does routinely is evidence based.

As Dr Goldacre says: "It's still not great and if you have any ideas on how to improve that, please do write about it."

Which brings us neatly to NHS Evidence, the web based solution to getting evidence into practice. Or at least it may be – given enough time to develop and embed itself. It was launched on 30 April this year and had over 4,000 hits in its first hour – most of them on the topic of the day, swine flu.

"Individuals cannot hope to keep up to date with the amount of information and research that is coming out every week," says NHS Evidence chief operating officer Gillian Leng. "NHS Evidence is there to provide access to evidence and it is aimed at everyone in health and social care, from the chief executive to commissioners to clinicians such as nurses and pharmacists."

Developed by NICE

NHS Evidence was proposed by Lord Darzi, who called for a new "knowledge portal" to "get information on what high quality care looks like and how to deliver it, tailored to [healthcare professionals'] own professional expertise and interests".

It has been developed by NICE, where it is now the biggest division, although NICE is particular on the wording of this as it is trying to clarify how the service will not just give access to evidence but also appraise its quality – including that of its own guidance.

"We call it NHS Evidence provided by NICE," says Dr Leng.



As yet, there is not too much to see. In some ways it is a rebranding of the National Library for Health, which for now forms the core of NHS Evidence. Anyone can access it – it is after all publicly funded. The top line figure is £20m a year but this pulls in a range of existing costs – for example of producing the *British National Formulary* and contracts with the 34 specialist libraries.

"There is very little additional money," says Dr Leng.

NHS users can still use their Athens log on to gain access to online journals and there is some added content. A swine flu search pulls up material from the Health Protection Agency, for example.

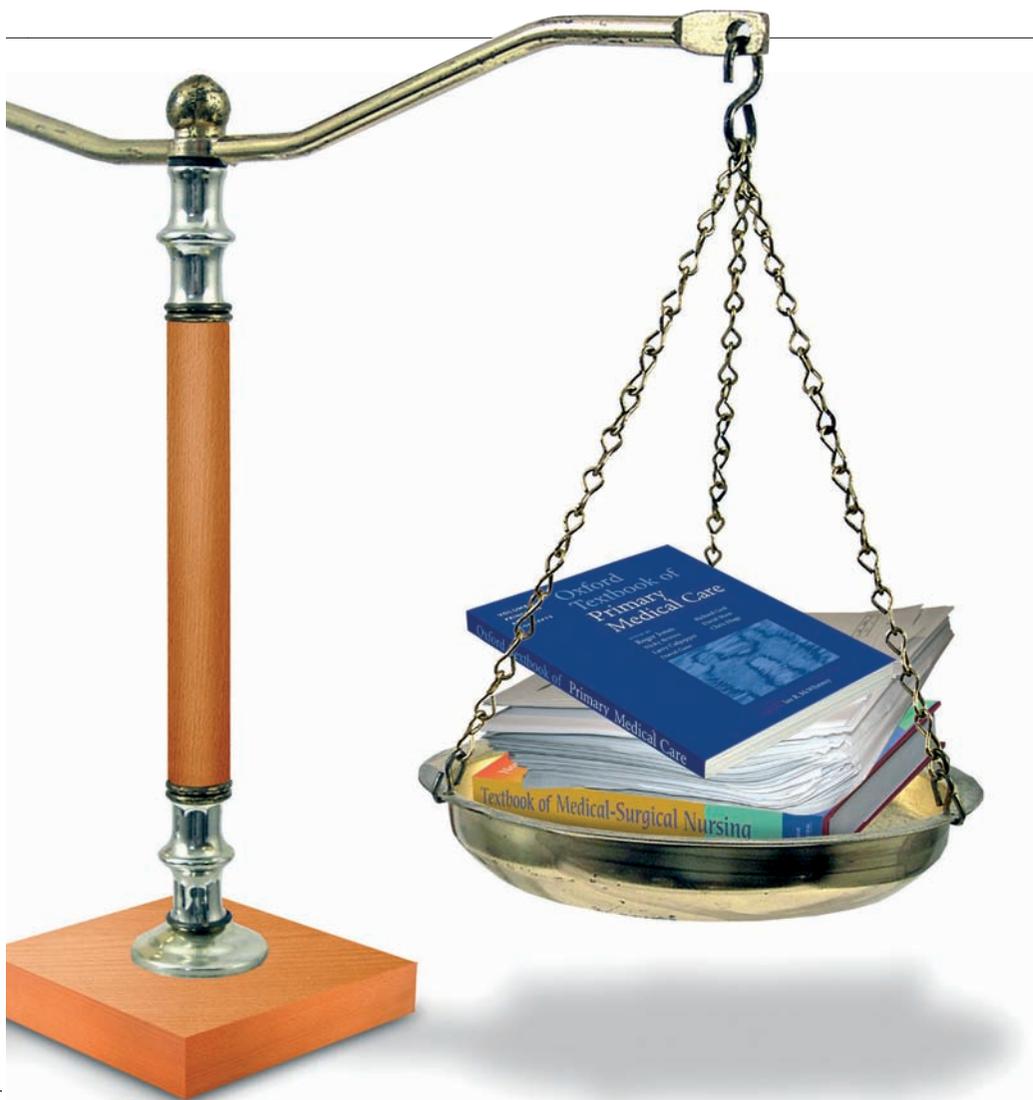
Dr Leng likens NHS Evidence to Google – but only in its ease of use. The front page is very simple, with a clear search box. Release 2 in October should offer the chance to personalise the front page, like iGoogle.

