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Health Governance Unit

Medical Research Institute
Alexandria University

# ABC of Governance

*Towards informed and transparent societies*

## Clinical Effectiveness

Clinical effectiveness is the provision of care that is based on best current evidence and in accordance with patient preferences offered by staff that are competent to deliver it. Clinical effectiveness is not carpet application of best available evidence to all patients but a tailored approach that takes into consideration other local factors such as patient values, resources, and available expertise. Clinical effectiveness fosters patient involvement in decisions related to their management all along their care pathway. Such engagement enhances patient satisfaction and care outcomes. Clinical effectiveness emphasizes patient oriented outcomes (symptom control, return to daily activity, survival) over disease oriented outcomes (radiological or biochemical changes). Clinical effectiveness is part of a wider framework known as clinical governance and should be practiced with the other elements of clinical governance such as clinical audit, clinical risk management, continuous professional development, patient and public engagement. Strategies for practicing clinical effectiveness include the use of clinical practice guidelines and their delivery through integrated care pathways. It is advisable to start on a small scale and when confident apply widely.

### ABC of Governance

**AIMS AT**

creating an awareness of issues related to health governance

providing a core of knowledge that is practice-based

encouraging communication between advocates of governance

## Clinical Practice Guidelines

Clinical practice guidelines are documents that contains a set of recommendations related to a specific topic or disease. The recommendations should be based on best current evidence derived from high quality research, risk benefit analysis of of the intervention, cost of the intervention, expected patient preferences (GRADE). Clinical practice guidelines are expected to cover several aspects of care including diagnosis, treatment, prognosis, cost, patient education, implementation strategies, and audit criteria. There should also be a section on the methodology used in the development of the guideline (AGREE); a key point for ensuring the validity of its recommendations. Guidelines are not static documents as best evidence changes with time; so it is important to be aware of the year of the guideline publications. A recent guidelines is one that is not more that three years old. Guideline recommendations used to be ranked according to their strength into multiple levels, however, now the strength of the recommendation is expressed through the words used in phrasing it such as “must” and “should do”. Guideline content is usually decided by authors after consulting with the various stakeholders. This is done through the identification of key clinical scenarios or questions that clinicians face related to the guideline topic or disease. Once identified, guideline authors search the literature to find the best solution or answer for that scenario or question. The answers are usually presented in the form of the guideline recommendations with the evidence that supports it. A full guideline is a big document in size and content with a large amount of knowledge that might hinder its utilization. That is why guideline producers usually have two several formats for a single guideline. First, the full version for reference. Second, a pocket size for use at point of care. Third, a patient version to ensure shared decision making. Recently, electronic versions have been produced to be used with mobiles and hand-held computers to encourage on the job consultation and evidence-based decisions. Guidelines are not textbooks nor protocols. Therefore, textbooks are still used for background knowledge. Guidelines are usually implemented in practice through protocols or care pathways.

# Resources

**Evidence Based Medicine**
www.cebm.net
www.ktclearinghouse.ca

**Evidence Based Practice**
www.medicine.ox.ac.uk/bandolier

**Guideline Producers**
www.sign.ac.uk
www.nice.org.uk

**Guideline Finders**
www.guidline.gov
www.tripdatabase.com
www.ncbi.nlm.nih.gov/pubmed

**GRADE**
www.gradeworkinggroup.org

**AGREE**
www.agreetrust.org

**ICP Guides**
http://www.wales.nhs.uk/sitesplus/documents/829/integratedcarepathways.pdf

www.gosh.nhs.uk/file/576/download?token=Wa01xTkr

www.pna.ie/images/ncnm/Integ_Care_Path_2006.pdf

**ICP Associations**
www.e-p-a.org
www.scottishcarepathways.com

**ICP Journals**
www.ijic.org
www.icp.sagepub.com

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Contributions are welcomed and will be published

# Integrated Care Pathways

**Definition**
According to the National Pathway Association integrated care pathways (ICP) are locally agreed, multidisciplinary plans for anticipated practice based on guidelines and evidence where available, for a specific patient or client group. It forms all or part of the clinical record and facilitates practice evaluation through frontline documentation of variations from planned care. In this context, ICP offer clinicians the vehicle through which they can practice evidence-based medicine and continuous quality improvement. They also offer patients a mechanism for their education and involvement.

**Patient Groups**
ICP are implemented on groups of patients with similar symptoms or disease requiring similar interventions, resources or services. Therefore, ICP are developed for high volume or high risk groups requiring interventions that can be reasonably predicted.

**Interventions**
ICP incorporate interventions, whether for assessment, diagnosis or treatment, that are based on best current evidence. Interventions incorporated in ICP are defined through delineating patient pathway through high and detailed process mapping. ICP also mention who will be responsible for the delivery of each intervention and when it should be delivered, However, clinicians have the right to deviate from the anticipated plan based on patient needs and preference.

**Teams**
ICP, to be successful, should be developed by all stakeholders who are involved in the care of the patient from start to end. This helps in creating a common understanding of patient care, consensus on local practice, and also in defining roles and responsibilities.

**Single Record of Care**
ICP offer the opportunity to standardize and simplify the process of care documentation as it is based on exception reporting against preplanned care. Clinicians do not need to spend much time on documenting what has been done as long as it is part of the ICP document. If they encounter a situation that leads to or necessitates deviation from planned care they have then to record it and mention the reasons and how it was managed in the variance section.

**Safety and Quality**
ICP enable care providers to evaluate the safety and quality of their care through variance tracking and analysis. Variance analysis is an essential element of ICP.

**Extract from an ICP on enhanced recovery after surgery.**