

# RESEARCH IN PRIMARY CARE: THE *SPREAD* INITIATIVE

SC Wetherell, M Wong, GPs  
Queen Square Surgery, Lancaster

This report will describe some of the changes in research and development that are occurring in primary care. We will then concentrate on the so-called SPREAD initiative, and how it has been undertaken at Queen Square in Lancaster. We will give details of how the research projects associated with the SPREAD initiative have been developed, but results from these studies will be published at a later date.

## AN OVERVIEW OF DEVELOPMENTS IN RESEARCH IN PRIMARY CARE

### R&D in primary care

Mant<sup>(1)</sup> states that although 90% of patient contacts occur in primary care, the evidence base that underpins this activity and decision-making (and the capacity to generate it) is inadequate. In 1995 only 335 out of 31,950 GPs had any form of academic contract, and many of these GPs were either part-time or involved mainly in teaching. Mant believes that evidence for clinical decisions taken only in primary care, and management decisions about such care, must be gained by the involvement in R&D of primary care professionals.

The 1996 white paper 'Primary care: delivering the future'<sup>(2)</sup>, recommended that funding for R&D in primary care be increased from £25 million to £50 million by 2002-2003. This figure remains tiny in comparison to the amounts spent on research in secondary care, but obviously allows for potentially very large increases in research to be done in primary care. Following this white paper, the department of health published 'R&D in primary care' in 1997<sup>(3)</sup>, describing how to manage the proposed expansion. This report laid out five strategic principles:

- 1 high quality patient care requires a sound evidence base derived from high quality R&D
- 2 high quality R&D requires effective collaboration between NHS service providers and universities
- 3 any increase in primary care R&D activity in the NHS requires parallel expansion of R&D capacity in the university sector
- 4 successful expansion of primary care R&D requires a coordinated approach from the NHS, MRC, universities and other research funding organisations
- 5 the expansion of R&D activity in primary care must be carefully managed. The need to demonstrate quickly the benefit to the NHS from investment in primary care must be balanced by the need to avoid dashes for growth and the need to preserve existing expertise.

This report also had five objectives:

- 1 to increase the amount of high quality R&D of importance

to NHS primary care and thus to improve the quality and value for money of primary care services

- 2 to increase the recruitment, development and retention of R&D leaders in primary care
- 3 to increase the number of clinical staff with R&D expertise
- 4 to increase the involvement of non-clinical disciplines
- 5 to achieve an evidence-based culture.

The report made 24 recommendations about how the objectives could be met. One consequence of the North West Regional Health Authority trying to respond to this report was the SPREAD initiative, which commenced in 1998 and which will shortly be described in detail. Also in 1998, the Research and Development Fund (RDF) was established to finance NHS research projects with the objective of making funding more accessible to under-represented groups, including those in primary care, with assistance to researchers from regional R&D support units prior to submitting applications. Funding from the RDF has been dependent upon the applicants demonstrating that research skills will be expanded during the course of the project. Here in Morecambe Bay we are very fortunate in having an extremely helpful support unit based at Lancaster University, with connections to the Institute for Health Research. Recently, due to financial problems at regional level, funding from the RDF has become scarce but the support units will still assist in getting research projects off the ground, with suggestions for funding. The commitment to primary care research is being maintained.

### The SPREAD initiative

This acronym stands for Stimulating Practice-based REsearch And Development. The Queen Square Medical Practice in Lancaster was involved in the first SPREAD initiative starting in autumn 1998 and lasting for two years. West End Medical Practice in Morecambe has just commenced on SPREAD II. The objectives of this initiative are as follows:

- to stimulate primary care research and development by freeing up practitioners from some of their clinical workload in favour of research
- to develop research skills in these practitioners through a structured programme of learning and peer support
- to develop a larger pool of professionals with R&D skills which can be transferred to other practices through the appointment of 'associates' to the projects.

At Queen Square, Simon Wetherell was the GP principal involved in this project. He was funded to undergo training in research techniques and to do a research project for half the week. Mike Wong was appointed as an assistant to replace this half of Dr Wetherell's clinical activity and to spend the

rest of his week doing his own research project and training. The net result was that these two doctors were effectively doing a job share on the clinical work at Queen Square, with each working half time on a research project and training.