For now, results come up in a list with the most relevant at the top. Searches can be filtered using some side tabs – for example click "commissioner" and it will pull up the most relevant pages for a commissioner. Like Google, it links to external sources rather than holding information itself.

In that case, why not just use Google?

Dr Leng says: "People can go to Google and it is easy to use but it does not necessarily give you what is relevant to the NHS or anything you can trust."

This is the crucial difference. Later this



‘Google is easy to use but it does not necessarily give you what is relevant to the NHS or anything you can trust’

year, NHS Evidence will launch a formal accreditation system so users can find the most trustworthy sources – or, at least, those developed to a set of agreed principles.

As Dr Leng says: “Nothing like this has been tried anywhere else before.”

The methodology is out for consultation now. It proposes an independent committee to look not at individual pieces of evidence but at the methods an organisation uses to produce all of its guidance. Producers who meet the standards will be able to use an accreditation marque for all their literature – probably an eye logo based on NHS Evidence’s iris logo.

“The process is clear and it is based on internationally recognised AGREE (Appraisal of Guidelines Research and Evaluation) criteria,” says Dr Leng.

“It will be up to information providers to come forward. I think it is likely to be those organisations that provide the biggest volume of guidance and have the biggest impact that will be appraised first.”

The Royal College of Obstetricians and Gynaecologists, British Association of Dermatologists and the Scottish Intercollegiate Guidelines Network are already queuing up – and yes, NICE will have to apply too. Not everyone will pass,

though. Dr Leng predicts a 30 per cent success rate.

But not all organisations will want to apply for the marque, and not all good evidence will be covered by it, so NHS Evidence will also be asking universities and trusts to review new papers and highlight particularly useful or relevant articles in a newsletter to which users can subscribe.

“We are envisaging updates in key clinical areas,” says Dr Leng.

NICE’s website gets over 6 million hits a year. Dr Leng wants to top that.

“I would like it quite simply to become the main route for finding information about evidence based healthcare,” she says. “People will want to use it as they will be able to find relevant stuff quickly. I think we will see an improvement in healthcare.” ●

NHS EVIDENCE: A USER’S OPINION

Intelligence asked Chartered Society of Physiotherapy head of professional policy and information Andrea Peace, who is a former health librarian, to look at NHS Evidence. This was her verdict.

“At present it’s just a rebrand of the former National Library for Health with two new sections added (the ‘sources by interest area’ and ‘accrediting guidance’).

“It is a bit in the medical model at present which is slightly worrying in terms of it catering for the whole health family. ‘Sources by interest

area’ only contains medical institutions/royal colleges in the links list for example – no mention of the Royal Colleges of Nursing or Midwives or any of the allied health professional bodies in the list. All these organisations also provide clinical guidelines and so on.

