

Research papers

Perceived aids and barriers to clinical effectiveness in the work of primary care organisations in England: a qualitative study

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ABSTRACT

Aims To understand the aids and barriers to the progress of clinical effectiveness within primary care organisations (PCOs).

Design A qualitative study based on interview data from a two-stage survey employing postal questionnaires and telephone interviews. Key informants in PCOs were nominated by their chief executives. Data collection started on 1 October 2000 and ended on 4 April 2002.

Setting PCOs in England.

Results Barriers to clinical effectiveness as perceived by the participants were mostly non-specific: under-funding, excessive central guidance, and constant reorganisation. Specific barriers included negative attitudes to clinical effectiveness and a limited

understanding of its nature. Leadership and the building of personal relationships were cited as aids. Involvement by public health doctors was seen as an aid by some, though some participants would have welcomed more involvement.

Conclusions Two options for PCOs in enhancing clinical effectiveness are suggested by these results. They could promote training to improve knowledge and understanding of clinical effectiveness within their organisations. Key figures in PCOs could raise the profile of clinical effectiveness through leadership and example.

Keywords: aids, barriers, effectiveness, primary care organisations, qualitative

Introduction

Clinical effectiveness is closely related to evidence based health care. Both terms refer to systematic attempts to improve the quality of health care by closing the research–practice gap.¹ Clinical effectiveness has a health service perspective with the emphasis on ensuring that research findings are disseminated to those who should apply them.² Evidence-based health is rooted in clinical practice with the emphasis on equipping clinicians with the skills needed to utilise

research findings.³ The term clinical effectiveness is used in this report because the focus of the study is at the health service level. Clinical governance is a systems approach for quality improvement which includes audit and education, as well as evidence-based care.⁴

The transfer of knowledge from research to practice is problematic.³ The rigours of evidence-based practice pose several obstacles: the time needed to find and evaluate relevant evidence, the lack of relevance of

evidence to some types of clinical problems, and information overload.^{5–10} It has been claimed that general practitioners (GPs) lack the skills to access electronic sources of information and an understanding of evidence-based practice.^{11,12} It has been suggested that GPs may not share the assumptions of evidence-based practice but other studies have found that some GPs welcome evidence-based medicine.^{8,13,14}

There has been less research on the attitudes of allied health professionals and policy makers towards evidence-based care, but what has been done suggests that they too see a skills gap, lack of time and irrelevance of available information as the main barriers.^{15–18}

The internal market created by the National Health Service and Community Care Act, 1990 introduced purchasing as part of a wider process of commissioning, which encouraged managers to evaluate the effectiveness of management options.¹⁹ The incoming Labour government of 1997 announced a greater role for clinical effectiveness in the White Paper, *A First Class Service: quality in the NHS*.⁴ Primary care groups and primary care trusts, collectively known as primary care organisations (PCOs), were established in 1999 and given the task of organising primary care and commissioning secondary care. The Department of Health required PCOs to implement nationally derived guidance in the form of guidelines from the National Institute for Clinical Excellence (NICE) and National Service Frameworks (NSFs). It also expected that effectiveness should be considered in all decisions:

Clinical decisions should be based on the best possible evidence of effectiveness, and all staff should be up to date with the latest developments in their field.⁴

The aim of the current study is to investigate aids and barriers to the progress of clinical effectiveness in PCOs as perceived by those entrusted to promote it within the organisations.

Method

A two-stage survey of PCOs in England was undertaken between 1 October 2000 and 4 April 2002. A one in two sample of primary care groups (PCGs) ($n = 217$), all 22 primary care trusts (PCTs), and all 24 PCGs that were scheduled to become PCTs in the study period were included. Chief executive officers nominated a key informant to participate.

The aim of the first stage was to describe the extent of clinical effectiveness activity in PCOs. This was conducted by postal questionnaire which included working definitions of clinical effectiveness and clinical governance. Respondents were invited to participate in the second stage, a semi-structured telephone interview. The interviews provided the data for this report.

