



## Why aren't we achieving our goals?

<b>This is about...</b>	Understanding gaps between current and recommended practice		
<b>Applicable to level(s)</b>	Single practice	Network of practices	Regional or national networks
<b>Likely skills and resources needed</b>	Clinical    Administrative    Management		
<b>Likely difficulty</b>			
<b>Likely time commitment</b>			
<b>Do...</b>	<p>Consider the range of individual, team and organisational level factors that can influence clinical care</p> <p>Focus on identifying the most important factors that you can change</p>		
<b>Don't...</b>	Assume that lack of knowledge is the main explanation for evidence-practice gaps		
<b>Illustrations</b>	<p><i>From research studies</i></p> <p>A <a href="#">qualitative study</a> to understand adherence to multiple evidence-based indicators in primary care.</p> <p>A <a href="#">qualitative study</a> to understand long-term opioid prescribing for non-cancer pain in primary care.</p> <p>A <a href="#">systematic review</a> of barriers to effective management of type 2 diabetes in primary care.</p>		
<b>Helpful resources</b>	<p>There are many frameworks which set out various ways of grouping factors that influence practice. Some are rather detailed but this sample illustrates a range of approaches.</p> <p>The <a href="#">Behaviour Change Wheel</a>.</p> <p>The <a href="#">Theoretical Domains Framework</a>.</p> <p><a href="#">Normalisation Process Theory</a> and an <a href="#">Improvement Science Snapshot on Normalisation Process Theory</a> (video).</p> <p>A <a href="#">checklist</a> for identifying determinants of practice (see Table 1).</p> <p>The <a href="#">Consolidated Framework for Implementation Research</a>: with <a href="#">pdf summary</a>.</p>		

### Barriers and enablers

Every clinician and manager knows that changing clinical practice is seldom easy. Change generally takes time, effort and supporting resources. In planning change, you may find it useful to identify and think about barriers to and enablers of change. Then you can consider which of these are important and are feasible to address, or too difficult within limited time and resources. You may decide that the effort-reward ratio is too unfavourable to prioritise a

given change and therefore choose to tackle a different priority. (Luckily, there is no shortage of priorities to address in primary care.)

### **Frameworks to help understand behaviour and guide behaviour change**

Frameworks can act as prompts to identify influences on clinical practice. They can help you consider factors that you might otherwise not have thought of. There is quite a variety of frameworks and they all tend to overlap. There is no evidence that one framework is any better than another. The choice largely comes down to whichever you find easiest or most intuitive to use.

Table 1 is adapted from an interview study of primary care staff, which used one framework to understand barriers to and enablers of adherence to a set of evidence-based indicators.<sup>7</sup> The Theoretical Domains Framework is useful because it focuses on beliefs, attitudes and so forth that you can potentially change.<sup>8</sup>

**Influences on the achievement of four indicators, categorised using the Theoretical Domains Framework.<sup>7</sup>**

	<b>Avoidance of risky prescribing, especially of NSAIDs</b>	<b>Treatment targets in type 2 diabetes</b>	<b>Anticoagulation in atrial fibrillation</b>	<b>Blood pressure targets in treated hypertension</b>
<b>Knowledge</b>	<p>GPs more knowledgeable compared to other staff</p> <p>Awareness of drug interactions and patient history</p>	<p>Variable awareness of recommended HbA1c levels</p> <p>Knowing the rationale and evidence behind recommendations</p> <p>Guidance generally familiar as standard practice</p>	<p>Indicators familiar because of QOF</p> <p>Importance of access to specialist knowledge</p> <p>Treatment often initiated in secondary care</p> <p>Lack of staff experience in starting treatment given relatively infrequent clinical presentation in primary care</p>	<p>Indicators familiar because of QOF</p> <p>Indicators ingrained as “bread and butter” of general practice</p>
<b>Skills</b>	<p>Communication skills for effective patient counselling</p> <p>Limited time to use skills, e.g. communication</p>	<p>Communication skills for effective patient counselling</p> <p>Need for technical skills such as medication initiation and titration</p>	<p>Communication skills for effective patient counselling</p>	<p>Communication skills for effective patient counselling</p> <p>Practice staff typically well skilled in measuring blood pressure and initiating and titrating treatment</p>
<b>Social professional role and identity</b>	<p>Prescribing perceived to be mainly the role of GPs</p> <p>GP autonomy to deviate from guidance</p> <p>Threat of litigation reinforces nurse prescribers’ adherence to guidance</p> <p>Key role of pharmacist in improving prescribing</p> <p>Prescribing practice driven by perceived patient needs than by guidance</p>	<p>Clarity of roles and responsibilities</p> <p>Can refer to practice diabetic lead if patient taking multiple medicines</p> <p>Tailoring care to patient needs more important than achieving strict targets</p>	<p>Tailored patient care can both help and hinder adherence, e.g. in elderly patients and patients with multiple conditions</p> <p>Role more focused on long-term rather than acute care as atrial fibrillation often initially presents to secondary care</p> <p>Contradictory advice from secondary care</p> <p>Clinicians with more cardiac expertise tend to be responsible for most patients</p>	<p>Clarity of roles and responsibilities</p> <p>Professional ethics and threat of litigation promote adherence</p> <p>Tailoring care to patient needs more important than achieving strict targets</p>

