Implementation of guidelines: An online survey for the Department of Health Respiratory Team

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This survey aimed to ascertain the current level of awareness amongst health care professionals (HCP), working for or with Clinical Commissioning Groups (CCG), of the work the Respiratory Programme has carried out to date to understand: (i) the perceived usefulness of the guidelines and tools; (ii) how these are being implemented locally; and (iii) what further support is required to improve implementation. An anonymous online survey was developed; the theory of planned behaviour informed the questionnaire design. 100 respondents attempted the survey; usable data was available for around 75 HCPs due to missing data. The findings highlighted the usefulness of the TPB for evaluating HCPs perspectives on guidelines and tools. Awareness of guidelines was high; the same applies to their perceived usefulness and importance. Additionally specific barriers to and support for implementation were identified.

HEALTH CARE GUIDELINES and tools exist to help professionals make optimal decisions about treatment or care for specific conditions and situations. They are usually written by experts in the field, such as NICE, professional bodies, research charities or the Department of Health (DH). It is essential that guidelines are implemented properly to improve health care services, professional practice and above all patient outcomes. However, guide- lines are not always implemented well and failure to do so can have negative conse- quences (Francke et al., 2008). A wide variety of interventions and research have been conducted by health psychologists to improve health care services (Michie & Abraham, 2004). This includes research into implementation of guidelines, which is an interesting and growing area that health psychologists can work within. For example, health psychologists are well placed given their broad range of skills, such as consul- tancy, research, training, and clinical skills to work with organisations such as the DH to understand whether the guidelines they develop are implemented at a local level.

Psychological theories such as the theory of planned behaviour (TPB; Ajzen, 1991) can be used to understand factors that influence implementation of guidelines. Constructs of the TPB explain processes that govern people's decisions and behaviours (Michie & Abraham, 2004). For example, implementa- tion or lack of implementation of guidelines can be influenced by knowledge or awareness of a guideline, perceived behavioural control over using it such as having the resources (e.g. staff time) to implement it, and subjec- tive norms such as organisational support for implementing it. For instance, an audit of NICE guidance found that guidelines were more likely to be adopted if there was strong professional support (Sheldon et al., 2004). Understanding these factors that influence intentions and behaviours will help to encourage positive behaviour change.

The DH Respiratory Programme has been responsible for producing a suite of guidance, tools, and resources aimed at improving outcomes and services for people with respiratory disease. These include the Outcomes Strategy for chronic obstructive pulmonary disease (COPD) and asthma (DH, July 2011) and the Respiratory Atlas of Variation (NHS RightCare, September 2012), all of which have been published over the last three years. In order to establish a better understanding of levels of awareness, perceived usefulness, and local implementa- tion of these amongst health care profes- sionals (HCPs) working for or with Clinical Commissioning Groups (CCGs), the DH commissioned a survey from Visions4health to gain insight into these aspects in 2012.

Aims

The aims of this survey were to ascertain the current level of awareness HCPs working for or with CCGs had of the work the Respira- tory Programme has done to date, to under- stand the perceived usefulness of the guidelines and tools, and to understand how these are being implemented locally, and what further support is required to improve implementation.

Methods

Survey and questionnaire

An anonymous online survey was designed by Visions4health, a health care network agency specialising in market access (http://visions4health.com/), who were commissioned by the DH to conduct the survey, with input from the Respiratory Programme leads at the DH. The survey started with an invitation letter which explained the aims and format of the survey. This was signed by Professor Sue Hill and Dr Robert Winter, the joint National Clinical Directors for Respiratory Disease.

The survey was comprised of a series of 16 questions addressing the project aims. Each question was accompanied by instructions. The survey was structured around the constructs of the TPB. Therefore, it included questions that addressed awareness, perceived usefulness, perceived behavioural control and subjective norms of the publica- tions. The survey also included questions aimed to gain insight into how the publica- tions are being implemented locally and what further support is required to improve imple-

mentation. For example, 'How useful do you perceive the following documents/guidance to be to support your local plans?' and 'What do you perceive to be the barriers to imple- menting the guidance and publications?' The question types were mixed and included open-ended, multiple choice and ranking questions. The survey was reviewed thoroughly by the members of the Respira- tory Programme and Visions4health.

The DH sent out the survey via a link. Respondents were recruited through the DH database. The link was also posted on the Primary Care Commissioning (PCC) website. Initially the survey was launched in December 2012. A reminder email was sent out/posted in early January 2013. This was important as it helped to maximise responses. The link remained active for a total of four weeks.