Public health doctors were given the responsibility for clinical effectiveness within health authorities.¹⁹ Therefore, questions were asked specifically about the role of public health doctors if interviewees did not spontaneously mention it.

Field notes were taken during interviews which were also recorded and transcribed. A grounded theory approach was used. Credibility was improved through investigator triangulation: the field notes were analysed by KH and the transcripts by GH independently before comparing emerging codes, concepts, and themes. Disagreements were resolved through negotiation.

Results

One-hundred and sixty questionnaires (61%) were returned. Ninety-four of the 160 respondents (59%) agreed to be interviewed. The professional backgrounds and positions of the participants are shown in Table 1.

Seven themes emerged. They did not fall into two discrete groups, aids or barriers. What seemed an aid to some was a barrier to others and sometimes both to the same people. We report each theme and explore its status as aid or barrier. Some themes were not specific but related more generally to the core tasks of PCOs.

Shortage of resources

The most common theme was the shortage of resources, mentioned by 90 interviewees. Two terms recurred in different guises: time and money (Table 2, comment 1).

Some saw clinical effectiveness as desirable but unaffordable. Others thought it vital to efficient expenditure (comment 2). Three types of resource shortage were identified. First, administrative infrastructure: a shortage of staff within the PCOs to support clinical effectiveness. Second, clinicians' availability: insufficient time to attend activities to promote clinical effectiveness. Third, a budget deficit: resources were insufficient to implement effective interventions, such as statin therapy. Several interviewees stated immediate needs left little time for reflection and planning, such as when considering effective prescribing (comment 3). One interviewee (from a PCT with an advanced system of quality improvement) dismissed financial constraints as an excuse, and stated forcefully that 'you just have to get down and do it'.

Tension between central directives and locally derived goals

The influence of central directives was mentioned by 24 interviewees in all. A few stated that they had used

Table 1 Characteristics of respondents and interviewees

Professional background	Questionnaire respondents (%)	Interviewees (%)	Position in PCO	Respondents (%)	Interviewees (%)
GP	46 (29)	23 (24)	Clinical governance lead facilitator or officer	87 (54)	59 (63)
Manager	73 (46)	45 (48)	Pharmaceutical advisor or prescribing lead	13 (8)	9 (10)
Nurse	13 (8)	7 (7)	Primary care development officer	19 (12)	14 (15)
Other	28 (18)	19 (20)	Chief executive officer	11 (7)	3 (3)
Total	160 (100)	94 (100)	Public health doctor	3 (2)	3 (3)
			General manager	5 (3)	2 (2)
			Other	22 (14)	4 (4)
			Total	160 (100)	94 (100)

Table 2 Expressed perceptions of aids and barriers to clinical effectiveness

Theme	Example
Shortage of resources	<p>(1) 'You are a GP yourself. You know what they would say. Cost and time ... Always. Not just to clinical effectiveness it's kind of across the board, those barriers you have to overcome whatever you want to do in primary care.' (PCO no. 235, prescribing advisor)</p> <p>(2) 'Well, the way I see it is that if you do something it has to be effective as there is no point spending a lot of money on ineffective treatment.' (PCO no. 85, GP and PCG vice chair)</p> <p>(3) 'The hindrance is always time, if there is a quicker way of doing it then it is usually an easier way which doesn't really look at the issue, then that will be the path with least resistance.' (PCO no. 47, prescribing advisor)</p>
Central versus local initiatives	<p>(4) 'I think one of the things that causes a tension between PCGs and general practice is the feeling that "we are independent practitioners and it is pointless you coming in with a big stick because we are professionals and we treat patients". Any sort of lever to facilitate and develop is particularly useful.' (PCO no. 115, primary care development manager)</p> <p>(5) 'Clinical effectiveness is part of a wider strategy for change, which includes education and involving practitioners in development of service – the "tide of top-down impositions" such as NSFs coming out threaten to stifle local initiatives.' (PCO no. 334, GP and clinical governance lead)</p>
Organisational change	<p>(6) 'Change fatigue, overload, continuous change on a daily basis, the formulation of new organisations in the midst of all of this leading to instability and uncertainty. In our patch at the moment we have four major reorganisations ... People are battle weary.' (PCO no. 151, chief executive)</p>
Attitudes and relationships	<p>(7) 'I think generally GPs do not like the term clinical effectiveness ... It's almost like questioning their ability to judge things for themselves.' (PCO no. 52, clinical governance)</p>