			Practice nurses viewed their input as restricted to reviewing medicines if required	
<b>Beliefs about capabilities</b>	<p>Clear guidance and access to specialist knowledge and training</p> <p>Adequacy of information technology system support</p>	<p>Confidence in ability to achieve targets depends on patient factors such as attendance and motivation</p> <p>Many clinicians confident with blood pressure and cholesterol but less so with HbA1c and any associated medication changes</p> <p>Organised links between primary and secondary care</p> <p>Confidence in diabetes lead</p> <p>Practice IT systems able to identify patients not achieving targets</p>	<p>Confidence related to availability of specialist staff, training and updates</p> <p>Supportive, organised links between primary and secondary care</p>	<p>Confidence helped by relative simplicity of guidance and decision support</p> <p>Confidence hindered by patient factors and limited resources for referrals</p> <p>Practice IT systems able to identify patients not achieving targets</p>
<b>Beliefs about consequences</b>	<p>Ensuring quality of care, patient health, and patient safety</p> <p>Reputation for following guidance reflects well on practice and professional</p> <p>Perceived threat of litigation to nurse prescribers if guidance not followed</p> <p>Immediate financial and time costs (prescribing budget, increased appointments, auditing) outweighed by the potential longer term NHS cost reduction</p>	<p>Achieving targets linked to quality of care and better patient outcomes</p> <p>Job satisfaction in achieving targets</p> <p>Perceived pressure to achieve targets undermines rapport with patients</p> <p>Achieving targets requires time and increases workload</p> <p>Costs for patients and side effects from additional prescribing to achieve targets</p>	<p>Ensuring quality of care, patient health, and patient safety</p> <p>Strict adherence to guidance inappropriate for some patients, e.g. elderly and those on multiple medications</p>	<p>Ensuring quality of care and patient health</p> <p>Perceived increased workload associated with following guidance, e.g. consultation length</p>
<b>Motivation and goals</b>	Adherence ensures quality of care, patient health, and patient	Achieving targets associated with short term gains in QOF	Ensuring quality of care, patient health, and patient safety	Ensuring quality of care, better patient health and job

	<p>safety</p> <p>Promoting a positive reputation for the practice</p> <p>Guarding against litigation</p> <p>Incentivisation of good prescribing</p>	<p>income and longer term NHS savings</p> <p>Achieving targets linked to quality of care, better patient outcomes and job satisfaction</p>	<p>Achieving targets associated with short term gains in QOF income and longer term NHS savings</p>	<p>satisfaction</p> <p>Achieving targets associated with short term gains in QOF income and longer term NHS savings</p>
<p><b>Memory, attention and decision processes</b></p>	<p>Patient history provides important information for decision making</p> <p>Automatic thinking processes useful in high-risk situations</p> <p>Patient history provides important information for decision making</p> <p>Decision aids and prompts for drug interactions</p> <p>Computerised prompts often not in line with consultation processes, e.g. triggered following clinical decision</p>	<p>Awareness of patient characteristics such as older age can influence decision of whether or not to aim for targets</p> <p>System prompts useful for embedding targets into memory</p>	<p>Relatively infrequent presentation of atrial fibrillation hinders commitment of guidance to memory</p> <p>Prompts and the ability to view guidance support decision making</p>	<p>High prevalence of hypertension helps embed guidance into routine practice</p> <p>Patient characteristics (e.g. older age) can influence tailored care to meet patient's needs</p> <p>Guidance considered easy to retain</p> <p>Prompts useful for supporting adherence to guidance</p>
<p><b>Environmental context and resources</b></p>	<p>Practice nurses can pick up medication issues during reviews but lack knowledge and suitable templates</p> <p>Prescribing policies, support and advice available from CCG medicines management teams and pharmacists</p> <p>Limited time (including for training and education) and decision support</p> <p>Limitations of information</p>	<p>External support from CCG, information technology systems and training opportunities</p> <p>Low staffing levels and high workloads</p> <p>Communication between primary and secondary care could be improved to support achievement of targets</p>	<p>Communication systems and established lines of responsibility within the practice needed to identify potential issues around professional adherence</p> <p>Inadequate communication between primary and secondary care</p> <p>Time and workload, especially as current information technology systems do not support easy identification of</p>	<p>Established lines of responsibility, clear templates and access to training and education</p> <p>Limited availability of home blood pressure machines, heavy workload and short duration of consultation makes it difficult to schedule a specific time to measure blood pressure which contributes to difficulties in achieving targets</p>

