NICE National Institute for Health and Care Excellence

Implementing NICE guidance CG127 in primary care: key findings of an online survey

Audience Insight Team

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Background

The Champs Public Health Collaborative in Cheshire and Merseyside is working with the National Institute for Health and Care Excellence (NICE) on a project to engage with primary care providers to help inform the implementation of the high blood pressure strategy. Part of this collaborative work is to understand the challenges and barriers of putting the NICE guidance on hypertension in adults: diagnosis and management (CG127) into practice and to explore potential solutions.

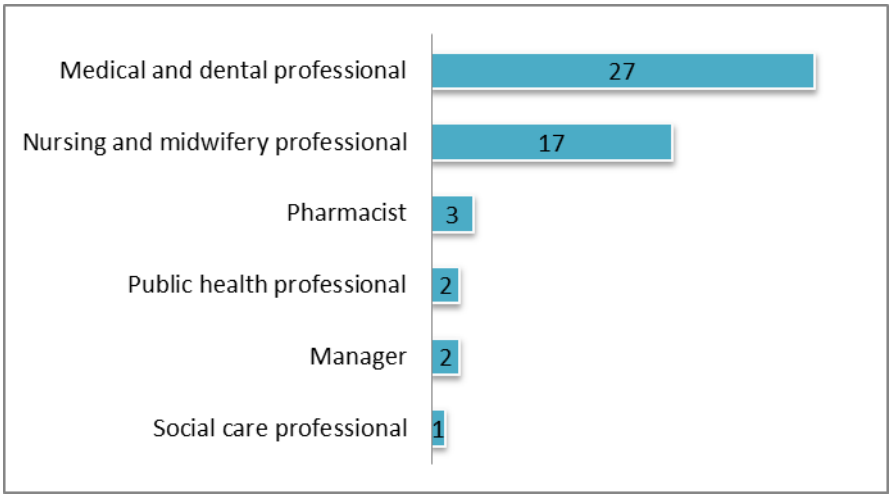
This short report summarises the findings of a survey conducted with primary care staff to identify the frequency of use of NICE guidelines and products, the potential challenges and solutions to implementing the NICE guideline and how measures of performance against NICE hypertension quality standards should be used to drive improvements in blood pressure care in primary care.

An online survey was made available from 14 September 2016 to 30 September 2016 and attracted 52 responses. Further information about the methods can be found at the end of this report.

Results

The 52 responses largely comprised of general practitioners and practice nurses. The detailed information relating to respondent's professional groups is shown in Figure 1.

Figure 1. Respondents' professional groups

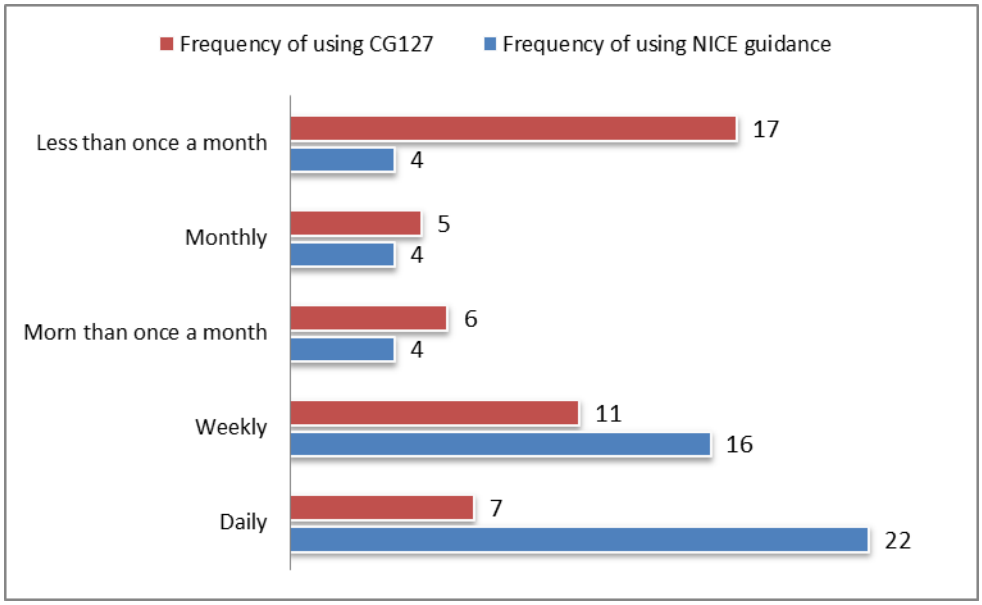


Use of NICE guidance in general and use of CG127

Among 52 respondents, 50 reported that they have used NICE guidance: 44% used NICE guidance daily and 32% used guidance weekly (Figure 2).

