Author's response to reviews

Title: What does a 'NHS friendly' complementary therapy service look like? A qualitative case study.

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Dear

Thank you very much for passing on the comments for this paper. I understand that you have had considerable trouble in finding reviewers. This may be because although there are many academics with clinical training, there are few with commissioning backgrounds. As this paper focuses heavily on the perspectives of PCT managers, I can understand why Professor Partridge found the paper challenging and appreciate his willingness in undertaking its review.

To address Professor Partridge’s major points:

1) Professor Partridge suggests that we re-word the research question to: “What features of a service offering a complementary therapy might be likely to be purchased by a commissioner in the current NHS?” As we were interested in both the views of PCT managers as commissioners and clinicians as referrers and powerful gatekeepers, this alternative question does not quite fit. We have rephrased the research question in the last paragraph of the introduction to:

What are the features of a NHS service offering complementary therapies that would be more acceptable to primary care doctors, nurses and PCT managers? (p.5)

2) We appreciate Professor Partridge’s confusion about whom we interviewed. To address this we have added the following paragraph.

In total, we interviewed 20 NHS professionals across the two case sites. These included: five PCT managers, nine doctors (six GPs and three women’s health specialist doctors), four nurses (two practice nurses, one health visitor and one women’s health specialist nurse) and two administrators (one practice manager and the administrator for the women’s health service). All of the PCT managers interviewed were based in the local PCT and included a Chief Executive, a Chair, two Public Health specialists and a pharmacist. The doctors, nurses and administrators were based at the GP surgeries (case site one) or community trust (site two). The NHS professionals we interviewed were either influential in decisions about funding the complementary therapy service (PCT managers), provided administrative support to the service (administrators) or were eligible to refer into the service (doctors and nurses). (p.9)

We also realise that we created some confusion with the word ‘site’, as we sometimes used it to mean ‘case site’ (which would include both PCT managers and NHS clinicians) and we sometimes used it to mean ‘site’ as in service location. To address this, we have added clarifications such as “the service at site one” to mean service location.
3) Professor Partridge suggests that a simpler conclusion of our findings would be that we state that “those spending NHS monies expressed a view that they only wish to spend money on services of proven value for patients for whom there is no other current effective intervention.” It would be nice if the views of the PCT managers in this study could be so succinctly rounded up! However, although PCT managers were clear that the treatments offered should have clinical evidence of benefit, they seemed equally (if not more) concerned that complementary therapy services avoid unmet need and address NHS cost pressures. The Chief Executive mentioned that he knew many biomedical treatments did not have robust evidence, yet they were still funded by the NHS, and so good research evidence was only one of many factors in their decision process. We did not go into this in the paper as it seemed to lead off into a tangent, but this could be revised if Professor Partridge feels it is important.

To address Professor Partridge’s minor points:

1) **Readers may not be familiar with regeneration funding.** We have amended this paragraph to read:

   The first case site included a complementary therapy service that was funded by New Deals for Communities money from the Office of the Deputy Prime Minister. This was part of a national urban regeneration programme, in which local communities bid for funds to set up a range of projects in health, education, crime and safety and housing. In this particular community, local residents opted to spend some of the funding on creating a low cost, local complementary therapy service. (p. 6)

   Furthermore, it was not clear why funding at this site stopped. We have amended this to:

   After nearly four years of funding, New Deals for Communities money finished as it was time limited. (p. 7)

   The paragraph about the second site mentions that the service appeared “better regarded” – what does that mean? We have amended this to:

   Having completed fieldwork at the first case site and concluded that the service was not popular with some doctors, nurses or PCT managers, we purposefully selected a second case site with a complementary therapy service that appeared better utilised and more highly regarded. (p. 7)

2) **What is the referral pathway into the second service? What were the indications for referral?** This has been amended to:

