

## Research papers

# Assessing the awareness of and attitude to NICE guidance within GP partnerships in one PCO in Wales: a qualitative study using focus group interviews

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### ABSTRACT

**Background** Guidelines from the National Institute for Clinical Excellence (NICE) have taken on a special prominence in the UK National Health Service (NHS). Many of these apply to primary care but there are few data available about general practitioners' attitudes to and practical arrangements for implementing NICE guidance.

**Aim** To explore GPs' attitudes to practice policies and practical arrangements for implementing NICE guidance.

**Method** Practice-based focus group interviews.

**Setting** One primary care organisation in South Wales.

**Results** A total of 36 doctors (62% of the sample) were interviewed, including at least one member from each of the 14 practices in the study. There

were high levels of awareness of NICE guidance, but few procedures for dissemination and implementation within practices. The guidance publications were often felt to be of limited practical benefit to professionals who were largely concerned with providing high-quality care to individuals.

**Conclusions** These findings may represent significant obstacles to the implementation of NICE guidance and thus limit their scope to enhance the clinical governance agenda in the UK NHS. The obstacles must be addressed in ways that enhance not burden current clinical activity.

**Keywords:** GP partnerships, guidance, NICE

## Introduction

The National Institute for Clinical Excellence (NICE) was set up as a special health authority for England and Wales in 1999. Its role is to provide guidance on current best practice, which is made available both to health professionals and to the general public. NICE guidance forms part of the clinical governance framework established in the Health Act in 1999. Primary and secondary care organisations are expected to ensure compliance with NICE guidance as part of their individual clinical governance

arrangements, which are assessed by the Commission for Health Improvement.

Primary care organisations (PCOs) have a responsibility to ensure compliance with NICE guidance at practice level. Despite their likely critical importance, there are few data available about general practitioners' (GPs') attitudes to and practical arrangements for implementing this NICE guidance. This lack of knowledge makes it difficult for PCOs to develop appropriate initiatives to aid their implementation.

We therefore undertook an exploratory assessment of GPs' knowledge and attitudes in relation to NICE guidance. The project sought to develop a deeper

understanding of these issues and thereby to identify possible opportunities and challenges for the PCO in ensuring compliance with NICE guidance at practice level.

## Methods

### Study sample and setting

The study sample was all GPs working in one local health group in South Wales (Torfaen). Torfaen has a population of 96 000 and includes both former mining and industrial towns in the eastern valley towards the north of the district and a new town in the south. A total of 6327 patients attract deprivation payments, although these are mainly concentrated in the north – which has 90% of the deprivation but only 45% of the population. At the time of the study, the population was served by 58 GP principals (19 female and 39 male) working from 14 practices. One practice was single-handed.

### Design and analysis

A qualitative design based on focus group interviews was used. The focus group interview method was chosen in order to identify group norms or a range of views, and to capitalise on the interaction within the group to elicit rich experiential data where the diversity of views could be explored.<sup>1,2</sup> The interview schedule was developed by the lead investigator (SV) and modified following discussion with the Clinical Governance Lead of the PCO (AE) and the Public Health Consultant Board member (see Appendix 1). The focus group interviews took place between January and April 2002. Field notes were taken during the interviews, which were then transcribed and analysed.

The interviews were analytical in nature (testing hypotheses arising from the researchers' prior experience from public health and general practice). However, they also sought to retain scope to be descriptive (exploring issues raised *de novo* by the participants, as might be expected to arise from this rich source of data).<sup>3</sup> The study used grounded theory principles so that subsequent interviews were modified and focused on dominant themes that developed as the study progressed.<sup>3</sup> Data analysis involved careful reading of the transcripts and the identification of agreements and disagreements in the views of practitioners within the predefined areas explored through the semi-structured interview schedule.

## Validation

After the study, the report was circulated to all participants in the interviews, and comments from the participants invited regarding accuracy of the description or interpretation of the data (as far as individual participants could assess this from their own single interview).

## Results

Focus group interviews took place in 12 of the 14 practices. The remaining two practices were too busy to arrange a formal meeting, however, an informal meeting with two of the GPs from one of these practices was held after a GP 'network' meeting (when all GPs in the PCO meet for personal and professional development sessions). A GP from the remaining practice was interviewed over the phone. A total of 36 GPs were interviewed – 10 female GPs (out of 19 available; 53%) and 26 male GPs (out of 39 available; 67%).