“There is a new section on accreditation – this was one of the things that was stressed was new and exciting when NHS Evidence was announced, namely that they would provide some sort of accreditation scheme. This would

be very helpful to clinicians in terms of confidence that resources they are accessing via NHS Evidence (or other portals) have been through a robust development process.

“However, the link on the page was broken when I tried it so there is little information about when it will be launched and how other organisations can access the accreditation scheme to ensure the development of their clinical products follow the scheme and therefore can gain accredited status.

“It is unclear whether resources that have not been through the process will be dropped over time or not promoted.

“There have been some rumours within the health library sector that certain resources transferred across to NHS Evidence from the National Library for Health may not be supported or funded long term – for example, certain specialist libraries are unsure whether they will be funded when their contract comes up for renewal. So far we have had no answer on this.”

MYTH BUSTER

EMERGENCY ADMISSIONS

How hard was winter for A&E?

Was there really an excessive growth in emergency admissions this last winter? A number of client trusts said they experienced an unprecedented rise.

Using a representative sample of trusts with good data (the Hospital Episode Statistics are not recent enough), CHKS analysed all emergency admissions (excluding well babies) in October to January.

The peak winter month varies from year to year, mainly due to the weather and flu epidemics (November will always look slightly lower as it has only 30 days).

Chart 1 shows the following year on year growth in the volume of admissions:

- 2004-05 on 2003-04: 5.5 per cent
- 2005-06 on 2004-05: 6.6 per cent
- 2006-07 on 2005-06: 2.4 per cent
- 2007-08 on 2006-07: 0.5 per cent
- 2008-09 on 2007-08: 6.0 per cent

The figures reveal that before winter 2008 the growth in emergency admissions had started to slow. Previous CHKS analysis has shown that the A&E four hour target was a major contributor to the growth in the first two periods (the 97 per cent level target came into effect in January 2005).

Identifying the relative components of the cause of growth is difficult. Certainly most growth has been in the short (zero or one day) length of stay patients.

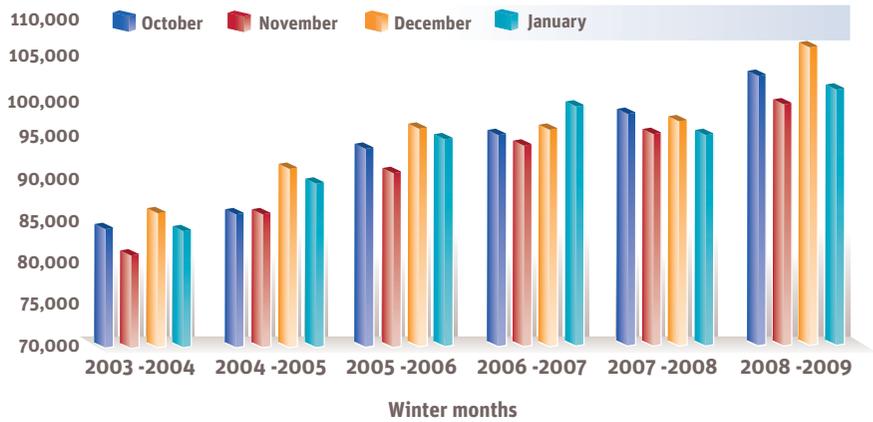
An analysis by admitting specialty (chart 2) shows that almost half the growth (46 per cent) in the last year was for medical admissions, one third (34 per cent) for A&E, and a fifth (19 per cent) in paediatrics. Surgical specialties had a much smaller increase (8 per cent) and the remaining "other" specialties dropped by 7 per cent.

There was no particular rise in GP referrals to hospital, but NHS Direct and out of hours services send patients to A&E. This tends to make this data item redundant in the analysis of emergency admissions.