continued

Table 2 continued

	(8) 'Yes, I think people are always looking at evidence more and more and within that yes it's growing more and more and rather than just accepting treatments people are looking wider.' (PCO no. 422, prescribing advisor)
	(9) 'It really starts at the top. The chief executive and of course the board gave us a free hand to do what it takes.' (PCO no. 14, clinical governance support manager)
	(10) 'It [building relationships] has shown to be effective when we have worked with other PCTs within the area, we are actually getting things done, it may take longer because we are having to get in there, but because the practices are feeling more supported in doing so they are more enthusiastic about doing it.' (PCO no. 408, business development manager)
Clinical effectiveness skills	(11) 'Naturally – primary care is given by GPs who are tuned into evidence based medicine.' (PCO no. 197, chief executive officer)
Extraneous factors that influence health care delivery decisions (power of secondary care, political pressure or demand, equity and fundholding)	(12) 'Many of the developments that have taken place had been driven more by the issue of access than effectiveness. For example counselling and probably physiotherapy were available at some practices though not all and so they were rolled out.' (PCO no. 13, public health doctor) (13) 'We have a staggering amount of work we do to keep up our relationship with them [local acute trusts]. Our only hope is to merge with one of them and to form a PCT, because you know, Kev, they still drive the agenda. Our hospital is going to spend £300 000 on something nobody wants but they are going to do it because somebody there thinks it is a good idea.' (PCO no. 233, general manager).
Involvement of public health doctors	(14) 'I think they [public health] must have some time on their hands, they certainly are reputed to have some expertise in the area.' (PCO no. 145, GP and clinical governance lead) (15) 'I would like to have a closer working relationship with them. I know they are under great pressure and I think they do what they can.' (PCO no. 224, nurse and clinical effectiveness manager) (16) 'Some developments are under way before I get to hear about them and when it is too late for me to act.' (PCO no. 13, public health doctor)

them to improve attitudes to evidence-based practice or as a useful lever against professional defences (comment 4). Several thought that they provided easily accessible information.

However, most interviewees were ambivalent, stating that central directives were also a hindrance. The view that too many central directives were swamping local initiatives spanned all professional categories (comment 5). They regretted the passing of the original notion of the Health Improvement Plan, a strategic programme led by local health authorities aimed at the needs of their populations, as envisaged in *The New NHS*.²⁰

Rapid and continual organisational change were major distractions from the core work of PCOs

Many interviewees reported that frequent health service reorganisations were distracting them from their

core tasks (comment 6). Recurring phrases were 'change fatigue' and 'continuous reorganisation'. One comment epitomised the theme: 'The agenda is ever changing and rapidly'.

Attitudes to clinical effectiveness and the relationships between practitioners and PCO personnel

Attitudes of practitioners

Thirty interviewees reported that practitioners' attitudes to clinical effectiveness were not receptive and sometimes hostile. Some interviewees focused on the attributes of practitioners while others focused on practitioners' perceptions of clinical effectiveness. Several attributes were felt to be important:

- a reluctance to change: 'GPs are anti-change', 'conservative outlook of nurses', 'GPs focused on short term and sickness'

- a lack of skills or commitment to quality improvement: the persistence of a 'largely anecdotal style' of medicine, 'GPs are not academic so they are not interested in measurement'.

