What if the Audit Commission visited you?

E. Stephen Searle, MRCGP, MFPHM, MFFP, *Consultant in Contraception and Sexual Health*

Correspondence: *Dr Stephen Searle, Consultant in Family Planning and Reproductive Health Care, Family Planning Services, Saltergate Health Centre, Chesterfield, Derbyshire, S40 1SX, UK. Tel: 01246 4600/01 Fax: 01246 559 763*

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Summary

Readers will be familiar with high profile media items, like the Audit Commission investigating national public institutions, and publicising rigorous critiques of their 'value for money'.

Family planning (FP) services may be interested to learn that the Audit Commission also perform 'district audits' (nothing to do with 'clinical audit') and that these can analyse broader concerns to do with quality of patient care and acceptability of services, not just efficiency.

'Out of the blue' our service was the focus of such a district audit conducted over just 3 weeks. We were asked what areas, apart from 'value for money', we would like investigated. We were keen to measure if our efforts of collaboration with Primary Care and other agencies had been effective. We learned that there is a national system (DATIS)[1] to compare each FP service's expenditure per thousand patients. We also learned that being the subject of such an investigation need not be a threatening experience, and can be an opportunity to review quality of care and demonstrate our cost effectiveness.

This account is the report of the district audit team of our service and our attempts at collaboration.

Key words

collaboration on sexual health, family planning services district audit, value for money

Key message points

- Develop a communications strategy with internal and external agencies in order to: -
  - Establish a formal dialogue with all other agencies
  - Keep stakeholders informed of service developments
  - Disseminate good practice.
- Establish a forum for multi-agency joint planning.
- Research the needs of PCGs and individual GPs in order to plan service developments.
- Establish what service FP can currently offer to other agencies in order to 'market' these as appropriate.
- Analyse FP data in order to:
  - Establish patterns of referral for generalist and specialist services
  - Consider the impact of changes in these patterns on the future of the service
  - Analyse and compare FP costs with payments received by GPs in order to assess value for money.

Introduction and aim

The Community Health Service in North Derbyshire provides a comprehensive range of generalist and specialist FP services at 12 locations across North Derbyshire.

All clinics are open access. In addition to most clinics being open during the evenings, some offer sessions during office hours and Saturdays. The central clinic is open 6 days a week.

Since 1994 there has been a 45% overall increase in activity with total attendance now over 16 000. The total direct expenditure on FP services is in the region of £420,000.

Patterns of GP referral vary widely and it is not entirely clear why this should be. It is also unclear to what extent referral patterns may change in the future with the establishment of Primary Care Groups (PCGs) and eventually Primary Care Trusts (PCTs) who may wish to develop their services in response to locally identified needs.

Advice from the NHS Executive states that Health Authority (HA) FP should complement, rather than duplicate, those services which GPs provide. However, with the recent NHS changes, further discussion and planning is needed between the Trust, the HA and local PCGs to clarify and develop the service in North Derbyshire.

The Trust wished to seek the views of the key current stakeholders, especially local PCGs and the HA, in order to further develop a collaborative Trust strategy/framework for FP services based upon the needs of the local population. The District Audit did not seek the views of patients.

The District Audit aimed to improve collaborative working with major stakeholders (both internal and external) in order to further develop the FP service. A secondary aim of the District Audit was to analyse, in broad terms, the cost-effectiveness of this district's FP clinic service.

The major role of FP services in training nurses and doctors is acknowledged locally. This was not included in this work, which focused instead on our external relationships with Primary Care and others.

Similarly, areas where the implications of the Service was lost or became too specialised (e.g. for teenagers only) were also excluded from the specific aims of the study. However, the report is an important awareness-raising document for managers and purchasers forcing budget-rationing decisions.

Methods

The District Audit included the following elements:

- A review of documents relating to the management of the FP service.
- A review of key local and national strategy documents.
- Semi-structured interviews with:
  - The Consultant in Contraception and Sexual Health
  - The Lead Nurse for FP Services
  - The Head of Specialist Child and Family Services
  - The Consultant in Genito-Urinary Medicine
  - The Director of Public Health
  - The Director of Health Promotion
  - The GP clinical governance leads of 3 PCGs in the district
  - Officers from: The Local Education Authority (LEA)
    Youth Services
    Social Services

The views of the PCGs

The time scales and resources of this short District Audit did not permit us to seek the views of all GPs in the area. Instead, the clinical governance leads were chosen as representatives of the three PCGs. All had slightly different perspectives reflecting largely their own experiences with the FP services.

FP was perceived by the GPs interviewed as "an important service…that didn't cause any trouble…". The GPs interviewed also reported that FP was not on the PCG list of priorities and all said that their PCG was not planning to change contractual arrangements for the foreseeable future.

