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Contextual barriers to implementation in primary care: an ethnographic study of a program to improve chronic kidney disease care.

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Abstract**Background:**

Context is important in implementation – we know that what works in one setting may not work in the same way elsewhere. Primary care has been described as a unique context both in relation to the care delivered and efforts to carry out research and implementation of new evidence.

Objective:

To explore some of the distinctive features of the primary care environment that may influence implementation.

Methods:

We conducted an ethnographic study involving observations, interviews and documentary analysis of the ENABLE-CKD project, which involved general practices implementing a chronic kidney disease care bundle and offering self-management support tools to patients. Analysis was based on the constant comparative method.

Results:

Four elements of the primary care environment emerged as important influences on the extent to which implementation was successful. First, delivering general rather than specialist care in this setting meant that prioritizing one condition over others was problematic. Second, the lack of alignment with financial and other incentives affected engagement. Third, general practices' relative autonomy meant that there were few mechanisms through which engagement could be mandated. Fourth, working relationships within practices impacted on engagement.

Conclusion:

Those seeking to implement interventions in primary care need to consider the particular context if they are to secure successful implementation. We suggest that there are particular kinds of interventions which may be best suited to the primary care context.

Keywords:

Primary health care; general practice; implementation; context; qualitative research; Great Britain

Introduction

Ensuring high quality is a priority for primary care, but UK primary care has traditionally demonstrated high variability in care quality.^{1,2} This has often been addressed through structural or system-level mechanisms such as the Quality and Outcomes Framework (QOF).³ Improvement interventions using recognised methodologies to implement change and improve care quality have seen much less penetration.⁴

Primary care has been described as a unique context,⁵ and the evidence-to-practice gap for complex interventions in this setting is currently receiving attention.⁶ With some exceptions, implementation in primary care tends to be under-studied compared with other settings such as hospital care, despite evidence of the importance of contextual modifiers.^{4,7} The context in which implementation takes place is important, and better understanding of how context influences implementation can help explain why the same intervention may have a significant impact in one setting, but 'fail' when attempts to implement it elsewhere are made.⁸

Previous research on implementation in primary care has shown that staff may lack experience of using recognised improvement approaches,⁹ and there may be limitations in the capacities and capabilities of the workforce to undertake systematic improvement.⁴ Although other factors – such as stakeholder motivation and resources, external motivators and opportunities for change¹⁰ – obviously have a role to play, this perceived skills gap may also be important. Improvement efforts tend to be disease-focused or pathway-specific, and changes are not always sustained or spread across practices. Using 'practice facilitators' to support change has been identified as a possible solution, but does not appear to have a longer-term effect on culture.⁹ Tailoring the intervention to the practice may have positive outcomes, though this may be a 'messy and iterative process'¹¹ not necessarily appropriate for large-scale roll-out.

A better understanding of how the primary care context may influence attempts to improve care quality is vital if improvement efforts in this setting are to succeed.⁴

This paper focuses on a primary care based improvement project seeking to improve the care of patients with chronic kidney disease (CKD). We examine how aspects of the primary care setting influenced implementation, paying particular attention to the challenges it posed.

Methods

We used a multi-method case study approach to look at one improvement project in UK primary care. The project, *Enhancing Care and Saving Lives of People with Chronic Kidney Disease* (ENABLE-CKD), was hosted by Kidney Research UK (a charity) and funded by the Health Foundation (an independent charitable foundation) as part of a programme of eleven projects seeking to close the gap between best evidence and current practice.¹²

CKD is estimated to affect 5-10% of the population and is associated with cardiovascular mortality and morbidity.¹³ Performance in relation to CKD management in UK primary care has been linked to financial reward through the QOF (Box 1).

Box 1. CKD-related indicators included in the Quality and Outcomes Framework (QOF) at the time of the intervention*

- The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD).
- The percentage of patients on the CKD register whose notes have a record of blood pressure in the preceding 15 months.
- The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the preceding 15 months, is 140/85 or less.
- The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE inhibitor) or angiotensin receptor blocker (ARB).
- The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (or protein: creatinine ratio) test in the preceding 15 months.

* Since this study was undertaken the QOF CKD-related indicators have been revised over time and the majority now retired. All that remains for the 2015/16 year is the indicator related to establishing and maintaining a register.

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3 The gap identified by ENABLE-CKD was between contemporary National Institute
4 for Health and Care Excellence (NICE) guidance on best practice for CKD
5 management in primary care and current practice, evidenced by apparent problems
6 in recorded prevalence rates in CKD registers and exception reporting.¹³ The project
7 team sought improvement by: trying to establish consistent implementation of NICE
8 guidance; building confidence through increased understanding of CKD; and
9 facilitating collaborative self-management with CKD patients. To achieve these aims,
10 general practices were supported to improve their CKD registers (a QOF indicator –
11 Box 1); received training sessions on optimal CKD management and patient self-
12 management; and were encouraged to use a care bundle approach (Box 2).