However, some interviewees reported a hostile attitude to clinical governance in general rather than specifically to clinical effectiveness. Perceived attitudes varied from indifference ('apathy' or 'waste of time') to outright suspicion (comment 7). Some GPs were reported to fear that it was either a cover for cost cutting or an exercise in 'policing'.

Several interviewees reported more positive attitudes. Nineteen reported that GPs were favourably disposed. Thirteen believed that nurses and allied health professionals were more favourably disposed than GPs, offering various reasons: nurses are accustomed to guidelines, they are more reflective, and they have something to gain from the expanded role offered by clinical effectiveness initiatives. Thirteen interviewees reported that they felt that attitudes to clinical effectiveness were improving with time (comment 8).

Attitudes of senior PCO members

Levers for change included leadership from key figures and personal relationships. The views of key figures such as chief executives were seen to be important in influencing the culture of the organisation and the allocation of resources (comment 9).

Several interviewees believed that they had won over practitioners to the PCO in general, and hence overcome negative attitudes to clinical governance and clinical effectiveness by building amicable relationships with practitioners. These interviewees were either managers or prescribing advisers. Building relationships was recognised to take longer but considered to give better results (comment 10).

A lack of familiarity with the concept of clinical effectiveness and the skills to practise it

Several interviewees stated that practitioners or PCO personnel lacked skill and competence in clinical effectiveness. Individuals cited as having and applying the requisite skills included public health doctors, clinical governance leads, or clinical effectiveness facilitators but the most frequently cited person was the prescribing adviser. However, a few managers assumed that all practitioners were practising effectively (comment 11).

A striking feature of many interviews was that the answers given by interviewees to direct questions on clinical effectiveness had little to do with clinical effectiveness, but rather with other related clinical governance matters. This occurred even though all interviewees had been provided with working definitions

of clinical effectiveness and clinical governance. This implies a widespread under-appreciation of clinical effectiveness. Other activities often mentioned as if they were the same as clinical effectiveness included audit, education, and the equalisation of access (see Box 1).

Only a few interviewees commented on the difficulties of practising clinical effectiveness as reported in the other surveys. The relative paucity of references to difficulties with the search for and the appraisal of evidence could be because these activities were infrequently undertaken. However, one group reported frequently undertaking search and appraisal of evidence as part of their work, and these were the prescribing advisers.

Extraneous factors: the legacy of fundholding and the power of secondary care

In all, 30 interviewees believed that the traces of fundholding continued to influence the work of the PCO. Four thought this was beneficial, believing that ex-fundholders were more receptive to change. Others disagreed. Three stated explicitly that fundholding had left a legacy of inequity and the strategies for primary care development reported by another 26 respondents revealed that the inequity of services between former fundholders and non-fundholders was an important issue in shaping their strategies. The commonest examples were counselling and physiotherapy (comment 12).

Secondary care was seen as still beyond the influence of commissioners even though increasing such

Box 1

(Interviewer): 'But did you ever have to sit back and look for evidence for the effectiveness of things you decided to do that were not nationally inspired?'

(Interviewee): 'We have provided counselling in practices now.'

(Interviewer): 'Tell me more about that.'

(Interviewee): 'We have equalised access for all practices. Before that, all the fundholding practices had counsellors and maybe one or two non-fundholders. It was part of getting equality of access for patients.'

(Interviewer): 'That is interesting, did the effectiveness of counselling get considered at all?'

(Interviewee): 'Not really, it was about equality of access.' (PCO no. 45, clinical governance support officer).

influence was the stated aim of so many NHS reorganisations (comment 13). One commissioning manager reported receiving a hostile response after asking for the evidence base for new business proposals made by the acute Trust.

The role of public health doctors

Involvement by public health doctors in the work of PCOs varied greatly in the degree of involvement and the content of their work.

Degree of involvement

The degree varied from virtually none to close involvement. Poor relationships between the PCO and the health authority were reported as the cause of poor relationships with its public health department by several interviewees. Some interviewees reported a specific apparent lack of interest in clinical effectiveness by some public health doctors (comment 14).