The HA echoed this view. FP is not included in the current Health Improvement Programme (HiMP) although teenage pregnancy is an issue of national and local concern. FP therefore remains for the present an issue for each practice to deal with individually.

It has long been a contentious point that there is duplication of services, which our review tended to confirm. One GP interviewed, in partnership with his health visitor, was about to set up a contraceptive clinic for teenagers in his practice. He had, by his own admission, not considered the impact upon the community-run clinic close by, and neither had he consulted the FP services.

Current referral patterns indicate that some GPs provide more FP services than others. It is important that the FP service establishes why this should be and to understand future intentions.

GPs may wish to increase their practice revenue and may see community FP as a direct competitor. For example, GPs receive in the region of £55 per patient for a coil fitting, and £20 per patient per annum for providing contraceptive services. Depending on the age-sex profile of the practice, this could be a substantial extra revenue stream.

It is estimated that there are 67 500 females of reproductive age using contraceptive services in the district with 16 051 attendance's at the FP service in 1998/99. There is an increasing number of males beginning to use the service. These figures represent a substantial potential increase in revenue for GPs in the area, if they were able and willing to take on the workload.

There were mixed predictions of the long-term future of the FP service. Some had not given it a great deal of thought, although one GP indicated that the future of the community FP service lay in the provision of specialist services and possibly a role in leading on multi-agency work, for example in teenage pregnancy.

Although GPs need to be responsive to local needs, there also needs to be a strategic view agreed for the HA as a whole. It is conceivable that this lack of strategic planning may pose a more insidious threat to the future of FP services and continue to contribute to inequity of provision of services.

Clinical standards and audit

There was an acknowledgement by all of the GPs interviewed that standards of clinical practice varied greatly amongst GPs, although the PCGs have not audited the quality or activity within general practice. Most audit work for the foreseeable future will be targeted on areas identified in the HiMP.

None of the PCG clinical governance leads interviewed was aware of any audit work to analyse the number of patients using the FP services as compared to their own services for general contraceptive services. They were also unaware how many patients were being referred for specialist FP services, although they indicated that data was available in their own practices.

One PCG had carried out some work to compare the number of coils inserted per year per GP.

It is clear from data that new referrals for general FP services are rising, but the GPs interviewed appeared reluctant to accept that these referrals were from their practices.

Value for money

A literature review shows some data comparing the cost of community and GP FP services.[2,3] This concludes that investment in contraceptive services saves NHS resources. The activity within the FP service in North Derbyshire is growing year on year. A conservative estimate is that the cost per attendee is in the region of £20. This information compared alongside other FP services placed North Derbyshire in the lower quartile nationally. However, our data in Figure 1 appears to indicate an average cost per FP first contact compared with other community trusts.

There was a *perception* amongst GPs interviewed that the unit cost per attendee at the FP service was much higher than the item of service received by GPs, and that the extra cost accounted for higher staffing levels which in turn allowed longer consultations with patients. There are no current data comparing the costs of the two services. GP items of service do not include all the costs associated with attendance at the GP, for example drugs and pharmacy costs.

A view from GU medicine

There is inevitably some duplication of services between sexual health and FP, and until recently there was a FP clinic held at the acute hospital. However, this was closed because of too few patients.

The Consultant GU at the hospital has collaborated with GPs and the FP service in a wide *Chlamydia* audit. GU expressed a desire to collaborate on joint protocols and guidelines, for example emergency contraception and training for community staff.

There was concern expressed by the Consultant GU about the new urine testing method for *Chlamydia* costing approximately £6 compared to £3 for swabs. The Consultant expressed reservations that FP services would not be able to afford to use the more sensitive urine tests.

