Improving Health Outcomes

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Linking data for locality analysis in West Hertfordshire - Family planning as an example of how locality analysis can be used

Geographical Area covered: West Hertfordshire
Focus: Case studies focusing on subdistrict variation in health outcome

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Editorial comments on how case study is linked to improving health outcomes: (also published in Volume 1)
Frater describes how programme budgeting - allocating expenditure by diseases across health care settings with information on health in localities - provided a means for assessing whether current patterns of expenditure were in line with the understanding of the pattern of diseases by the then Hertfordshire Health Agency. This approach linked information on the mortality and morbidity of the population with health service utilisation through localities. They were able to devise referral rates by defined localities and relate these to demographic characteristics and to local health trends. Analysis of patterns of expenditure by disease then offered clearer insights into how well resources were allocated to meet current health needs.

The implications for family planning services as a result of their approach are explored. Family planning services became a priority for review because of local concerns about the level of provision, high % of late abortions and increasing abortion rates for women aged 16-19 years. Population based measures of resource utilisation were used to investigate the accessibility of general practice based family planning services in relation to population need. Improved targeting of services has taken place.

Their approach has informed discussion on the appropriate deployment of health care services, highlighted anomalies in the distribution of resources which merit further investigation in relation to improving geographical equity and raised questions for work on clinical effectiveness.

Abstract (also published in Volume 1)
Interest in developing a strategy for health in Hertfordshire which maximised the possible health gain for the population from the resources available led to a population based approach to understanding health investment. Information from a number of sources was used to characterise the population of geographically defined localities within the area covered by the health authorities. Health care utilisation rates were developed by linking information from the hospital episode system by localities and expenditure information was disaggregated by disease code. The analysis has a number of applications principally informing overall strategy on the balance of resources needed to secure efficient and effective health care - and - in particular policy areas.

The case of family planning is explored further to illustrate a possible application of this approach. For this, population based measures of resource utilisation were used to investigate the accessibility of general practice based family planning services. Family planning services became a priority for review because of local concerns about the level of provision and the potential value of using accessibility as a direct measure of successful outcome for family planning services.

Introduction:

Why this clinical area was chosen:

There were a number of reasons for undertaking this approach to family planning services. Firstly
Further information that was required:

An analysis of the accessibility of general practice based family planning services was undertaken as part of a wider review of family planning services in Hertfordshire. Accessibility was considered to be a key indicator of the success of family planning services in a county where nine times more women seek contraceptive advice from their general practitioner rather than from community based family planning clinics. Access was determined by calculating the uptake of family planning services on a practice basis using information provided by the Hertfordshire Family Health Services Authority (FHSA) from the Exeter computer system. Methods of evaluating the effectiveness of family planning services have looked at the balance of service provision between general practitioners and specialist family planning services (Allaby 1995), and measured the effectiveness of contraceptive services as a function of conception rate in a local population (Faculty of Public Health Medicine 1994). By comparing uptake rates for general practice family planning services across the county, within localities or by individual GP practices, commissioners can target resources appropriately. The aim should be to encourage service developments in areas with high uptake, to encourage improved services for those with below expected uptake, and to develop alternative provision in areas where women are clearly unable or unwilling to seek help from their general practitioner. Family planning clinics might best be judged on the extent to which they attract women in groups at high risk of unintended pregnancy particularly young and perimenopausal women or those in need of specialist provision, such as subdermal contraceptive implants.

Claims for payment for the provision of family planning services are made to the FHSA on an annual basis using forms FP1001 or FP1002. The FP1002 form is used to claim reimbursement for intrauterine device (IUD) fitting, and FP1001 for all other contraception. The Exeter computer system was used to provide data on the number of women registered with a general practitioner for whom a claim for reimbursement of contraceptive services had been made during the year June 1994 to May 1995.