As the methods were primarily analytical rather than descriptive in relation to the topic areas, we present the data under the relevant headings as follows:

- awareness of NICE
  - individual
  - practice
- practice policies in relation to NICE
- implementation of NICE guidance – attitudes in the context of:
  - professional responsibilities within the practice
  - personal responsibilities to continuing professional development
- emergent themes
  - pressures/morale
  - guidelines/priorities
  - population/individual tensions.

### Awareness of NICE

All of the GPs interviewed were aware of NICE and the majority of them had kept the guidance documents that they had received, although they indicated that they had not read them all. All the different types of guidance had been kept together, but most GPs were not aware of the fact that some were technology appraisals, some clinical guidelines and that one document was referral advice.<sup>4</sup> Most GPs were not specifically aware of all the guidance that had been issued. Only two reported that they had found the *Compilation of NICE Guidance* useful, and

most were not specifically aware of the compilation's existence.<sup>5</sup>

However, at practice level it was found that in most practices there was at least one GP who had read the guidance documents with direct relevance to primary care.

## Practice policies in relation to NICE

The majority of practices had no formal way of noting NICE guidance as documents are disseminated. In two practices the practice manager had been instructed to note them as they are received. In one practice all the partners receive a photocopy of the first page of each new guidance, which summarises the main recommendations. The majority of practices (11 out of 14) did not have procedures to discuss the guidance together. The other three practices may discuss the guidance if they are relevant to the development of practice-based guidelines or to the topic chosen for a practice-based audit. One practice mentioned that the partners had discussed the National Service Frameworks (NSFs, e.g. coronary heart disease<sup>6</sup>) but not NICE guidance. Seven of the practices have the NICE guidance filed 'centrally' – either in the library or in a file kept by the practice manager. In the other seven practices it is the responsibility of each individual doctor to keep his/her own copy. Only one practice mentioned that they had done an audit specifically related to NICE guidance.

## Attitudes towards the implementation of NICE guidance

### *Practice level*

None of the practices would make the implementation of NICE guidance a priority when considering practice development – several practices mentioned that the NSFs take a higher priority as these deal with the major causes of morbidity and mortality. Nevertheless ten of the practices said that they would use NICE guidance if it related to a topic that they had identified for audit or protocol development.

Practices had a wide range of practice development issues that were already occupying time and resources and these were not directly related to disease management. Issues included:

- new computer systems
- building projects
- employing new practice staff/finding a new partner
- fulfilling requirements to become a training practice.

### *Individual level*

In terms of individual attitudes to NICE there appeared to be a wide range of views among the GPs – from those who perceived the guidance as useful to those who did not see the guidance as having any relevance to general medical practice. The important issue for all the GPs interviewed was the provision of high-quality care to their patients and, therefore, being able to identify 'best practice' in any given clinical situation. Some GPs saw NICE guidance as being an important educational tool in this respect, whereas others identified best practice from other sources and felt that NICE is not necessary. Should the NICE guidance differ from advice from other sources, the status of NICE was not generally felt to carry any weight when attempting to identify best practice. Several GPs mentioned that they had lost confidence in NICE following the perceived change in recommendations in relation to Zanamivir.<sup>7</sup> One GP stated that the concept of NICE as a non-political, purely scientific institution was positive. However in practice, NICE appeared to have allowed politics to influence its decisions and therefore its credibility had gone. Several GPs felt that NICE decisions might be influenced by pressure from the pharmaceutical industry. The majority of GPs interviewed would not be against using NICE guidance as part of their continuing professional development programme, although they did mention that not having enough time to read their publications was a significant problem. Two GPs had used NICE guidance as part of their personal development portfolio. Some GPs felt that NICE was already being promoted to the extent that they could not avoid learning about the guidance.

## Emergent themes

### *Pressures/morale*

All the GPs felt that the ever-increasing workload is making it very difficult to do anything other than simply see large numbers of patients, sort them out and 'get through each day'. They are spending much of their time 'fire-fighting' with little time available for reflection and practice development. In addition to the pressures of patient demand, GPs are also feeling under increasing pressure 'from above'. It was clear that they are feeling overwhelmed with more and more 'paper' (i.e. paperwork including guidelines) which they do not have the time to read. The impossible tension between needing more time for patients and more time away from them was obviously causing stress and lowering morale among many of the GPs interviewed.