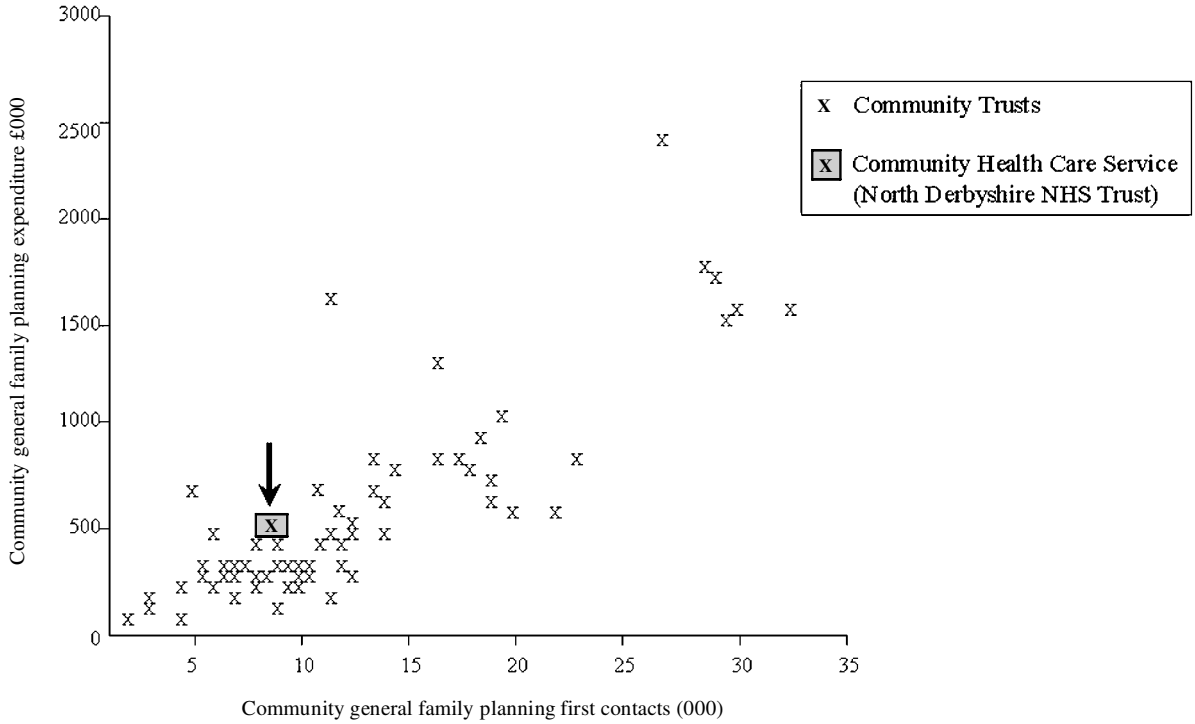
The views of external agencies

The FP service works in partnership with a number of non-health agencies to provide outreach services, mainly to young people. Relationships with these agencies are good and there is joint working on a day to day basis for several projects. Nit 10, a sign posting service for young people, is one example of multi-agency working where the FP service has a consultancy role within the management committee. The FP service also provides a nurse on Saturdays for emergency contraception and sexual health within a general health context.

Joint working with external agencies is largely focused on the needs of young people. The contraceptive and sexual health needs of young people may not always be appropriately served by mainstream health services, as the current focus on the rise in teenage pregnancy indicates. There is evidence that young people prefer the anonymity and confidentiality afforded by the FP clinic rather than a visit to their own GP.

We found a number of joint projects being carried out where the FP service provided services or advice to external agencies, for example the High Peak Project. Professionals at the 'coal face', for example nurses and youth workers, are working well together. However, we found that the FP

Figure 1 *Family planning first contacts compared with total expenditure on family planning. The Trust's unit costs per first contact are around the average compared with other community trusts*



Source - District Audit Trust Information System (DATIS) - from 1997/98 TFR3

service does not tend to publicise its involvement in such projects and, as such, risks understating and underselling its achievements.

There was concern expressed that sexual health advice for young people should be set in a broader context including general health, relationships and responsibilities rather than a contraceptive focused service. In line with the rest of the country, Derbyshire needed to have a local co-ordinator in place to pull together all local services by the 31st December 1999. At the time of the District Audit, none of the agencies interviewed was aware of any County plans for joint working on teenage pregnancy.

The youth services offer help and support to young people, some of whom have opted out of mainstream society and may not have a GP. Concern was expressed about the possible loss of established networks should FP be divided up between the PCGs.

Discussion

Challenges and potential threats facing the FP services

FP provides services to two main 'customers':

- Internal customers including: the Health Authority (HA), PCGs and the acute hospital
- External agencies including: Youth Services, Social Services and the LEA.

The FP services are currently managed by the Community Trust. However, with the increasing power of the three local PCGs, it is becoming more likely that there will be major changes that could affect the Community Trust FP services. No national guidance exists on the future of FP services, creating both opportunities for, and threats to, the current service.

PCTs will be able to commission FP services from a preferred supplier or choose to provide all services 'in house'. Should any of the current PCGs be granted Trust status and in future commission services using a different service model, this may threaten the viability of the current FP.

An urgent need was identified to establish a mechanism for multi-disciplinary practice between the FP service, GPs and other agencies. This is essential if the inequalities in service provision and quality are to be eliminated.

Conclusion

It is inevitable that PCTs will bring about change in service delivery, which may ultimately result in a new service model for FP. The future is not yet clear, and PCGs have priorities elsewhere. Those working and managing the FP service have a great deal of experience of service delivery, consultancy and training. The service does appear to need to have more of a 'market focus' by taking a more proactive approach to establishing closer relationships, promoting its specialist services and possibly developing new services within the HA.

There are a number of steps the FP service may wish to consider in order to be in a stronger position to influence the future of the FP services. These are summarised in the Key message points.

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