For CG127 specifically, 46 out of 50 respondents reported that they used this guideline. Of 46 users of CG127, one quarter used it weekly and just over one third used it less than once a month (Figure 2).

Figure 2. Frequency of using NICE guidance and CG127



Frequency of using other NICE products

Among 50 respondents who have used NICE guidelines, 9 in 10 used NICE Pathways to support the implementation of NICE guidelines. One third used quality standards and one fifth used baseline assessment tools.

When using CG127, the most popular products used by respondents to support its implementation were NICE Pathways (90%), followed by quality standards (28%) and baseline assessment tools (13%).

We asked what the main challenges or barriers were to implementing CG127 in supporting the high blood pressure strategy, how could identified barriers be overcome and how measures of performance against NICE hypertension quality standard (QS28) should be used to drive improvements in blood pressure care in primary care. Respondents' feedback was grouped into four main themes: resources, content, patient aspect, and targets.

Resources - *Lack of resources and time pressures could be potentially overcome by using the skills of other healthcare professionals (HCPs) and providing targeted training and support*

Respondents placed a major emphasis on the lack of resources and time pressures within the general practices as a barrier to communicate information on lifestyle and management of the condition and treatment with patients and other professionals, while balancing priorities with many other initiatives to complete.

"Staff resources - nurses and doctor time access to phlebotomy access to domiciliary services" GP

"Staff time - so many other initiatives to complete" Practice Manager

"Time within practice to discuss with GP's new drugs to commence, also side effects of Ramipril" Nurse

"Capacity issues in GP practices meaning that patients do not get regular BP measurements and follow ups, and lack of screening and utilisation of the skills available in community pharmacy." Pharmacist

Respondents felt that the newer guideline would increase the numbers of eligible patients for diagnosis and treatment. There were also comments about targets being unrealistic.

"The numbers of eligible patients is dramatically higher with newer guidance" GP

"Lack of knowledge in primary care lack of link to incentive/not measured in QOF" Consultant

"Unrealistic targets sometimes one size doesn't fit all" Practice Nurse

Respondents suggested better utilising the skills available from other healthcare professionals, providing more training and support to increase the existing capacity, and improving collaboration between services to deliver the high blood pressure strategy.

"Encourage screening by non-medical people/automated situations and then signposting people." Doctor

"Write out some PGD's/PSDs for nursing staff to use within clinic practice and cut down on some of the hypertensive pts that could be managed at nursing level" Nurse

"Additional training and support offer to surgeries who are currently not meeting QOF hypertension targets." Practice Nurse

"Use existing and novel services in community pharmacy joined up with GP surgeries" Pharmacist

"Easy access to good secondary care services for patients who are difficult to manage in primary care..." Nurse Practitioner

Despite that, respondents cited that the GPs authority and experience was essential when dealing with issues of side effects or polypharmacy. Moreover, respondents suggested that more investment, resources and incentives in primary care was required.

"Funding for surgeries to have a BP machine in reception which data can be uploaded onto patients' notes reducing white coat syndrome and over diagnosis, access to funding for more 24hr BP machines and home omron machines which can be calibrated" Practice Nurse

"More money with public health, more education for patients, and more resource to incentivise validation of practice registers" GP

"Increasing GP numbers and resources, having more time, more nursing time, and people have own BP monitors at home" GP

"National Publicity campaign giving cold hard facts, more investment in general practice. Cut workload, statistics collection to enable clinical staff to deal with clinical tasks" Practice Manager

Content - *More up-to-date, robust evidence and easy access to quick reference information is required*

Respondents commented that the guideline did not account for differences in individual patient's characteristics. A GP gave an example to illustrate the point: *"no allowance for patients' inability to tolerate a lower BP e.g. due to falls risk, and advice for intolerable side effects … [this should] be covered in the guidance".* The need for patients to be aware of the evidence base was also suggested.

"Some changing of targets dependant on age, some studies have shown reduced mortality with slightly higher BP in elderly and not reflected in guidelines or targets." GP

"Patients should also be aware of the evidence base and the NNT to prevent CV events which isn't always clear." GP

GPs felt that NICE guideline did not cover people with multiple morbidities, and they suggested that more attention was needed on reducing health inequalities and putting patients first rather than simply following the guideline.