By calculating the number of claims as a proportion of the population at risk of unwanted pregnancy,
defined as all women in the fertile age range of 13-49, access to family planning services by general practice could be determined as uptake rates. In addition, because claim forms include date of birth, uptake rates can be calculated by age bandings and also by type of contraception specified. This approach combines service use information with an assessment of need in a clearly defined population. It is a means of measuring the success of family planning in primary care and of identifying gaps in provision.

Uptake rates of family planning services varied on a locality basis from 22% to 39%. Within localities there was even greater variation. In one locality uptake rates varied on a practice basis from 22% to 62%.

Hatfield, Ware and Hoddesdon including some of the least deprived wards in Hertfordshire have the highest uptake of family planning provision whereas Oxhey the poorest area in the county has the lowest uptake of GP based family planning services. Targeting services effectively by encouraging the deployment of family planning clinics in low uptake areas may be a possibility though this is difficult to monitor. Information collected routinely by family planning clinics does not contain postcode. Age is collected and can be used to ensure appropriate targeting of services.

Discussion
If uptake rates are to be useful in assessing the effectiveness of family planning services some estimate of the expected uptake is needed. Table 1 shows data on method of contraception used by women aged 16-49 on a national basis. This might suggest a minimum local target uptake rate of 27%. Although 30% of women are shown as using either the pill or IUD a proportion of these will access community based family planning clinics rather than general practice, and work done within Hertfordshire suggests that 10% of women seeking contraception attend community based family planning clinics. Because other methods of contraception can be claimed for by using the FP1001 and FP1002 forms a more realistic minimum uptake rate is probably higher than 27% and more in the region of 30%.

Applying this target level to local uptake figures shows practices falling broadly into three types: the top third reaching more than 30% of women registered with the practice, the middle third achieving target levels, and the remainder falling below 27% uptake. This suggests that while some practices can offer a wide range of services and achieve high uptake rates, other practices do not. The strategy development could, therefore, be to develop excellence in the good practices, develop GP services for the middle group to a high standard and advise women in the localities where GP services are weak of their options for alternative services. Community clinic services can be strengthened to ensure access to vulnerable groups who are unwilling or unable to use GP services and to ensure the overall level of provision is improved in those localities where this is required.

Community based family planning uptake information would further supplement these uptake figures to provide a more complete picture. Other limitations of this methodology includes issues of cross boundary flow where the data presented here relate only to Hertfordshire paid general practitioners and patients resident in Hertfordshire.

Recent publications on the effectiveness of family planning services have highlighted the importance of uptake rates and the need for more effective use of services by young people (Allaby 1995, Faculty for Public Health Medicine 1994, Secretary of State for Health 1992). It is commonly believed that family planning clinics are especially needed to provide services for young people. While this is undoubtedly true - and that clinics should be judged on their ability to welcome the young - many more people of all ages will receive help from their family doctor. With the closure of family planning clinics the need to encourage general practice based services is unassailable. Other indicators which might usefully be considered include abortion rates though these are influenced by many other factors particularly the supply of services. An increased abortion rate may be interpreted as an improvement in care where it merely reflects an increase in availability of the service. We considered that conception rates for women under 16 were inadequate since most unintended conceptions are to people over the age of 16. The more contrived ratio, combining uptake rates in family planning clinics and general practices as a function of conception rates, may be useful in analysing the impact of a balanced service on conceptions but are vulnerable to misinterpretation. The effectiveness of services in areas of high uptake with a high conception rate may be judged as less effective than those in low uptake areas but where conception rates are low because non medical methods of contraception are being used. There is clearly value in judging the success of family planning services separately in primary care or in family planning clinics. They have different aims and target different subgroups of the population.

By using routinely available data it has been possible to demonstrate the variability of access to family planning services provided in general practice. Calculating uptake rates has proved relatively simple and straightforward compared with the complexity of other suggested methods of assessing
family planning services. It is also possible to monitor accessibility over time and in particular to monitor changes in accessibility as a result of policy changes.

