Running educational outreach meetings in general practice

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Educational outreach meetings are an evidence-based way of making long-term behaviour changes, such as improving prescribing. This article discusses how to run educational outreach meetings to obtain the best possible outcomes in general practice.

Changing established behaviour is difficult, whether this is stopping practice that is known to be ineffective or implementing new knowledge and practice. The earlier new research findings are implemented, the greater the benefit to patients, but NICE acknowledges that it can take up three years for a clinical guideline to be fully implemented.

There are many barriers to implementation of new evidence and it is important to understand what these barriers are before an intervention for behaviour change can be implemented. The behaviour change wheel (see Figure 1) provides a useful theoretical tool on which to start identifying behaviour barriers and potential interventions (which can potentially be implemented at a practice level) and policies (which are more useful at an organisation or government level).

Overcoming barriers to change

The NICE guide on how to change practice identifies seven potential methods to overcome barriers to change. These methods vary in their costs and the effort required to develop and implement them. Consideration also needs to be given on how widely they can be implemented, for example whether they can be delivered to all prescribers, and whether the methods can be delivered to new staff.

- **Educational materials** are useful to raise awareness of what needs to change but are not necessarily effective in changing behaviour when used on their own.
- **Educational meetings** are effective in changing behaviour if they are made interactive.
- **Opinion leaders** can motivate and inspire others but it may be hard to identify appropriate individuals.
- **Patient-mediated strategies** focus on giving information to patients and the wider public, e.g. mass media campaigns to discourage requests for antibiotics for...

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Figure 1. The behaviour change wheel (taken from Michie et al., 2011)
coughs and colds engage patients, and can be effective.

- **Reminders and prompts** using computer-aided decision-support systems such as ScriptSwitch or OptimiseRx are designed to remind the prescriber of best practice at the time the action is to be taken. They are best used if tailored to important, pre-agreed situations. Too many reminders tend to give prescribers prompt overload leading to them being ignored.

- **Clinical audit and feedback** involves retrospectively reporting information to individuals and organisations about their practice. Clinical data is collected from actual practice to provide an insight into how care is delivered. The data is presented against audit standards and can be compared against other similar organisations (or clinicians) to show variation in performance.

  Clinical audit is more effective if the staff involved ‘buy-in’, are involved in the data collection and have consented to the process. Feedback is best delivered as an educational outreach meeting (see below) by a person whom the practice respects, for example another GP, a clinical pharmacist or a nurse specialist.

- **Educational outreach meetings** are run by a facilitator who visits healthcare professionals (in this case, general practice staff) and feedback on clinical audit data of the practice’s performance, as well as educational material on best practice. Importantly, the facilitator aims to explore the barriers to change with the practice staff and to agree an action plan or way forward for change.

**Educational outreach meetings**

Educational outreach (also known as academic detailing) was originally developed by the pharmaceutical industry but it has been used by healthcare professionals as a method to improve prescribing since the early 1990s. In England, the earliest examples of educational outreach involved the Family Health Services Authority GP and pharmaceutical adviser visiting practices to discuss prescribing using the (at the time) newly available Prescription Analysis and Cost (PACT) data that allowed practices to compare their prescribing with other practices and with their own over time. Comparison of PACT data is rarely used today on its own because richer data can be obtained from general practice clinical information systems, which can relate prescribing to individual prescribers, diagnosis and patient demographics, for example.

A Cochrane review found that educational outreach visits, alone or combined with other interventions (such as clinical audit and prompts/reminders), had effects on prescribing that, although relatively small, were consistent and potentially important. In UK practice, studies have found improvement in the implementation of evidence-based clinical guidelines with educational outreach delivered by a pharmacist.

The effect is more powerful if educational outreach is supported with audit and feedback (of practice prescribing) and dedicated practice support. For example, in the PINCER study, this multi-faceted approach was more effective than computer-generated feedback.

While educational outreach meetings can be effective, they can be expensive to organise and conduct, and time consuming for the practice staff and the organisation facilitating the meetings (eg the CCG), and they may need to be repeated to establish long-term behaviour change. The process could be organised and run by the general practice itself, for example by the practice pharmacist.

**Preparing clinical audit data**

Educational outreach meetings work best if the discussion is illustrated with clinical audit data from the practice. NICE has produced guidance on preparing for audit and feedback. They set out five stages:

- Preparing for audit
- Selecting criteria
- Measuring performance
- Making improvements
- Sustaining improvement.

It is beyond the scope of this article to go into detail on these five stages but a detailed account can be found in the NICE guide.