### *Guidelines/priorities*

GP priorities are primarily related to caring for individual patients – particularly the ones who present with acute illness on a day-to-day basis. In addition, GPs have responsibilities in relation to their employed staff and, in many cases, to the premises that they work from. One or more of these issues were all top priorities for each practice and issues relating to guideline implementation featured low down or not at all. It was notable that those GPs with academic links – either to the Royal College (as trainers) or to the university (five of the interviewees) – did not view NICE guidance as being of particular importance in relation to training or clinical practice. Several GPs pointed out that guidelines are a useful guide but not authoritative, although others were concerned that they may be used to judge performance in a legal setting. This was of concern as it was felt that guidelines reflect perfection in an ideal world, but are often not practical given the limitations imposed through working within the NHS. Concern was expressed by several GPs that the topics chosen by NICE did not actually reflect the clinical priorities that present to primary care on a regular basis. It was felt that resources may move from primary to secondary care in order to fund the implementation of the guidance and, therefore, disadvantage patients overall.

### *Population/individual tension*

The importance of treating the individual patient was a theme identified in many of the interviews. It was pointed out that guidelines are developed from evidence based on population studies, but every patient is an individual to whom the evidence may or may not apply. Treatment decisions must, inevitably, be based on clinical judgement, which should be ‘informed’ by guidelines, but not bound by them. In addition patients may have several conditions to which different guidelines apply. Time in a short consultation was felt to be inadequate to go through them all. The issue of NICE guidance being used as a form of rationing was raised in a number of practices. It was felt that decisions reached by NICE were not necessarily best for patients as individuals. Many GPs viewed their role as one of ‘patient’s advocate’ in the NHS system, and thus they would attempt always to do what is best for the patient. It was recognised that at times, this may bring them into conflict with guidance from NICE (or other bodies). However, some GPs did find NICE guidance useful in managing some individuals’ care in that it enabled them to say ‘no’ to patient demand in specific areas with ‘government backing’. It also enabled patients’ responsibilities in the management of certain conditions to be emphasised.

## Discussion

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### Key findings

All doctors in this sample were aware of NICE guidance, and the guidance publications were retained in all practices. However few practices had procedures for ensuring dissemination of the guidance within the practice, and none had procedures to ensure implementation. Scepticism about the political independence of NICE was noted by many respondents and consequently the weight of its ‘messages’ was felt to be often undermined. The guidance publications were felt in general to be purist and population health-orientated and not of practical benefit to professionals who were largely concerned with providing high-quality care to individuals. These are important issues when considering how the dissemination and implementation of NICE guidance may be improved.

### Strengths and weaknesses of this study

The findings from this study should be interpreted with caution however, as it was a small study which used qualitative methods. It is not possible to generalise the results to all GPs working in England, Wales and Northern Ireland (where NICE guidance applies). The issues raised by the study require further evaluation including a wider sample and some quantitative methods. However, the study did include a whole sample of practices within one PCO area and a representative sample of GPs working within those practices. The results were validated by sending a copy of the report to each GP who participated and inviting comment. For this reason the study offers useful insight into GP views for one PCO area and highlighted areas that could form the focus of a wider study covering other areas within the UK.

### Context of current literature

The extent to which the quality of healthcare is improved by the production of guidelines is dependent on the implementation of the guidelines. This involves, to a greater or lesser extent, some degree of behaviour change. This study did not look at behaviour itself, but examined some of the pre-requisites that must exist before change can occur. Effective dissemination of guidelines is important, but belief in the guidelines, trust in their source and having the time and motivation to change are all important aspects.<sup>8</sup> This study highlighted a number of barriers that exist in these areas.

These results are consistent with the results of previous research reviewed in the Effective Health Care Bulletin *Getting Evidence into Practice*.<sup>9</sup> The bulletin concluded that there is no single answer to the effective dissemination of guidelines and consequent behaviour change necessary to implement them. However, a multifaceted approach is important along with a 'diagnostic analysis' in order to identify factors likely to influence behaviour change. This research could be viewed as a 'diagnostic analysis' for factors that may influence the specific implementation of NICE guidance in primary care.