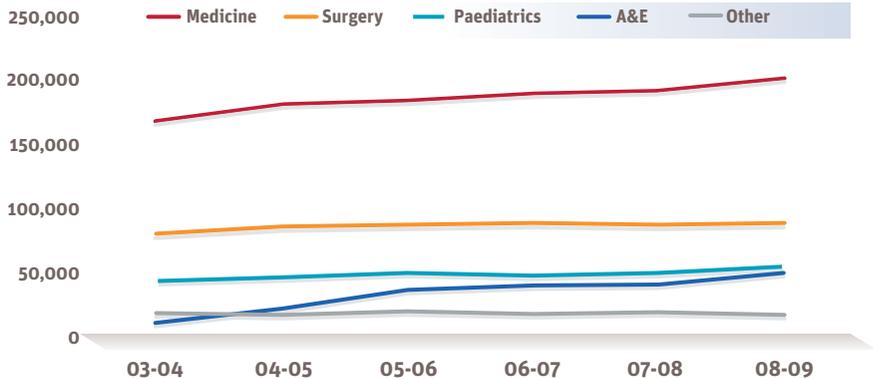
Clearly, high growth was the reality for trusts this winter, but averages can hide a great deal. Chart 3 shows the 2008-09 growth on 2007-08 by trust. This shows while the average growth was 6 per cent, three trusts had negative growth and a fifth had growth over 10 per cent, one over 20 per cent. This is the lowest proportion of trusts to have negative growth across the six years. The data supports the anecdotal evidence that this was a particularly stressful winter for the number of emergency admissions. ● Paul Robinson is head of market intelligence at CHKS, www.chks.co.uk

WINTER ADMISSIONS

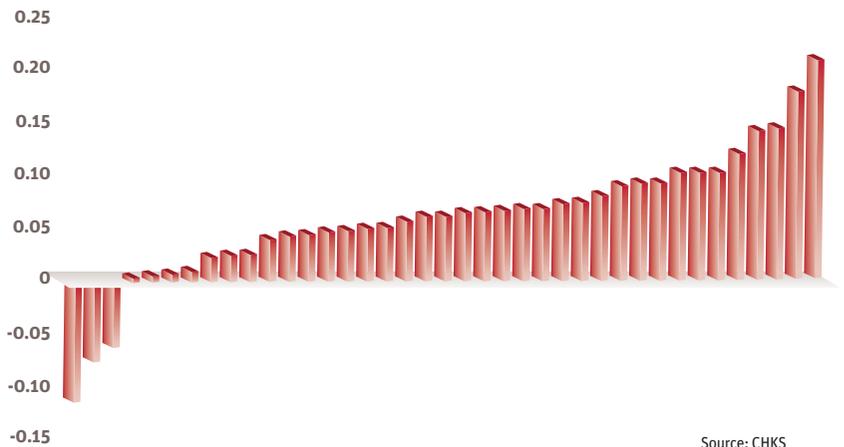
Winter four months for the past six years
Emergency admissions of a sample of hospitals



Emergency admissions by specialty



2008-09 growth on 2007-08 by trust



Source: CHKS

INFORMATION SHARING

SAFE FROM HARM

Stuart Shepherd looks at a new system to help caring agencies share and safeguard information in order to provide the best possible service to children and young people

The case of Victoria Climbié and the subsequent recommendations from the report of Lord Laming's inquiry proved a turning point in services for children.

"Improvements to the way information is exchanged within and between agencies are imperative if children are to be adequately safeguarded," begins one of the key passages in the report.

Now in the early phase of a roll out across England, ContactPoint – an online directory that allows authorised staff to see promptly which other professionals are involved in working with a child – is one step in those improvements to information sharing aimed at making sure vulnerable children and young people no longer slip through the net.

"As a result of programmes such as *Every Child Matters* and the child health strategy *Healthy Lives: brighter futures* more people from health and other agencies are being asked to take a multi-agency approach that relies on good information sharing," says David Jones, a Newcastle GP who sits on the Department of Children Schools and Families' Information Sharing Advisory Group.

"ContactPoint will be a valuable tool in that process, bringing together professionals quickly, without days of delay trying to find each other and in a manner that leads to a better and faster co-ordinated response that meets the best interests of the child."

The ContactPoint directory will hold basic information – including name, address, date of birth, contact details for parents/carers, school, GP centre and other services working with the child – for all children in England up to their 18th birthday. The lead practitioner and the completion of a Common Assessment Framework can also be indicated. The system will not hold notes, assessments, medical data or other case based information.