Data analysis

Responses were analysed using frequency tables and graphs, with the help of Excel. Open-ended questions were analysed thematically.

Sample

The sample included HCPs working for or with CCGs. For example, lead managers for long-term conditions and general practi- tioner (GP) leads. This sample was chosen as they are the key stakeholders involved in implementation of guidance and related documents. The sample only included respondents from England.

Results

A total of exactly 100 people responded. There was a range of role types across the respondents (Table 1).

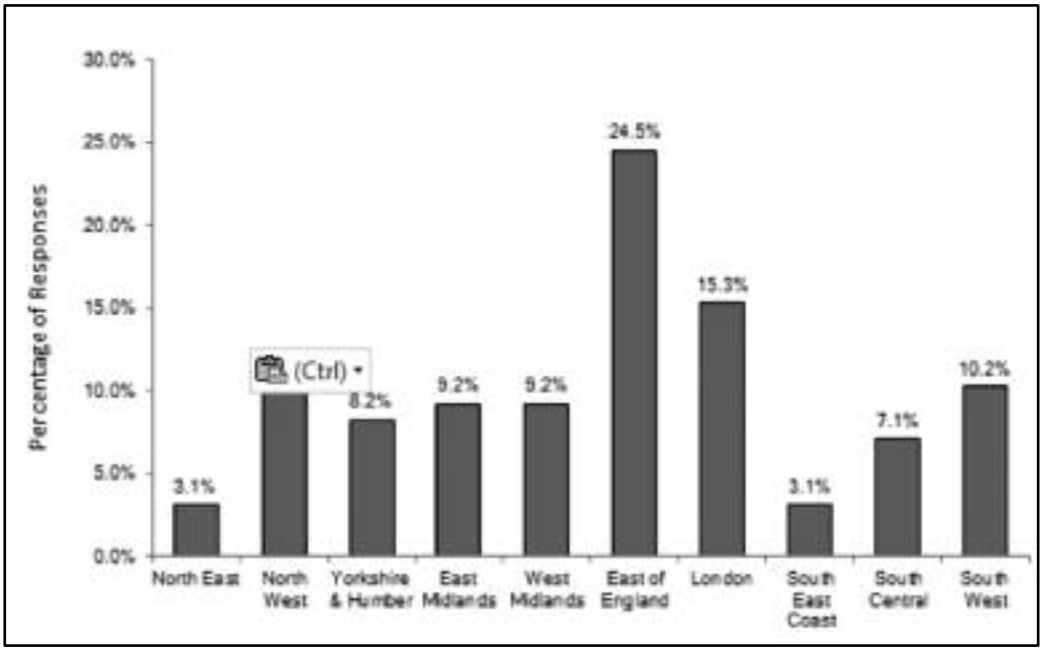
Overall there was a good regional spread of responses from across England. Figure 1 shows the responses per region. Responses were highest from East of England and London. All regions were represented in the sample.

The findings have been presented in line with the key themes.

Table 1: Role breakdown (*N*=75).

Role	Percentage (*N*)
Chief Executives	5.3% (4)
Lead Manager for long-term conditions	28% (21)
GP Lead or Board Member for long-term conditions	22.7% (17)
Other, for example, nurse roles, acute trust consultants, clinical directors, public health consultants, commissioners	44% (33)

Figure 1: Regions of respondents' organisations (*N*=98).



Key themes

Awareness

A high awareness of key strategic documents and associated standards of care was noted, for example, the Respiratory Atlas of Varia- tion (NHS RightCare, 2012). There was less awareness of documents associated with support and implementation of national standards of care. For example, the Compe- tence Framework to Support the Outcomes Strategy for COPD (Skills for Health, 2011) and the national improvement and emerging learning publications (NHS Improvement, 2012). One document, the

COPD Commissioning Toolkit (DH, 2012) which is a document associated with support and implementation of national standards, had a high awareness even though it was not a key strategic document.

Perceived usefulness

The attitude towards the suite of publica- tions was assessed in terms of their 'perceived usefulness'. The extent to which someone perceives something to be useful or beneficial will influence whether or not they decide to take a course of action (Rutter & Quine, 2002). For

example, if a document is perceived to be highly useful, it is more likely to be used.

There was a very low percentage of responses that perceived any of the docu- ments not to be useful. Lower perceived usefulness was associated with lack of aware- ness.

Subjective norms

Subjective norms represent perceptions of significant others' preferences about whether a behaviour should be engaged in or not. Understanding subjective norms will show one's motivation to comply with a given behaviour (Connor & Norman, 1995).