	technology systems and communications with secondary care		eligible patients	
<b>Social influences</b>	General approach and support of practice team Patient preferences	Pressure from QOF to achieve targets, including comparison with other practices Practice managers aware that achieving targets is linked to practice QOF performance Overall team approach in practice Patient preferences	Pressure from QOF to achieve targets, including comparison with other practices General approach and support of practice team Patient preferences	Pressure from QOF to achieve targets, including comparison with other practices Team factors and support within and outside the practice (e.g. network meetings) Patient preferences
<b>Emotion</b>	Discomfort when guidance conflicts with patient-centred care Feeling constrained by guidance Caution and worry when prescribing additional medication Workload-related fatigue restricts ability to have in-depth conversations with patients	Achieving targets lead to job satisfaction Adverse impacts of fatigue on achieving targets Frustration from missing targets and patient factors, e.g. resistance, low motivation Perceived pressure from targets which can generate tension between clinicians and patients	Frustration caused by complicated guidance making treatment difficult to explain to patients Limited time, mood and fatigue result in deferring decisions to further consultations Discomfort with pushing adherence amongst elderly patients	Achieving targets lead to job satisfaction Fatigue and workload influence whether targets were considered at every consultation Unease created by patient reactions to additional prescribing
<b>Behavioural regulation</b>	Computer prompts for drug interactions, templates, audit and medication reviews Problems associated with rapidly accessing and interpreting full patient records Computer prompts not always useful – can be overwhelming	Help from computer prompts, recall systems, clear protocols and templates Habitual action sequences helpful, e.g. reviewing patient medical notes and setting electronic reminders for action to self within patient record	Help from computer prompts, recall systems, clear protocols and templates Limited ability of current computer prompts to support adherence to guidance	Help from computer prompts, recall systems, clear protocols and templates Patient risk factors act as prompts Opportunistic reviews of patient records Computer prompts not always considered useful and potentially distract from main

				purpose of consultation
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## Methods to explore barriers and enablers

There are a number of ways to influences on practice. How intensive this needs to be inevitably depends on judgment and resources available. For example, you may already have a good working knowledge of factors that influence the care of common clinical priorities, such as diabetes or hypertension. However, you might still find it useful to set out the most important enablers of and barriers to recommended practice before deciding what action to take. The key is to ensure that those targeted by any planned change are involved and agree upon the main barriers and enablers. Table 2 summarises some approaches you could consider.

Table 2. Methods of exploring barriers and enablers.

<i>Method</i>	<i>Advantages</i>	<i>Disadvantages</i>
Brainstorming team meeting	Simple to organise Allows contributions by all involved (as long as you remember to listen to quieter or minority views)	Risk of 'group think' and fixation on issues the group is comfortable discussing
Interviews with staff or patients	Can be structured to ensure good range of issues covered Allow deeper exploration of views, especially more sensitive issues that people may be less inclined to share in a group	Value depends on interviewer skills and analysis Take time to organise Tricky to ensure the right range of types of participants
Focus group of staff and/or patients	Allows detailed and structured exploration of issues if facilitated well Multiple views can be explored at same time	Needs facilitation skills, e.g. to moderate the impact of dominant views Can be difficult to get the right range of people to participate
Observation (e.g. videoing consultations)	Can allow understanding of 'real world' rather than hypothetical situations (observed actions may speak louder than words)	Logistically difficult to organise Can require a lot of observation to pick out specific clinical practices (e.g. prescribing decisions for hypertension) Intrusive, and people may change behaviour when observed
Surveys	Allow simultaneous assessment of a larger number of views and reported practices	Prone to response bias, resulting in less representative data Low response rates because of 'survey fatigue' What people say they believe and do may differ from actual beliefs and behaviour



## **Making sense of barriers and enablers**

Consider prioritising for action:

- Those which are most important, e.g. frequently encountered, pivotal steps in patient pathways
- Those with strongest consensus amongst team members
- Those most amenable to change, e.g. staff beliefs and processes of care as opposed to structures and wider environmental factors
- Those which can be readily linked to one or more approaches to change practice