Details of the family GP will be automatically placed in the directory from its start while healthcare and other agency workers – health visitors, social workers etcetera – are to be added in time.

"Family doctors are used to getting and sharing lots of information via medical records," says Dr Jones. "Once we need to start working with other agencies outside health though – when perhaps a child presents with injuries that might be related



Play safe: ContactPoint will enable agencies to keep track

'Some of the most chaotic households do a lot of moving around. This will be a really important tool'

to bullying at school and it would be helpful to speak with a professional from education or a school nurse who knows them well – there is no automatic pre-existing channel of communication. ContactPoint is going to help me find who that person is and how I can reach them."

Vulnerable families

As Dr Jones points out, it wouldn't seem unreasonable under such circumstances to suggest that you could ask the child's parent or carer. But, as he explains, in the case of the most vulnerable families who have regular contact with lots of agencies, "it might be very difficult for them to tell you who a particular individual is or how they might be contacted."

Another advantage that the new directory will offer GPs like Dr Jones is its attempt to ensure a co-ordinated response to the needs of children from transient families.

"Some of the most chaotic households do

a lot of moving around," he says. "Now if somebody were to arrive at my practice having just moved in to the area I will be able to go on to ContactPoint and find out what professionals have been involved with the family elsewhere."

"It isn't the answer to everything," acknowledges Dr Jones, "but it will be a really important tool in facilitating better information sharing, in itself a key part of better facilitated multi-agency work."

Users from health, education, social care, youth justice and voluntary organisations will be required to complete mandatory ContactPoint and other relevant training before being granted access to the directory, which will be through case management systems or a secure weblink.

First steps to make the system active began in January and management teams from early adopter local authorities have already begun delivering training.

Rochdale local implementation manager Bernadette Gee explains: "People such as schools health practitioners and local authority staff who have been trained early on to use the directory will be able to spend less time stuck on a phone trying to track people down and more time working directly with the child." ●

→ www.everychildmatters.gov.uk/contactpoint

If primary care trusts are really going to be the local face of the health service, there is still a lot of work to do to engage communities online. PCT websites are difficult to find, and the quality of their design and information is remarkably low. Valuable central resources like NHS Choices are not being used or referred to.

There is very low awareness among the public about what PCTs do, because what they are interested in is easy access to services like GPs and dentists, information about their new walk-in centre and perhaps a sprinkling of health advice from time to time. Renaming PCTs seems to have done little to improve recognition or understanding in the public mind.

We have recently reviewed all PCT websites in England (149 as of January this year). What emerged was a surprisingly poor standard of web communication with little to engage the human heart.

Little seems to have changed since a 2006 survey of the quality of PCT sites, when 303 sites were evaluated. That study found sites to be lacking in terms of design and content, and public users rated them poorly.

Today, our research still shows the basic conventions of web usability and accessibility are often not adhered to. This means that sites are likely to be difficult to use – and it only takes a second to lose your audience on the internet. Foreign language content is rarely provided even for PCTs with diverse populations. When it is present, the information is very limited in scope.

Service listings vary widely between one PCT and the next. Some have a compact and coherent set of services, such as Oxfordshire PCT, which has 13; some have as many as 40 or even 50 services. If local authorities can agree and implement a standard A to Z taxonomy of services, why can't the NHS?

The terms some PCTs are using in their service A to Zs are just not friendly enough for public consumption – tissue viability, wound care. Some are just weird – “ectoparasitic service”.

The same problem is found with hospital and mental health websites, where services are often described using medical jargon that is off-putting if not frightening to the public.

Helping the public to find local services is surely what PCT sites should excel at. But we found that only just over half the sites

reviewed allowed direct access to services from the home page.

The NHS is such a complex system that PCTs need to make it easier, not harder, for local communities to find what they need. But PCT provider businesses are now going online too and competing for attention.

The public are likely to be left baffled unless the purpose of online NHS services is clearer and is joined up. Only NHS Direct has good brand recognition by the public, and while NHS Choices surfaces easily in Google searches for conditions, it is not understood as a destination or brand.