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20 Box 2. Items comprising the ENABLE-CKD care bundle

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22 A. Ask the patient whether they want to take part in a self-management
23 programme
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25 B. Measure and document proteinuria and prescribe appropriate medication
26 (ACEi/ARB) if proteinuria present
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28 C. Document Blood Pressure (BP) and treat if above NICE (2008)/SIGN targets
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30 D. Document cardio-vascular (CV) risk using an appropriate CV risk calculator
31 e.g. QRisk2 (www.qrisk.org)
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35 Following the training session, each practice was asked to regularly supply data on
36 their bundle implementation rates, and to participate in progress review
37 teleconferences. Training was completed in 29 practices and 26 returned baseline
38 data. Twenty practices returned 6+ months of data and were regarded as having
39 completed the project.
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44 Our study design was a case-study of ENABLE-CKD. We completed 16.5 days' non-
45 participant observation focusing on the project team's activities, and 38 interviews
46 with the project team and staff at a purposive sample of five participating practices
47 (including GPs, nurses and practice managers), chosen to reflect the diversity of
48 sites involved. Our data collection thus covered the "blunt end" of project
49 management through to the "sharp end" where practitioners implemented change.
50 Observation fieldnotes were de-briefed, audio-recorded and transcribed. Interviews
51 were audio-recorded and transcribed. Relevant project documents were analysed,
52 including project plans, reports and training materials.
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3 Data analysis was based on the constant comparative method.¹⁴ Through
4 comparison across transcripts and fieldnotes, initial open codes were organised into
5 thematic categories, which provided a framework for processing all data using QSR
6 NVivo software.
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10 11 12 **Findings**

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14 Four distinctive features of the primary care context emerged as important influences
15 on implementation: the delivery of general rather than specialist care; the relative
16 lack of financial or other incentives to encourage participation; the relative autonomy
17 of general practices; and working relationships within practices.
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20 21 ***General rather than specialist care***

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23 General practice is, by its very nature, concerned with the delivery of general rather
24 than specialist healthcare. Many improvement interventions, as was the case with
25 ENABLE-CKD, tend to be focused on specific conditions and/or processes. Tensions
26 between the generalist ethos of primary care and the specifics of managing CKD
27 recurred throughout the project. Problems arose, and improvement efforts
28 sometimes stalled, because practice staff's time was divided among competing
29 demands.
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36 *I think it's just pressure of time really – splitting our energies and our focus across*
37 *such a broad area of clinical problems. (GP 2)*
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41 ENABLE-CKD also encountered specific problems relating to legitimacy. The project
42 team was aware that some clinicians were not convinced CKD was a problem
43 warranting attention, something crucial for successful implementation.
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47 *I had somebody sitting in that chair yesterday – I was more concerned about their*
48 *liver and he said 'oh, how are the kidneys?' and they were fine, he's got really*
49 *good EGFR. He could live out his life without any problems but he's now spending*
50 *every day worrying about his kidneys. It's medicalising something in the patient's*
51 *mind and exaggerating the impact of it on their lives. (GP 2)*
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56 These issues combined to mean that busy clinicians were not always willing and/or
57 able to prioritise CKD-related activity.
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Financial incentives

Practice staff talked about 'running a business,' with a focus on budgeting. Fiscal pressures resonated and priority was given to activities providing the most financial gain. Staff were especially driven to align their activities with the QOF.

The QOF takes preference over pretty much everything, because that's the big earner for the practice, that's what keeps the practice running. (Practice manager 1)

[QOF has] a financial implication for funding of how the practice runs, funding wages, funding lighting, everything fundamental about the practice. (GP 1)

Because of the financial consequences, meeting QOF targets was often a motivator for initial engagement with ENABLE-CKD; practices were attracted by the specialist training and expertise offered by ENABLE-CKD.

GPs' lives revolve around QOF. So if something's not in QOF then it gets pushed to the back, and it's not a focus. Bringing [CKD] into QOF certainly made us look a bit harder at what we were doing. (Practice manager 1)

We knew that CKD was an up-and-coming area of clinical practice that was being talked about in all of the medical press and we realised that we weren't compliant with the QOF. We're going to have to make changes in order to comply with the QOF expectations and it was an opportunity to get our act together really. (GP 2)

However, while there was overlap between the QOF indicators and the care bundle proposed, there were important differences. First, self-management for CKD was not included within the QOF indicators, meaning engagement with this aspect went beyond that for which practices could expect to be financially rewarded. Second, the blood pressure target included in the care bundle was taken from the NICE guidance rather than from QOF itself, and was more challenging to achieve. Once practices had obtained all the QOF points available for CKD, they had little incentive to go further and meet the other objectives of ENABLE-CKD such as the self-management element.