   This complementary therapy service was part of a city-wide women’s health service that provided treatments for women with pre-menstrual syndrome and menopause. As an adjunct, the women’s health service also provided homeopathy, reflexology and aromatherapy treatments which were delivered by two medically trained professionals (a doctor and a nurse) and one professional therapist. To receive complementary therapy treatments, any
patients with menopausal or pre-menstrual syndrome symptoms could self-referral into the women’s health service or be referred by any NHS clinician across the city (e.g. GP, practice nurse, district nurse, health visitor). After initial assessment by one of the three specialist doctors in the women’s health service, these doctors then referred on patients who could not have or did not want pharmacological treatments to the complementary therapy service. Only these three specialist doctors could refer patients to complementary therapists within the complementary therapy service. (p.7)

3) **Why didn’t we interview therapists?** We did not interview therapists (or patients), because we were particularly interested in the views of powerful gatekeepers such as clinicians and PCT managers, as these professionals set the terms for deciding which services are used and funded. This research was part of a larger study looking at the changes necessary for the incorporation of complementary therapies into NHS primary care. We have clarified this in the opening paragraph of the methods section and amended the statement about not interviewing therapists to:

*Although valuable, patients and therapists were not included, as we were not focusing on the features that would make such a service acceptable to therapists and patients, but instead wanted to find out what features would be acceptable to NHS doctors, nurses and PCT managers.* (p.8)

4) **Where do we refer to documentary data in the results section?** See the following:

*For example, data from steering meeting minutes and interviews at case site one indicated that therapies should be chosen on the basis of robust evidence.* (p.14)

*Moreover, a doctor at the first site, who claimed during interview that her decisions were based on evidence and she believed there was insufficient evidence for complementary therapies, was the third highest referrer of the 24 doctors to the complementary therapy service, according to the referral database.* (p. 15)

*For example, although PCT managers claimed that research evidence was an essential precursor to NHS funding of the complementary therapy service, the PCT funding bid for the revamped service in 2006 included no reference to evidence of therapeutic or cost effectiveness.* (p.15)

*An e-mail from the relevant commissioning manager confirmed that this was not needed.* (p.15)

*Similarly, the funding bid for the service at the second case site in 1998 cited an audit study on homeopathy for one type of female hormonal condition [42] and a more general systematic review on homeopathy [43].* (p.15)
Funding bids showed that patients could have up to eight treatments at the complementary therapy service at the first case site and patients could have up to six at the service at the second case site. (p. 19)

For example at the services at both sites, evaluations had been conducted. (p. 19)

To address the safety issue, data from minutes of meetings at site one and interview data from both sites indicated that only trained therapists registered with a recognised professional body would be employed at the services. (p. 22)

We have also amended the methods section to explain our use of interview and documentary data to:

With these data, we identified both consistencies with interview data (e.g. indications for referral) and inconsistencies (e.g. the role of research evidence in funding decisions), which will be elaborated in the results section. (p. 10)

And:

We used these data to check the reported behaviour of clinicians against their documented behaviour. For example, during interviews the two practice nurses stated that they were in favour of NHS funded complementary therapy services and were enthusiastic about the complementary therapy service located in their surgeries. Yet on checking against the referral database, neither had referred a single patient to the service. This then fed into interpretation of their interview data in teasing out what service features encourage clinicians to refer. (p. 11)

We hope that these changes in the methodology section make our use of the multiple data sources clearer.

5) **Clarification is needed on the point about evidence.** The point we are making is that although PCT managers and clinicians stated that research evidence of clinical effectiveness (not evidence of benefit as Professor Partridge states – this is a different thorny issue!) would be necessary to fund complementary therapy services, they actually knew little about the clinical evidence for complementary therapies. Furthermore, they were ‘wrong’ in their views of which therapies have good evidence and which do not. Thus, this suggests that their decisions are not really being made on the basis of the research literature, just their (possibly misguided) understandings of the research literature. We acknowledge that evidence of clinical effectiveness is important to NHS professionals, but it may not be as influential in their decision processes as purported. This section has been amended to:

PCT managers and NHS clinicians in this study stated that another criterion for therapy and condition selection is ‘good’ evidence. But interestingly, this appeared to be based more on perceptions of research evidence than actual knowledge. For example, only three of the nineteen NHS professionals interviewed had directly accessed the research literature on complementary
therapies. Their opinions on which complementary therapies had good evidence appeared to be based on collective, unchallenged perceptions, rather than grounded in fact based knowledge.