Much of what PCTs are trying to achieve on their websites is already being done by NHS Choices. All national campaigns, such as www.nhs.uk/smokefree, are at the Choices address now. High quality health and lifestyle information with pages on over 1,000 conditions – often with multimedia – are also available centrally on the Choices site. Yet PCTs often create their own bespoke content in these areas.

Local service information maps, based on a postcode search, are at NHS Choices. All PCT web teams have to do is plug in the code to their own sites and the data can be displayed locally. Few are taking this golden opportunity to use central data efficiently.

Islington PCT gets it right with service search functionality syndicated to the home page from NHS Choices as well as swine flu information from the same central resource.

In our review, we didn't have access to site usage statistics. However, our impression is that PCT sites are not just underfunded and under-resourced, they are rarely used by the public. Many can only be found by searching on the name of the organisation rather than a condition or service.

If they are worth having, the objectives of these sites must be defined so that their performance and worth can be evaluated.

With almost 150 PCT commissioning websites online today and perhaps the same number of provider sites soon to be launched, there is the risk of a huge amount of duplication of effort when many of the messages and services are already available elsewhere on the web.

Campaign sites continue to proliferate too, for smoking, drinking and other initiatives and, while the local issues do need to be reflected, the core information and tools are again available centrally. The

microsite explosion costs money and fragments the messaging.

There must be a case for both simplifying this experience for the public and rationalising duplication to create efficiencies for the NHS.

It is quite possible to imagine life without PCT websites. In fact, if GPs were to use and promote NHS Choices during patient consultations then most of what the public needs is there already – but only if it is endorsed by trusted health professionals. However, many GPs don't know or care about NHS Choices and at best prefer to



COMMUNICATIONS

Most PCT websites could become much stronger with a basic rethink, says Michael Guida

ALL RIGHT C

'There is a fight for attention online and at the centre of it all is the public, who just want help that makes sense'

print out Patient UK (patient.co.uk) information from their desktop system, or at worst ask the patient to Google their condition at home.

If PCT sites are worthwhile and necessary, what should they be doing for the public? There are five goals for a successful site:

- Help find local services like GPs, dentists, pharmacists, opticians
- Give healthy living tips and campaign information, but with a local flavour and emphasis
- Communicate Darzi reforms like

polyclinics, and Choice

- Engage, consult and listen to views and experiences, and publish feedback
- Make commissioning/providing PCT businesses invisible.

There is a fight for attention online and at the centre of it all is the public, who just want help that makes sense. Bringing NHS and council services together may be a more effective way to boost people's health and well being. Knowsley, where an integrated service is run by the local authority and PCT collaboratively, provides a good example with its Knowsley, Health and Wellbeing For All site, which shows how the service is delivering positive results to the community and cutting through layers of bureaucracy and pooling resources to improve efficiency.