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3 *Whilst maybe our project might have helped with their CKD QOF, it will have*
4 *taken away attention from all their other QOFs, so we had to work within that and*
5 *to us, you know, it's all about kidneys...but it's obviously not to them. (Project team*
6 *member 2)*
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10 This focus on the bottom line presented a major challenge in securing engagement.
11 Practice staff often balanced the desire to improve care with the financial
12 implications of implementation, and thus some practices showed little desire to
13 engage fully with the project unless it was financially beneficial or at least cost
14 neutral. Some practices presented ENABLE-CKD with full costings (e.g. backfill for
15 staff attending training, intervention set-up expenses) and requested reimbursement.
16 ENABLE-CKD, despite some reservations, secured additional funding to cover these
17 costs as they felt being able to offer funding was necessary to ensure credibility in an
18 environment where this appeared to be the norm.
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25 26 **Autonomy and accountability**

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28 ENABLE-CKD were not prepared for how autonomously general practices
29 functioned; each practice essentially operated in isolation as a small business and
30 was not part of a wider accountability structure such as a hospital trust. Identifying
31 “sticks” to motivate practices to engage was difficult.
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36 *ENABLE-CKD are using lots of soft tactics, dangling lots of carrots in front of the*
37 *practices, being collaborative, nice, but says that sometimes this isn't enough: are*
38 *there harder edges? Are there sticks as well as carrots? [Project team member]*
39 *says, GP practices would just say “stuff it, go away then, we won't work with you”*
40 *and [project team member] says “it's a different ball game” and [project team*
41 *member] says “they are very autonomous.” (Observation de-brief)*
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46 As a result, ENABLE-CKD relied primarily upon softer tactics, such as appealing to
47 clinicians' desire to follow best practice. This reliance on soft tactics had several
48 consequences. First, it was difficult to generate momentum, not least because there
49 were competing “hard edges” already in place that played a significant role in guiding
50 activities (such as the QOF).
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55 *QOF says you don't need to do it for everybody all the time. That's the basic*
56 *problem [...] You can miss things out and still get QOF points and hence get*
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3 *remuneration. It doesn't ask you to do everything it just says that if you do some*
4 *things well but other things not so well, we'll still give you some points. (GP 3)*
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7 Second, while using soft tactics might attract enthusiasts who were already
8 motivated to tackle CKD, it could do little to engage those who were more sceptical.
9 Third, it was time and labour intensive, relying on constant communication to sustain
10 engagement.
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15 Fourth, by using soft tactics, the project team inevitably occupied a less powerful
16 position in encouraging continued engagement, which resulted in some practices
17 taking time to begin implementation of the care bundle, if indeed they did so at all.
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22 *[Project team member] says "often moving them [the participating sites] forward,*
23 *it's difficult to do..." And she said that she feels like a nagging woman.*
24 *(Observation de-brief)*
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27 Although the relative autonomy of general practices caused difficulties, it did offer
28 some advantages; an enthusiastic practice that wanted to commit to improvement in
29 this area had the independence to do so. Control over resources (such as facilities
30 and staff) tended to lie within the practice itself and therefore motivated practices
31 could quickly and easily implement change.
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37 **Staff working relationships**

38 Working relationships within practices were found to be different to secondary care
39 (the context with which ENABLE-CKD was more familiar), and this impacted on
40 engagement and implementation. The employer/employee relationship within
41 primary care (i.e. that GP partners employ all other practice staff) created important
42 power dynamics. Even though nurses would typically be responsible for
43 implementing the intervention, GPs and practice managers tended to have the final
44 say over whether they did so. Thus, if GPs and managers were not engaged, nurses
45 could not push things forward on their own, even if they were enthusiastic. Without
46 the necessary gatekeepers to authorise activity, little could be accomplished.
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56 *I'm not sure how it's going to be instigated at the moment, I think that's obviously*
57 *going to be decided higher up. (Practice nurse 4)*
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5 In training sessions, the ENABLE-CKD team was conscious of the potential for
6 nurses to feel excluded and tried to ensure that all groups were engaged in
7 discussion. Two project team members had a nursing background and were
8 sensitive to the potential for nurses' voices to be marginalised; however, even they
9 appeared surprised at the stark contrast between the secondary and primary care
10 context.
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16 *The hierarchy is much greater in primary care than in secondary care. The nurses*
17 *hardly say anything; the GPs are in control, because they employ them. That's the*
18 *difference with secondary care. (Project team member 1)*
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20 21 22 **Discussion**