The respondents were asked how much of a priority they perceived respiratory disease to be for their CCG. Organisational support has been shown to be influential in implementation of guidelines (Sheldon, Cullum, Dawson, et al., 2004). The majority perceived respiratory disease to be of high to medium priority (Figure 2). Of the respon- dents who answered this question, 59.1 per cent perceived respiratory disease to be of high priority, 36.4 per cent of medium priority, and 4.5 per cent answered low.

Implementation

Perceived behavioural control incorporates internal and external factors that will predict whether one thinks they have the necessary resources and opportunities to perform behaviours. Understanding the perceived barriers to implementation is imperative to be able to address these barriers in order to support implementation. If perceived barriers outweigh perceived usefulness the likelihood of an action is reduced (Rutter & Quine, 2002). Figure 3 shows the respon- dents perceived barriers to implementation. The highest perceived barriers were diffi- culty in implementing the guidance, lack of time, lack of resources and insufficient support. Respondents disagreed that they did not have the skills within their local team or that they perceived a lack of benefit from using the guidance.

Respondents were asked what support could be provided to enable implementation of the objectives set out by the Outcomes Strategy for COPD and Asthma and the respective NHS Companion Document. This was a qualitative question and the data was analysed thematically. Table 2 shows the findings.

Figure 2: Level of priority at CCG (*N*=88).

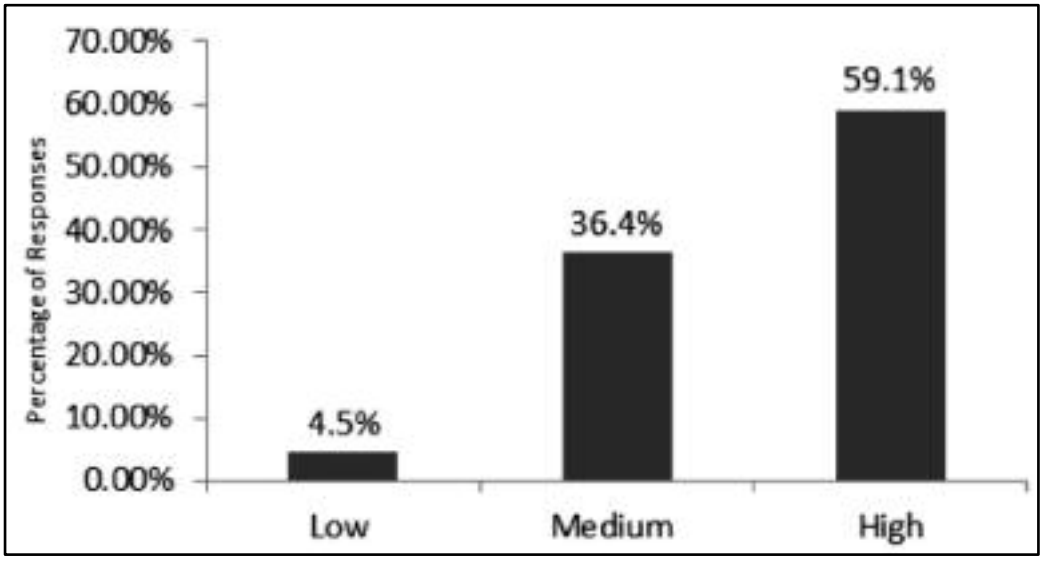


Figure 3: Perceived barriers to implementation (*N*=61)