There were seven other first round SPREAD projects in different areas of the north west. Slightly different models have been applied in these different projects, but in all cases

there was the opportunity for established health professionals to take time out from clinical work to do research training. Those coming in to assist with the clinical load also had the same research opportunities. The result has been a number of worthwhile research projects in primary care around the north west region, as well as a significant expansion in the numbers of professionals in this field with research skills.

## RESEARCH ON DIABETIC EYE SCREENING

Simon Wetherell

I intend in this next section to describe how I developed my research project. This is not the only way to do this, simply one option. But I will take this opportunity to point out the pitfalls that I have stumbled across in the hope that others may avoid them. I will also highlight areas where I have found assistance.

I entered the SPREAD initiative with clear ideas that I wanted to do some research looking at the optometrist-based diabetic eye screening scheme which was just becoming established at that time in Morecambe Bay. This service is aimed at people with diabetes who do not attend the hospital diabetic clinic and who are not under the care of the ophthalmologists. In other words, it is for patients with diabetes who are being monitored in the primary care setting and it uses trained, accredited optometrists to do yearly ophthalmoscopy through dilated pupils. The optometrist returns the results to the GP and the computerised diabetic register, which issues recall notices.

Following discussion with the Local Medical Committee (LMC) I had been encouraging the Health Authority to establish such a service for several years and I now wanted to know how well it was working. I had been involved in a local audit of GP records in 1995 which showed that 72% had a record of a retinal examination in the previous twelve months. This was considerably better than the 54.5% reported by Sullivan from Lanarkshire<sup>(4)</sup>. I wanted to do more than just audit process and outcome measures; I wanted to know the reasons how and why (and in what areas) the service was succeeding or failing. This was the basis of a research question.

I had, however, no real research experience, and I was basically pretty clueless about how to go about fulfilling my objective. The SPREAD initiative gave the necessary time that I would need to follow this project through. The MA in Health Research at Lancaster University seemed to be the perfect way to gain the academic background knowledge to enable me undertake the research. I therefore enrolled at the university for the two-year part-time course from October 1998. Other short courses have allowed me to fill in areas not fully covered by the MA syllabus.

### The research question

One of the hardest parts of the whole research process was refining a research question from my vague ideas about assessing the diabetic eye screening service. The starting point was reading the available literature about screening for diabetic retinopathy. Much of this concentrated on the technical merits of retinal photography versus ophthalmoscopy (direct and indirect). I became more

interested in why people go for screening tests and why others fail to attend. More literature on such matters is available about other screening schemes such as cervical cytology and mammography. One huge advantage of being enrolled at the university was that I had a supervisor, Professor Colin Pooley, who pointed me towards this second mountain of literature.

As a result, my research question became 'What are the important factors that influence people with diabetes to determine whether or not they attend for screening for diabetic retinopathy?' I hypothesised that factors involving the person with diabetes, his or her GP, practice nurse and optometrist, as well as the eye screening service itself would be important in determining this attendance. The objective was to elucidate these factors so that this information could subsequently be used to enable better planning of services and education of health professionals, thus promoting an increase in the uptake rate for the eye screening service.

### Methodology

I needed information from people with diabetes and the health professionals involved with their diabetic care. After much thought, I decided that I would seek both quantitative and qualitative data. Quantitative data seems to make doctors happy because it shows, for example, the proportions gaining benefits. It gives us hard figures that we can use to back up our arguments. However, I felt that adding qualitative data would allow me to gain a much fuller, richer picture of how the service was working, and how it could be improved.

I designed questionnaires to obtain the quantitative data. One was for the GP and practice nurse most involved with diabetic care in each surgery. One was for optometrists, both accredited and non-accredited for diabetic eye screening. The final one was for the diabetic patients. The numbers of health professionals to be sent questionnaires were limited by their availability, but at this stage it was essential to calculate numbers of people with diabetes who would be sent questionnaires. Sally Hollis at Lancaster University can give invaluable statistical advice of this sort. After estimating the response rate and the questions I wanted my data to answer we decided that 900 questionnaires to patients would be needed.

Designing a questionnaire is a slow and painstaking business, which needs to be done well if useful information is to be collected. I would advise any would-be researcher to read up on this subject before embarking on research questionnaire design - Bowling's 'Research Methods in Health' is a good starting point. Piloting the questionnaire is