In contrast, some interviewees reported good relations with the health authority and its public health department from the start. Some authorities had already played a leading role in clinical effectiveness through such programmes as the PACE programme (Promoting Action on Clinical Effectiveness) before the creation of PCOs.²¹

Other interviewees identified lack of resources as a barrier to public health doctors' involvement (comment 15). Involvement improved when public health doctors were appointed to PCOs, a situation which occurred as PCGs became PCTs.

Several interviewees realised during the interview that they had not sought as much help as they could have, raising the issue of who should be taking the initiative. Several interviewees reported that public health doctors based at their health authority tended to take a reactive approach to the work of the PCO, providing information only in response to requests. Several interviewees stated that they would have preferred a more proactive approach.

Content of work

Public health doctors have many skills and access to information that is potentially useful in the work of PCOs: local epidemiological data, needs assessment, education, performance indicators, audit and evaluation, and searching and appraisal. Those interviewees who stated that the public health department had supported them in their pursuit of clinical effectiveness were asked to elaborate. More frequently than not, the examples given had little to do with search and appraisal but more to do with epidemiological data, needs assessment, and audit.

Some public health doctors, including those based at health authorities, went beyond providing

information and took a leading role in clinical effectiveness in the work of PCOs, for example, running clinical effectiveness units. Some PCOs pooled resources with others to participate in shared clinical effectiveness units. All had evolved out of units that had existed prior to the creation of PCOs, such as former medical audit advisory groups. In a few cases, such initiatives which had existed before 1999 disappeared with the reorganisations following 1997 and were not replaced. Three interviewees were public health doctors. They would have liked to contribute more if allowed to (comment 16).

Discussion

A potential weakness of a survey of individuals is that the views expressed may not be representative of the organisation as a whole. However, the perceptions of these individuals are both credible and significant since they were key informants in their organisation on the subject under study. A wide range of professional backgrounds was represented, so the views are not confined to any particular group.

The main barriers to clinical effectiveness perceived by the interviewees were similar to the barriers to the work of PCOs in general. These barriers, which have been reported in several studies, are: shortage of resources, excessive organisational change, and tensions in delivering national directives. The shortage of resources was identified as a barrier in the National Evaluation of Primary Care Groups and Trusts and a qualitative study of PCGs and PCTs.^{22,23} The Tracker Survey reported that chief executive officers of PCOs perceived shortages to be the main obstacles to progress including quality improvement.²⁴ The compounding effect of the disruption caused by organisational change has been noted in several studies.²³⁻²⁵ The hindrance posed to local initiatives by a large volume of guidance from the centre, and the priority commanded by national targets over local ones has been noted in other studies.^{23,24}

These three barriers to the work of PCOs in general appeared to be of greater importance than any specific barriers to clinical effectiveness itself. Negative attitudes of practitioners were mentioned by only a third of interviewees. This was less than might be expected from studies of practitioners themselves, and the reasons for it are open to conjecture. It is unlikely that the practitioners belonging to the PCOs we surveyed were different from practitioners as a whole, since nearly a quarter of PCOs in existence at the time were included. A more plausible explanation is that few negative attitudes were encountered because PCOs on the whole did not promote clinical effectiveness in

their early years, when the emphasis was on launching themselves as organisations.²⁶ Whatever valuable contributions public health doctors were making to PCOs, their potential to support clinical effectiveness appears to have been less fully realised than their other conventional public health roles.

Although the main barriers are beyond the power of PCTs to change, there are two areas where they can make a difference. First, they could promote training to improve knowledge and understanding of clinical effectiveness within their organisations. Second, key figures in PCTs could raise the profile of clinical effectiveness through leadership and example. The perception of some interviewees that attitudes among practitioners were improving might mean that such moves would find more favour amongst practitioners than has hitherto been expected.

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CONFLICTS OF INTEREST

None.

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