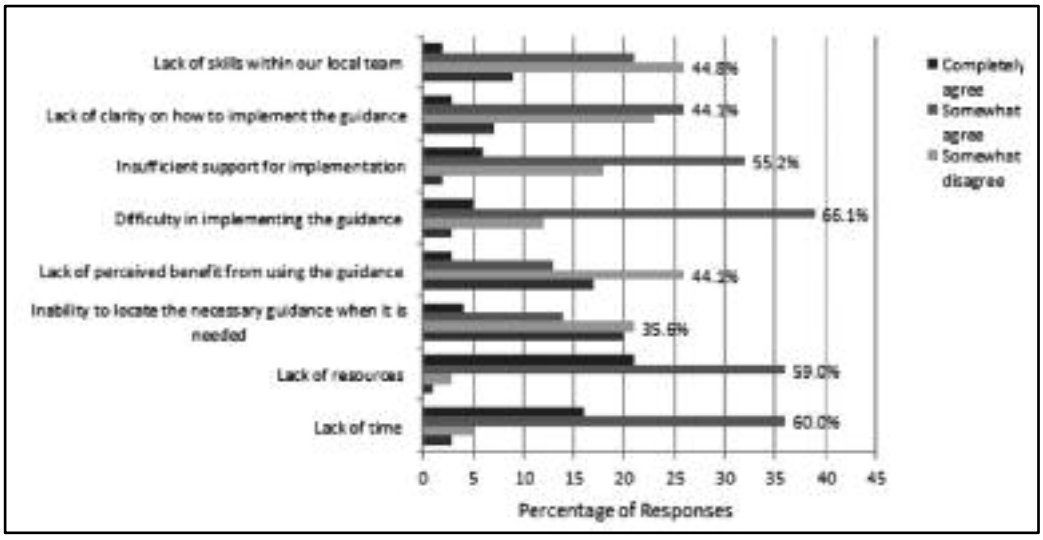


Table 2: Support to enable implementation of the objectives set out by the Outcomes Strategy for COPD and Asthma and the respective NHS Companion Document (*N*=39).

KEY THEMES
Dissemination and Awareness of Publications
▪ Improved dissemination and awareness of respiratory disease and of the guidance via better communication with NHS stakeholders, that is, via a respiratory network.
▪ Training and education, that is, of GPs to raise awareness.
Data
▪ Support data collection at a local level as well as supporting understanding and interpretation of data.
▪ Support local measurement of data, that is, benchmarking that complies with NICE.
Leadership
▪ Support greater partnership working and collaboration, that is, between primary and secondary care.
▪ Support the local accountability and leadership of the publications, that is, by having a local respiratory lead who is responsible and can drive change.
▪ Support local stakeholders be more involved in the implementation of the publications, that is, nurse driven input to drive implementation.
General Respiratory Condition Support
▪ Support a focus on prevention and early diagnosis of respiratory conditions.
▪ Focus on co-morbidities rather than conditions by themselves.

Respondents were asked for examples of specific support that they would find useful to enable implementation of guidance. Table 3 shows the qualitative themes.

The final question in the implementation section looked at how best to communicate to respondents. Gaining insight into preferred methods of communication will help to inform effective dissemination of guidance. Respondents top three ways of keeping abreast of developments in respira- tory disease (Figure 4).

Discussion

Interesting insights were gained through the Respiratory Programme survey. The survey set out to gain insight into HCPs, working for or with CCGs, perceptions of the work the Respiratory Programme has done to date. There were some key messages that came out of this research.

There was high awareness of key strategic documents; however, a lower awareness/ utilisation of documents that support imple- mentation was noted. Overall this demon- strated that respondents were more aware of the higher profile documents as these would have been publicised more. One document, the *COPD Commissioning Toolkit* (DH, 2012) also had a high awareness even though it was not a key strategic document. This docu- ment had received a lot of publicity, explaining its high awareness. Support to improve dissemination and raise awareness especially of publications with low awareness is recommended. The non-key strategic documents which respondents had a lower awareness of, provide information around support of implementation. Therefore, raising awareness of these documents will help to equip HCPs with some of the support they need to tackle respiratory disease.

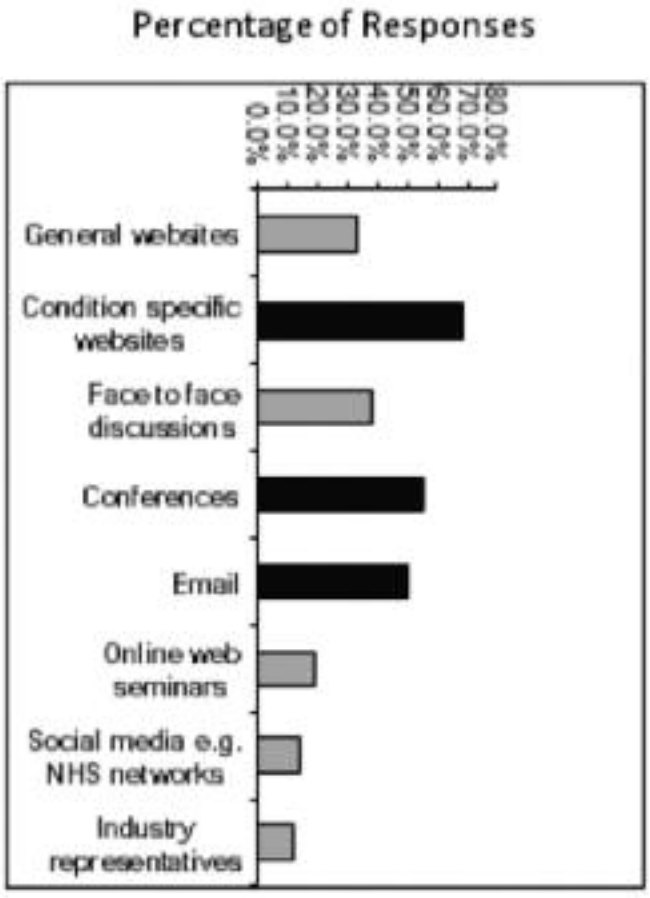
Positively overall there was a very low percentage of responses that perceived any of the documents not to be useful. This is very important as it demonstrated that the documents were more likely to be used. Where there was a low perceived usefulness this was related to a lack of awareness. There- fore, raising awareness will be imperative to enhance implementation.