Before commencing the audit, there are a number of important issues that need to be agreed by the practice such as:

- Staff, and ideally patients, should be involved in selecting the topic, as their participation is most likely to identify a topic that is important to address and may help reduce resistance to change.
- All practice stakeholders must agree to be involved in the educational outreach meeting.
- The practice needs to recognise that all other relevant staff (eg administrative and reception staff, allied healthcare professionals) may need to be involved in the meeting, and protected time needs to be set aside for the meeting and implementing agreed changes in practice.

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**Figure 2.** Cephalosporin prescribing: how presenting data on antibiotic prescribing can affect prescribing behaviour

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**Table:**

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<thead>
<tr>
<th>Month</th>
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<td>Apr</td>
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<td>May</td>
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<td>Jun</td>
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Educational outreach meeting held and action plan agreed

Individual GP prescribing reported on a weekly basis.
• A person with appropriate skills in audit needs to be given time (and possibly funding) to conduct the audit. This could be a practice pharmacist, a GP registrar or possibly a person external to the practice.

Preparing for the meeting
Having selected the topic, the facilitator should collect evidence of best practice that can be used to educate the team and inform the debate. NICE guidance and clinical knowledge summaries, MHRA Drug Safety Alerts and guidance produced by professional bodies are obvious sources of best practice information.

Running the meeting
Presenting the data
Data should be presented in a visually interesting way. You might want to prepare this as an ‘audit and feedback’ document, which shows the data but also provides educational outreach messages. Try to avoid data overload by sticking to a small number of important issues. Comparison with other prescribers, other practices and the same practice over time provide a more useful comparison (the ‘social norm’ – nobody likes to be at the wrong end of the graph!).

Prior to the meeting, agreement should have been sought on the rules of disclosing prescribers’ data to others. In the example shown in Figure 2, where a reduction in cephalosporin prescribing was the desired outcome, the GPs agreed to see each other’s prescribing data on a weekly basis (weighted by number of consultations each GP had, to try to provide a fairer comparison). The educational outreach meeting was powerful in reducing prescribing but over time prescribing increased again. Presenting data on each prescriber’s figures seven months later had a dramatic effect in further reducing prescribing. If one prescriber is very out of line with others, try to talk to them prior to the meeting to understand the reasons, so they are prepared and not embarrassed in front of colleagues.

Gaining everybody’s involvement
Ensuring as many people as possible involved in the care pathway attend the meeting will allow a wider discussion and identify factors that might not otherwise have been considered. Two examples:
• In a practice meeting on how to improve blood pressure (BP) levels, a receptionist reported that they immediately coded all BPs that were handed to them over the counter from patients. This meant that many uncorroborated high readings were going onto the patient records and distorting the data. One outcome from the meeting was to agree a new system for receptionist collection of BP readings.
• A practice meeting was arranged to discuss the falling diabetes management data, but it wasn’t until the practice nurse arrived late from a clinic that it became clear that the main contributing factor was the reduction in the frequency of nurse clinic time with diabetic patients.

The facilitator also needs to ensure that all attendees have a chance to speak, particularly bringing in those who don’t tend to speak up or who feel intimidated by other members of the group. This may improve the chances of the behaviour changes being sustainably implemented into ongoing practice.

Handling conflict
In any group discussion, there is potential for conflict, but the facilitator should provide a ‘gatekeeper’ role, inviting contributions from those who haven’t already spoken and reducing the time of those who would dominate. Also, they can have a ‘harmonising’ role, reducing tension and emotions, and pointing out the feelings of the group or of a participant.

Identifying behavioural barriers and interventions to overcome them
An important consideration in making an outreach meeting likely to be more successful is to recognise behavioural barriers that need to be overcome. The facilitator needs to help the group to identify the gap between recommended practice and current practice (baseline assessment). This will help to identify the potential and actual barriers to change, allowing the group to pinpoint the practical actions needed to implement the change along with the groups of professionals who are key in bridging this gap.¹

The potential impact of any new recommendations can be described in terms of:
• Type of staff required
• Number of staff required
• Training and equipment needed
• Relevant established networks, meetings and forums