"Carefully as we are at risk of over-treating and polypharmacy, guidelines rarely take account of multiple morbidity or older age etc. as there is precious little research to inform the guidance so it tends to get left out ... We need to concentrate on health inequalities, managing the most vulnerable better, and those not accessing treatment…" GP

"… after over 30yrs working in the NHS I am aware of how important it is to put patients before guidelines..." GP

GPs suggested that the need for *"shorted summaries [of NICE guidance]"* and *"dividing [NICE guidance] in single simple dedicated actions"* so that clinicians could easily access quick reference information and use it during consultation.

Finally, respondents felt that NICE guideline was seen as a guide rather than a protocol that should be followed, and there were various *"in-house protocols and guidelines"* for professionals to follow. It was suggested the need for standardised protocol/procedure in place.

"Standardised algorithms for practice nurses and HCA's to follow which abide by NICE guidance" Practice Nurse

Patient aspect - *Lack of engagement from some patients could potentially be reduced by education, offering follow up service and access to 24hr blood pressure monitoring*

Healthcare professionals cited that there was a lack of engagement from some patients and reluctance to take medication.

"Patients are not engaged with advice and treatments." GP

"Patient intolerance of medication/ reluctance to take additional medication" Practice Nurse

Practice nurses suggested that the lack of engagement from patients could be minimised by *"educating and engaging patients about the risks of uncontrolled hypertension"*, *"discussing risks and benefits of treatment and medication,"* and *"follow up to achieve optimum treatment recall system so all patients [can be] seen and none slips through the net unless patients decline treatment".*

Respondents recommended that patients should be able to access 24hr blood pressure monitoring via a number of channels to improve access.

"Improving access to screening through work place, social venues, etc." Nurse Practitioner

"Sometimes delay in booking 24hr ABPM appointments sometimes patient working away from home we provide evening appointments for working patients" Practice Nurse

"… We use recall system on EMIS and text reminders to patient when due check or blood test/clinic appointment as stated evening appointment available" Practice Nurse

Targets - *Multiple means to measure the performance against NICE hypertension quality standard (QS28) with flexible targets to allow clinical judgement*

To enable better use of measures of performance against QS28, respondents suggested that all the requirements of CG127 on diagnosis and monitoring should be incorporated into the hypertension template.

"Not everything in the guidance is on the current hypertension template and therefore it is easy to forget things, e.g. checking ACR on diagnosis" Practice Nurse

"Add everything that is required for both diagnosis and monitoring on the template" Practice Nurse

Respondents felt that practice audit and KPIs needed to put into place to measure the performance of implementing CG127. More importantly, respondents recommended linking with QOF (such as adding ABPM at diagnosis to QOF), whilst clinical judgement should be allowed for flexible measures to allow individual's differences.

"Link with QOF make clinical audit tool more user friendly as it is not usable in current format, practices locally were unable to use it" Consultant

"Make allowance for other factors rather than just targets - not everyone fits the box of 'target BP' for multiple reasons. It is unfair to penalise us on not reaching target BP's in these people, in whom we have discussion with regularly about negotiating accepting a slightly higher BP" GP

Balancing the need for and over treatment for patients was also highlighted.

"As always it is a balance between over treating patients to achieve a target and reaching a shared understanding and shared management plan in which the risks are discussed is probably more beneficial." GP

Finally, to measure the performance against CG127 and QS28, collaborative working across primary care to implement the existing dashboards was required.

"Work with existing primary care teams and implement into existing dashboards" GP

Conclusions

The findings demonstrate that primary care staff, particularly GPs, frequently use NICE guidelines on multiple topics. When using NICE guidelines in practice, respondents are more likely to use NICE Pathways and quality standards to help with implementation. When implementing CG127, time and workload pressures are key factors, which could potentially be overcome by better utilising the skills available from other healthcare professionals and providing training and support to increase the existing capacity.

The findings indicate that, although it is essential to measure the performance of CG127 via audit, incorporating the targets into KPIs, linking with QOF, and using the existing dashboard, the targets need to be flexible in order to tailor care that is responsive to patient needs. The findings also suggest the need to clarify the roles and responsibilities within primary care as to the implementation process. Finally, the outcomes illustrate that, to effectively engage with eligible patients, education and improving access to 24hr blood pressure monitoring for patients should be considered.

Appendix 1: Research methods

Design	An online, 10-item survey.
Sampling	Purposively targeted primary care staff, in particular GPs, practice nurses and practice managers, in Cheshire and Merseyside.
Recruitment	The survey invited all primary care staff who had been invited to attend the primary care blood pressure workshop in May 2016. The survey was also cascaded widely through HCPH Leads, DsPH, and the C&M Blood Pressure Board.
Data analysis	All quantitative data were imported into Excel and analysed to produce descriptive statistics, and all qualitative data were analysed using thematic analysis with constant comparison to generate, merge and refine themes.