**Data validity studies:**

Information available from FP10021 and 2 is generally of very high quality since it is used to make claims for payment. In general in Hertfordshire practices are well organised and have efficient administrative systems to ensure timely provision of information needed to secure payment. Bias may be introduced if less well organised practices are also less likely to complete and submit the appropriate information while experiencing high attendance for family planning services. Moreover claims may be made for the ‘provision of advice only’, leading to a possible difference in definition when comparing uptake rates between practices. Further work is needed on a subset of women to assess how well the pattern of provision of the contraceptive pill - by far the most commonly prescribed method of contraceptive in general practice - matches the pattern found from the claims data overall. Uptake in GP practices may also be influenced by staff characteristics such as the welcome offered by reception and clinical staff to particular groups of women and the availability of a broad range of services including the provision of condoms not routinely available in family planning clinics.

**Summary findings from initial work:**

**Changes which were made:**

A number of improvements have been made in family planning service, the development of the information presented here was primarily to stimulate discussion between locality managers from the health authority and GPs. A nurse run counselling GPs session has been established in one of the areas of greatest deprivation in the county within a young peoples drop in centre. Better advertising of family planning clinics including sex education sessions with schools has improved the uptake of family planning services in certain areas and family planning clinics are continuing to monitor their services in terms of key indicators such as the proportion of young women seen. Most family planning clinics in the county see a far higher proportion of young women as a percentage of the total women seen compared with women attending general practitioner family planning services. The analysis has been used as the basis for targeting condoms to general practitioners with priority given to practices showing high uptake rates for family planning services. It was felt that these practices would be most likely to have the facilities for offering training to practice nurses in teaching the use of condoms and for making opportunities available for people attending for family planning to explore the risks and benefits of use of condoms instead of or in addition to their main method of contraception. Further work is underway to fully assess the particular features characterising those GPs who have been successful in achieving a high uptake rate for contraceptive services among eligible women.

**How changes will be monitored:**

Family planning uptake rates are now routinely available for monitoring and regular review in meetings with GP practices.

**Resource Implication:**

Discussions at health authority meetings has been concerned with ensuring that an appropriate balance of family planning provision is available within existing resources. At present the main emphasis is on maintaining the current level of provision and working with GPs using regular feedback of information to make improvements in uptake rates and services available where possible. Further funding was made available for the deployment of community nurses which will hopefully contribute to the development of services by appropriately skilled nurses within general practice. Funding has also been made available through the condom scheme for family planning training for nurses working in general practice.

**Practical lessons learnt:**

The provision of population information can go some way to informing the appropriate balance of family planning provision. The issue does however include a great many areas of concern where different people and interest groups hold strong views. It is important to balance the view obtained from information sources with local values concerning the availability of choice in access to services. Process values such as the uptake of family planning services by age by locality seem to provide a
straightforward method of assessing the success of local services. Monitoring the success of family planning services using local abortion rates is difficult to interpret and can lead to misunderstandings. The information was presented to the LMC, discussed with GP advisers to the Health authority and presented to a joint commissioning group including fundholding and nonfundholding GPs and GPs involved in total purchasing pilots. GPs are interested in comparative information on uptake of services and were keen to support the health authority strategy for using the information to stimulate improvements in general practice. They were less impressed by arguments about targeting family planning clinics. Concern arose on a number of occasions that these would merely duplicate services provided by local GP practices. Better information is needed to properly tie in the utilisation rates of users of community based family planning clinics. This would be particularly important in areas of poor primary care where use of family planning clinics is higher than encountered in Hertfordshire. There are however considerable problems in collecting this information and on defining a denominator for a family planning clinic.

**Conclusion:**

**References:**


Committee on Health Promotion (1994). Measuring the effectiveness of contraceptive services. Faculty of Public Health Medicine, Guidelines for Health Promotion Number 37.


**Organisational Context:**