<table>
<thead>
<tr>
<th>COM-B</th>
<th>TDF domains</th>
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<tbody>
<tr>
<td>Capability</td>
<td>Knowledge</td>
</tr>
<tr>
<td>Psychological capability</td>
<td>Cognitive and interpersonal skills</td>
</tr>
<tr>
<td>Physical capability</td>
<td>Memory, attention and decision process</td>
</tr>
<tr>
<td>Physical opportunity</td>
<td>Behaviour regulation</td>
</tr>
<tr>
<td>Social opportunity</td>
<td>Social influences</td>
</tr>
<tr>
<td>Motivation</td>
<td>Social/professional role and identity</td>
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<tr>
<td>Reflective motivation</td>
<td>Motivations and goals</td>
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<tr>
<td>Automatic motivation</td>
<td>Belief about capabilities</td>
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<td></td>
<td>Optimism</td>
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<td></td>
<td>Beliefs about consequences</td>
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Table 1. The capability, opportunity and motivation (COM-B) behaviour model and theoretical domains framework (TDF) can be used to help identify types of behavioural barriers against which evidence-based solutions can be applied.¹

Educational outreach meetings
Prescriber.co.uk
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Prescriber December 2017
• Ongoing educational initiatives.

Table 1 shows the ‘capability, opportunity and motivation’ (COM-B) behaviour model, which forms the hub of the behaviour change wheel, further broken down into the 14 domains of the theoretical domains framework (TDF). The TDF is an overarching framework encompassing 33 different behaviour change theories. It was developed to identify individual factors known to influence the gap between evidence-based practice and the routine delivery of healthcare. An awareness of this framework can aid planning for the likely barriers to change that may be encountered during a meeting. It can also direct the meeting and the questions raised, to find out what the key factors are to improve capability, increase opportunity, aid motivation, and make behaviour change more likely to be successful.

For example, have GPs got the ‘belief about capabilities’ to offer anticoagulants to people with atrial fibrillation (AF)? Research has shown that prescribers overestimate the risks and underestimate the benefits, and consequently only 50% of AF patients are on anticoagulants, which could prevent two-thirds of strokes following AF.

Agreeing an action plan

An action plan is a useful tool for agreeing what needs to be done, who will do the work, when it will be done by, and how improvement will be measured. Effective action plans break long-term goals into small, manageable steps, so that people continually take action towards the goal and feel a sense of achievement.

Use of an action plan allows the group to determine a specific goal and the steps needed to achieve it. Both goal and steps should be measurable so that it is possible to tell whether the goal has been met by examining the outcome. An action plan format such as the one shown in Table 2 provides a framework for the facilitator to guide the group to agree and record:

- What needs to be done – by agreeing actions to achieve the required change. This works best if the actions are specific, realistic and to the point.
- Who will co-ordinate and champion the

<table>
<thead>
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<th><strong>Action plan agreed at team meeting</strong></th>
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<tbody>
<tr>
<td><strong>To:</strong> Reduce the number of antibiotic items prescribed at our surgery</td>
</tr>
<tr>
<td><strong>Target</strong></td>
</tr>
<tr>
<td>To reduce the total number of antibiotic items to below the CCG average</td>
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Table 2. An example of an action plan for reducing antibiotic prescribing
work? This should be a named person who has agreed to the role.
• Who will do the work?
• When should it happen by? Setting a realistic deadline provides an aim to work towards and a measure of when it has been achieved.
• How will improvements be monitored and discussed? There needs to be a method to show when the goal has been achieved.

In the example shown in Table 2, the practice team have identified reducing the prescribing of antibiotics as an area for improvement. The practice staff agreed to measure and give feedback on the number of antibiotic items per 100 consultations, use patient information leaflets as an alternative to antibiotic prescriptions, and try out the use of the FeverPAIN score for sore throats. The practice manager would oversee and co-ordinate the work. The chart also shows when the work was to be completed by.

Conclusion
Educational outreach meetings are an evidence-based way of making long-term behaviour changes. NICE\(^1\) states that the evidence shows:
• Outreach meetings are effective in tackling certain types of change, such as change in prescribing, the delivery of preventative services and management of common clinical problems in general practice.
• The facilitator visiting more than once increases its effectiveness.
• The identity of the outreach facilitator may have an impact on its effectiveness.
• Visits are more effective when combined with reminders and/or interventions aimed at patients.
• Visits are also more effective when tailored to individual barriers and situations.

Educational outreach meetings work best if the end users are involved in choosing the subject and are fully engaged in the process. By exploring the barriers to change with all the practice staff involved, investigating clinical audit data of performance, and using educational material on best practice, an action plan can be developed together to agree a way forward to change established behaviour, and implement new knowledge and practice.

References

Declaration of interests
Duncan Petty has received funding from Bayer for presenting at a conference.

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