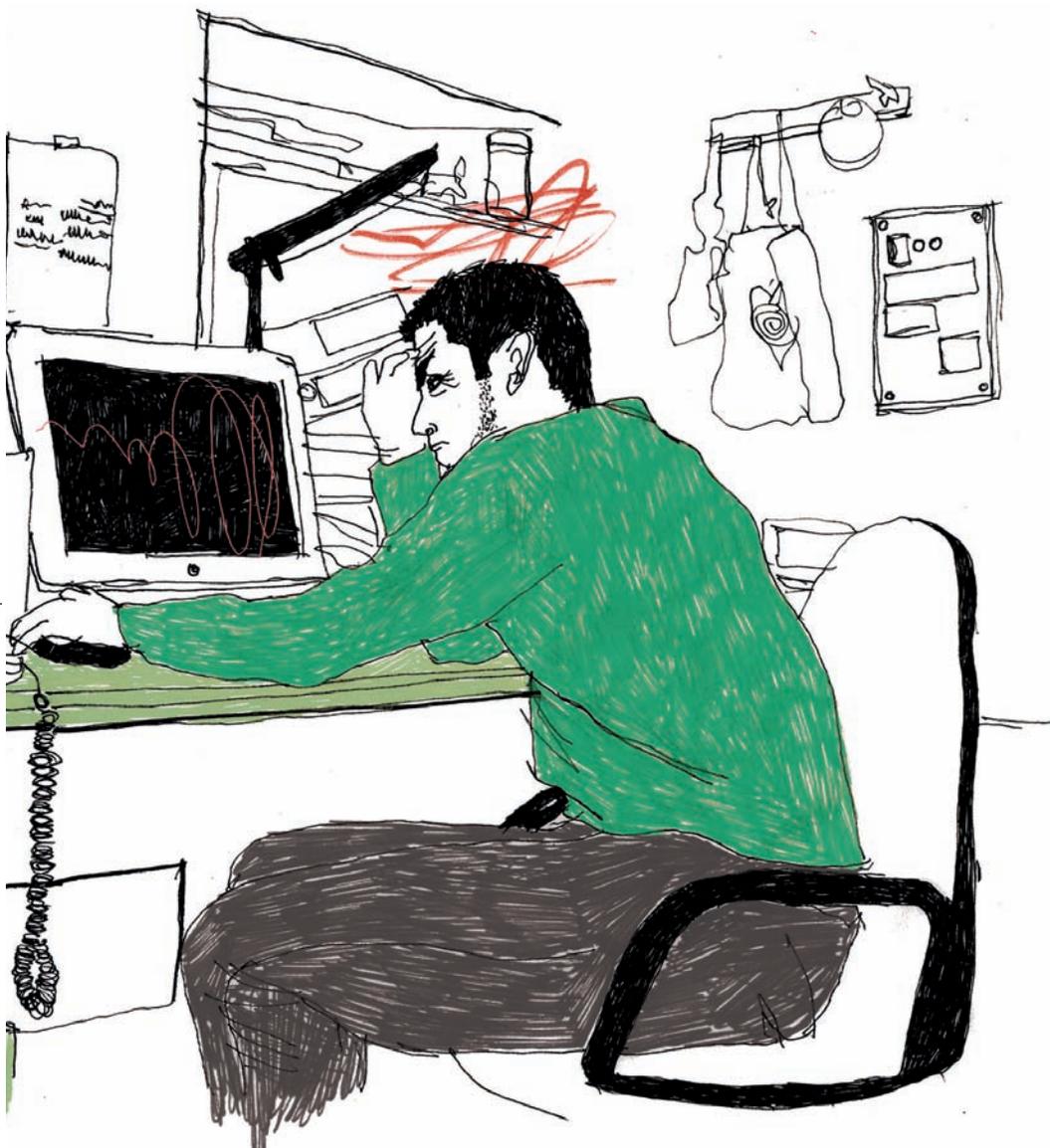
A change from a corporate focus to a more open and friendly look and feel is also required. Too often PCT sites are dominated by press releases and corporate announcements rather than the warm engaging tones that the public might respond to. Photography has the potential to create an appealing mood and PCTs like Barnsley are using convincing local photography that brings the site to life.

Modern accountable local services are supposed to meet the needs of the community they are for by involving people in their design. Making it easy to complain is not the answer here – this is about surveying opinion and consulting on hot topics and then feeding back to the participants and others.

Manchester PCT is taking this seriously with a blog from senior managers at its Talking Health web pages (www.manchester.nhs.uk/talkinghealth) where the PCT is showing how services have been developed and adapted based on community involvement.

The public are canny consumers and expect and deserve better than PCTs are offering online today. The opportunity is to ensure that PCT sites are part of a coherent, high quality health service information service. Like all NHS communications, PCTs must seek to demystify the complexities of the NHS, not reinforce them. ●

Michael Guida is a health strategist at Precedent. Precedent publishes the findings of its review of all PCT websites in England with best practice pointers in full this month. For details email reports@precedent.co.uk



ON THE SITE

ALAN MAYNARD**ON WHETHER INVESTMENT
IN 'QUALITY' SAVES MONEY**

Having spent the first 60 years of the NHS obsessed by ensuring expenditure was matched by income, managers since Darzi's reforms are required to become the purveyors of high quality care for patients in the NHS.

The shift from mere financial balance to a concern for solvency and improved quality of care is a welcome development for patients and taxpayers.

However, the recession and the coming squeeze on NHS funding raises the nice issue of whether the pursuit of quality will save money, or whether savings can only be achieved with increased investment.