In addition, a review by Grimshaw of the effectiveness of guidelines concluded that guidelines were more likely to be effective if internally produced and disseminated in an educational setting.<sup>10</sup> Conversely, effectiveness was likely to be reduced if guidelines were externally produced and disseminated by post. This research is consistent with those findings in that many of the GPs mentioned that NICE did not understand what it was like to work 'on the ground' and nearly all the GPs cited the increasing amount of paperwork as being a barrier to reading anything distributed by post.

## Implications for policy and practice

NICE is part of the clinical governance framework, which aims to improve the quality of healthcare within the NHS. A number of issues arise as a result of this research, which suggests that production of increasing numbers of guidelines in a regulatory context could have the effect of working against quality rather than for it. In the context of a high workload, there is little time to read the ever-increasing amount of information that is being sent out. There is a risk that producing guidelines simply increases pressure on GPs, but does not communicate with them effectively or increase their knowledge. This presents a challenge when considering the most effective ways to communicate with practices and to disseminate new NICE guidance.

Individuals who actually provide healthcare should be encouraged and inspired to do the best for their patients. It is of concern that many of the GPs interviewed felt threatened and overwhelmed by all the requirements of clinical governance and there is a danger that the process of clinical governance may have a negative effect. The PCO needs to give thought as to how to draw alongside their primary healthcare teams and encourage them in the work that they are doing. Guidelines need to be introduced in the context of encouraging best practice – rather than as a 'must do' document. The information needs to be readily available in a format that is quick to read and easy to assimilate. Efforts should be made to

promote 'local ownership', for example, by facilitating discussion at GP educational meetings.

Recognition of differing priorities between members of the primary healthcare team and members of the PCO is also important in considering strategies in relation to NICE guidance. The implementation of NICE guidance is a priority for the PCO as part of the clinical governance framework. However, as is quite apparent from the responses to the questionnaire, the priorities of those working 'on the ground' are quite different. This presents a challenge to the PCO in bringing the two groups together and developing a high-quality primary care service with robust clinical governance arrangements.

## Further research

The need for further research, including quantitative methods, to assess the generalisability of these findings has been noted earlier. In addition there would appear to be a need to develop and evaluate other methods of disseminating and implementing NICE guidance, alongside the current methods. Comparison of the relative effectiveness of these approaches will then be possible to assess whether there are better ways of ensuring that NICE guidance and the clinical governance agenda in general can be delivered but without compromising quality of care at the individual level or adding to the pressures on professionals in the NHS.

## Conclusions

GPs in this PCO were aware of NICE guidance, but not of the details of different types of guidance available.

GPs had differing views as to the status of NICE but the interviews consistently identified strong intentions to practice high-quality medicine and doctors were committed to caring for their patients. Increasing pressure on GPs from both patients and government was perceived by interviewees, and there was a widely held view that NICE was not addressing this issue. For NICE guidance to have realistic prospects for wide-scale implementation, attention must be paid towards practical suggestions of how difficulties could be overcome by people working in an overloaded system. Otherwise there is a risk of decreasing morale in the workforce, and this is likely to produce opposite effects to those that the clinical governance agenda is trying to achieve.

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## COMPETING INTERESTS

The authors have no competing interests though they note that they are both practising principals in general practice in Gwent.

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## Appendix 1

### Semi-structured interview schedule

- 1 Which of the NICE guidelines issued so far have you found helpful?
- 2 What type do you read and why?
- 3 Do you have a formal way of noting them as a practice?
- 4 Do you discuss the guidelines as partners?
- 5 Where are they kept for reference?
- 6 Have you undertaken any audits to ensure compliance with the guidelines?
- 7 How do you view NICE guidelines (e.g. compulsory and must be followed; irrelevant bureaucracy, etc.)?
- 8 How would the implementation of NICE guidance rank as a priority in the development of practice protocols/procedures/audit programme?
 

1	2	3	4	5	6	7	8	9	10
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- 9 Are there any other practice developments which take higher priority, e.g. LHG formulary/protocols?
 

1	2	3	4	5	6	7	8	9	10
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- 10 How would the implementation of NICE guidance rank as a priority for your own continuing professional development?
 

1	2	3	4	5	6	7	8	9	10
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- 11 Any other comments.