23 Effective implementation requires sensitivity to context and there are some important
24 features of the primary care environment that need to be taken into account. This
25 case study illustrates how the particular context of primary care can pose challenges
26 for implementation. First, the delivery of general rather than specialized care affected
27 engagement. The value proposition of ENABLE-CKD was not always clear. CKD
28 was only one small concern among many priorities: it was a specialty interest not
29 part of the mainstream workload. This supports previous suggestions that measuring
30 indicators that transfer across different chronic conditions and co-morbidities meets
31 with greater success than those focused on a specific condition.¹⁵
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39 Second, the nature of general practices as small businesses influenced motivation to
40 implement change. While the issue of financial incentives driving clinical activity is, of
41 course, not unique to either primary care or CKD, the ways in which they played out
42 in this case are of interest. As private businesses with revenue streams linked to
43 specific targets, practices sometimes struggled to accept that CKD management
44 required action over and above that required to generate QOF points. Practices were
45 accustomed to being paid for participation in 'non-core' activity and some sought
46 payment for participation here. Although the evidence about the effectiveness of pay-
47 for-performance on outcomes is mixed,¹⁶ ENABLE-CKD's experience suggests this
48 needs to be considered.
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56 Third, the autonomy of general practices meant that ENABLE-CKD struggled to
57 identify effective ways of encouraging engagement; it was easy for practices to opt
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3 out from some or all elements. While clinicians' motivation to deliver high quality care
4 can help secure participation, relying on this "carrot" may not always be enough -
5 "sticks" may be needed to encourage change more effectively.¹⁷
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8 Finally, working relationships and the locus of power was significant. While nurses
9 typically were the implementers here, GPs and practice managers needed to
10 authorise this. The status of nurses as employees of the practice could problematize
11 effective engagement. Concerns about hierarchy have already been identified as
12 hampering multidisciplinary work.¹⁸
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17 When looking at implementation of complex interventions in primary care, a
18 systematic review of reviews identified four domains as important: context,
19 organisation, healthcare professionals, and intervention.⁶ The most important of
20 these was context, and the degree of fit between the intervention and the context in
21 which it was being implemented was the most influential inter-relationship.
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26 Our findings suggest that the intervention ENABLE-CKD sought to implement was
27 perhaps not best-suited to the primary care context: it was too specific for many; did
28 not always fit well with external motivators/incentives; could not be 'enforced'; and
29 had not sufficiently taken into account the relationships between those who needed
30 to be involved in implementation.
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35 The same review looked at features of effective implementation and identified audit
36 and feedback, educational strategies, and financial incentives as most useful.⁶
37 ENABLE-CKD did use educational sessions and these were positively reviewed by
38 participants, they tried to use audit and feedback but without 'teeth' this largely fell
39 flat, and while they did ultimately provide some funding, financial incentives were not
40 initially built in.
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45 The issues identified as problematic in this case study needs not always be so – they
46 could be alleviated through more optimal alignment of intervention and context. For
47 example, the 'payment culture' was experienced as a challenge, but if factored in
48 early on, could be an opportunity to promote engagement through identification of a
49 strong business case. Also, despite doubts about whether financial incentives are
50 adequately aligned to maximise health gains, evidence shows QOF has changed
51 clinicians' behaviour;¹⁹ better alignment with the current incentive system could have
52 been beneficial. Finally, for ENABLE-CKD, practice autonomy largely worked against
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3 implementation efforts. As autonomous organisations, practices approached change
4 with caution. However, when clinicians were more willing to engage this could be
5 extremely valuable; being free of bureaucracies and hierarchies could lead to quick
6 and efficient implementation.
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10 This paper presents data from one, condition-focused, improvement project,
11 although the purposively-sampled data come from several locations and sources.
12 Conceptual transferability, not statistical generalizability, was the priority. While
13 ENABLE-CKD experienced some significant challenges, not all of which they were
14 able to tackle successfully, this evaluation provides important insights into the nature
15 of these challenges and how they influenced implementation.
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19 Understanding the context in which you are trying to implement change is vital, and
20 the specific characteristics of primary care are no exception.⁴ In the case of
21 ENABLE-CKD, project team members were not themselves from a primary care
22 background and so, as evidenced here, they sometimes struggled to navigate this
23 unfamiliar terrain. From the outset, the project team struggled to secure consistent,
24 meaningful input from primary care professionals at the project level, despite their
25 best efforts to do so. Teams require members with 'insider knowledge' to highlight
26 potential problems, identify strategies likely to be effective in any setting, and
27 maximise the likelihood of sustainability.²⁰
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31 Improvement is a priority in all healthcare contexts, and this study identifies some of
32 the factors that may influence its implementation in primary care. A lack of
33 awareness of the specific facets of the environment may affect outcomes, as shown
34 in this study. Further work needs to determine to what extent the challenges
35 experienced by the ENABLE-CKD project are found in other cases. Future
36 improvement work will need to be embedded in the context and culture of primary
37 care in order to ensure success.
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Ethical approval

This study was given a favourable opinion by the Leicestershire, Northamptonshire & Rutland Research Ethics Committee 1(10/H0406/77).

Competing interests

None

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