For example, data from steering meeting minutes and interviews at case site one indicated that therapies should be chosen on the basis of robust evidence. Herbal medicine was rejected, because clinicians believed that there was not any research evidence, while other therapies such as reflexology and aromatherapy were adopted. Yet, the evidence base for herbal medicine has been identified as the strongest amongst complementary therapies [41], while the research base for reflexology and aromatherapy is less robust. Moreover, a doctor at the first site, who claimed during interview that her decisions were based on evidence and she believed there was insufficient evidence for complementary therapies, was the third highest referrer of the 24 doctors to the complementary therapy service, according to the referral database.

We also found discrepancies in PCT managers’ reported positions that research evidence was paramount in the decision process. For example, although PCT managers claimed that research evidence was an essential precursor to NHS funding of the complementary therapy service, the successful PCT funding bid for the revamped service in 2006 included no reference to evidence of therapeutic or cost effectiveness. An e-mail from the relevant commissioning manager confirmed that such evidence was not needed. Similarly, the funding bid for the service at the second case site in 1998 cited an audit study on homeopathy for one type of female hormonal condition [42] and a more general systematic review on homeopathy [43]. No specific randomised controlled trials on homeopathy for menopause or premenstrual syndrome or any research on aromatherapy or reflexology were referenced as research evidence in this bid. Thus, factors other than research literature appeared to be influencing both perceptions of ‘good’ evidence and referral and funding decisions for clinicians and PCT managers. (p. 14-15)

6) **Is the comment about the PCT funding bid an example of documentary data?** See response to point 4.

7) **Clinicians may refer to a service when it is available but still want services that have evidence of benefit.** We agree. But then surely if they are referring to a service that they believe is without evidence of clinical effectiveness, then something other than research evidence is motivating that referral? See response to point 5.

8) **The first paragraph of the discussion section is excellent.**
    Thank you!

9) **There needs to be some discussion of the phasing of these hurdles.** We are not entirely clear what Professor Partridge means by this as this could be interpreted as phasing in terms of a linear progression (which change rarely is and so we cannot attempt that here) or in terms of
weight of importance. We assume it is the latter. We agree that the evidence issue is crucial, as Professor Partridge states “If a complementary therapy service seems to fill an effectiveness gap and commissioners can see a beneficial effect on outcomes, there would be no logic in denying an enlargement of the contract subsequently to encompass these extra patients.” (The underline is our emphasis as we are not entirely convinced that logic is the guiding principle for either funding or referral decisions.) This was the case at the second site where regular evaluation demonstrated appreciable beneficial health outcomes, both clinicians and patients were very happy with the complementary therapy service and it filled an effectiveness gap (women who could not or would not use pharmacological agents for menopause or pre-menstrual syndrome). However, the complementary therapy service was still de-commissioned. Although our fieldwork had finished when this happened, subsequent discussions with clinicians at case site two suggests that de-commissioning came about because the local PCT was in a financial crisis and all non-essential services were cut. So the reasons for commissioning and de-commissioning services may have more to do with money than research evidence. Further studies would be needed to test this.

10) **The opportunity to better understand why services were discontinued was an opportunity missed.** We agree. But when fieldwork finished in June 2006, those interviewed at case site two thought the service was relatively secure (one told us that on a 10 point scale in terms of security it was a 7). So the de-commissioning of the service in September 2006 was a great surprise. Unfortunately, we did not go back into the field, as resources did not stretch to further data collection. Furthermore, as we were asked by those within the women’s health service not to interview local PCT managers, we had not developed relationships with commissioners in order to subsequently collect informal data, such as reasons for de-commissioning the service.

We would like to thank Professor Partridge for his thorough review of this paper. It is always rewarding to know that your work has been properly assessed.

We look forward to your response.

Yours sincerely,

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