Politicians and policy makers preach the gospel of saving cash by improving the quality of care. This notion is uplifting, but is it another example of faith based policy making?

A recent analysis of medical errors in an NHS hospital used case record review to identify an error rate of 8.7 per cent. Nearly nine in every 100 patients suffered some sort of error, minor or major. The authors estimated that 30 per cent of these errors were avoidable.

The avoidance of such errors would improve the quality of patient care and might also save hospitals money. Some are what the Americans call "never events" – things that should not happen to patients. They include pressure sores, catheter induced infections, falls from beds and trips when walking about wards, and that nice issue of "items left in patients after surgery".

The list could also include wrong site surgery, as happened recently in Ireland when a surgeon removed the wrong kidney. Administering the wrong drug or dose appears to be commonplace in hospital. And poor hygiene can lead to MRSA and *C difficile*. It is likely there are similar errors in primary care, although there is little political focus or measurement of such problems in this sector.

US Medicare has, since October 2008, refused to reimburse hospitals for the consequences of never events. If

a patient in for pneumonia acquires pressure sores and falls out of bed, breaking a hip, Medicare pays the pneumonia tariff and requires the hospital to meet the cost of its error.

It is possible that the mitigation of these obviously avoidable errors can be achieved at a reasonable cost, but has this been proven or, like most of healthcare, is this investment of unknown cost effectiveness?

Even if these issues are "low hanging fruit" that can be harvested to the benefit of the taxpayer and the patient, is there evidence of the cost effectiveness of the more ambitious Darzi induced investments in quality? If not, is evaluation being funded to dissipate our ignorance about these speculative and costly investments?

NHS North West has implemented the US Premier system of incentivising five areas of clinical practice. Hospitals must use standard treatment protocols in heart failure, hip and knee replacements, heart attacks, pneumonia and coronary heart bypass surgery, and measure adherence to them.

In the US Medicare system those hospitals that are in the best 10 per cent (decile) of performers get 2 per cent added to their tariff income. Those in the second best decile get 1 per cent. Those in the worst decile lose 2 per cent of tariff and those in the second worst decile lose 1 per cent. These incentives improve average performance in terms of adherence to protocols.

Saner Americans are applying Premier uniformly to Medicare hospitals. In England we have the chaos of commissioning for quality and innovation (CQUIN).

Each SHA, with an eye on NHS North West's Premier initiative, has drawn up a list of targets which hospitals have to measure in 2009-10. Subsequently they will be required to improve performance in relation to them or lose eventually up to 4 per cent of tariff income. SHA targets are a hotchpotch of input, process and outcome

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As ever, the NHS is hastily rolling out large reforms which may damage taxpayers and patients
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indicators whose evidence base can be disputed in many cases.

The finance director will want to know: does Premier-CQUIN reduce costs? The clinical director may want to know whether it improves patient outcomes. The answers to these questions are essential for those investing in such schemes.

In the best tradition of NHS faith based policy making, NHS North West is rolling out its quality initiative without a thorough review of Premier. They are evaluating their roll out. But what are the other SHAs doing about evaluating CQUIN? Patient reported outcome measures are part of CQUIN, but where is the evaluation?

As ever, the NHS is doing the bidding of the Department of Health and hastily rolling out large reforms which are social experiments which may damage taxpayers and patients.

A systematic review of Premier is showing that it improves adherence to protocols, but there is no evidence of cost savings or improvements in outcome indicators, in particular mortality rates.

An implication of this American evidence is that improved quality may require increased investment. This is not part of the current gospel of English policy makers. It is an unwelcome message for them. Quality may not release cost savings to help the NHS survive the recession. It may prove an expensive divergence from the traditional management of the NHS: financial balance.

So does investment in improved quality save money? The answer appears to be maybe for low hanging fruit but maybe not for more ambitious schemes such as Premier-CQUIN. The "maybe" in each case has to be emphasised. Unless those faith based policy makers in Whitehall invest in evaluation, the long neglected journey down the quality trail may bankrupt many NHS organisations. ● Alan Maynard is director of the health policy group at York University.