Subjective norms showed that the docu- ments were high on CCG agendas. Positively the majority of respondents perceived respi- ratory disease to be of high to medium priority for their CCG. This finding is in line with research that has found that organisa- tional support influences implementation of guidelines (Sheldon et al., 2004). Therefore, organisational leadership should drive implementation of the guidelines. However, support at a local level however will be imperative. A local respiratory lead is suggested to drive implementation and provide leadership

Table 3: Specific support to enable implementation *N*=39).

KEY THEMES TO SUPPORT IMPLEMENTATION OF GUIDELINES
▮ Increased manpower, that is, admin staff at a local level to help drive implementation of the publications.
▮ Checklists and simplified guidance as stakeholders are busy and do not have time to read lengthy documents.
▮ Provide real examples of best practice.
▮ Sharing of best practice and collaboration with other local areas. This is imperative as other local areas will have good examples of what has worked well.
▮ Support via an easily contactable local lead. This will be key so that there is local accountability and someone to drive implementation.
▮ Funding, that is, for educational meetings about respiratory conditions.
▮ Training, that is, of local stakeholders to collect data.
▮ Improve CCG engagement to make sure respiratory is high on the agenda.

Figure 4: Communication channels (*N*=61).



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Greater support to address perceived barriers to implementation is needed. Respondents felt they had the relevant skills within their local teams and that there was a benefit to using the guidelines, however they perceived barriers such as difficulty in imple- menting the guidance, lack of time, lack of resources and insufficient support. There- fore, barriers related to the practicalities of implementing guidelines and need to be tackled. Providing examples of best practice

and training around implementation, such as how to measure local outcomes, will enhance implementation. Lastly, using iden- tified communication channels will help to optimise implementation.

Limitations

The response rate was relatively low, partly due to the NHS re-structure. Therefore, the findings cannot be considered representa- tive of HCPs working for or with CCGs. Some respondents did not answer all of the questions resulting in missing data. Never- theless the survey covered a range of HCPs from a all NHS regions

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Conclusions:

The role of the health psychologist Health psychologists can bring a range of skills to projects such as these. With strong research skills and behaviour change knowl- edge, health psychologists are ideally placed to work as consultants and trainers within this domain. For example, health psycholo- gists can work as consultants with organisa- tions such as the DH to conduct research or surveys to help identify strategies that will improve implementation of guidelines.

Health psychologists can apply psycho- logical theories to review what is known about behaviour, test a theory, and then discuss the processes underlying the effec- tiveness of a potential behaviour change intervention (Michie & Abraham, 2004). With regard to the project at hand, the constructs of the TPB were applied to the survey and tested, and then the findings were used to recommend positive behaviour change. The DH can use the recommenda- tions to adopt behaviour change strategies or not. This may partly depend on resources. For example, some of the behaviour change recommendations will be simple and easy to implement, such as improving awareness of key documents via known sources of communication such as email. Other recommenda- tions will require more resources and planning, such as employing a local lead to support implementation of guidelines. While we are aware of the recent highly critical comments by Sniehotta, Presseau and Araujo-Soares (2014) concerning the TPB, we believe that our attempt at basing our evaluation on a theoretical model is an advance on purely empirical efforts to eval- uate HCPs perspectives on guidelines.

The TPB highlighted some of the prob- lems associated with guidelines and their implementation. HCPs are often very busy, especially in the current context of the NHS reforms. They feel increasing demands and lack of manpower in a time of austerity. Therefore, making guidelines as digestible and as easy to implement as possible will be key to their success.

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