SECTION FIFTEEN
CLINICAL EFFECTIVENESS

This section considers:

- the extent to which the PCT provides 'clinically effective care'
- methods for monitoring and gathering evidence of the clinical effectiveness of care
- the extent to which the PCT has an active 'knowledge management strategy'.

Clinical effectiveness and quality

There is a direct and transparent link between the clinical effectiveness of services and quality. Clinical effectiveness is thus a major constituent element of clinical governance – and is one key intended product of its 'technical components'. It is also one of the six building blocks of the quality of the patient experience identified by PCT Boards and PECs (see Section 5).

The Boards of PCTs must ensure that their PECs, in conjunction with their Clinical Governance Committees have clearly identified strategies and plans to monitor, support, improve and generate evidence of the clinical effectiveness of the services provided by the PCT.

They must also ensure that the PCT's commissioning process explicitly requires providers of care to:

- have an appropriate set of clinical effectiveness structures and processes in place
- demonstrate to the PCT evidence of the clinical effectiveness of the care that they provide as well as of the cost effectiveness.

This cannot safely be merely assumed. In their reviews of (predominantly) the acute sector, CHI has found:

'concerns about the dissemination of national guidance on effectiveness within many organisations.... Since August 2002 CHI has noted the need for collaboration with partners for the implementation of guidelines and effective practice in around a sixth of organisations.'

Commission for Health Improvement, 2002

Key learning from the pilot programme

Whilst recognising unequivocally its crucial importance, most PCTs struggle to identify concrete evidence of the clinical effectiveness of the care that they provide or commission.

Tracking the efficacy and outcomes of treatment in primary care and across the patient journey is notoriously more difficult than measuring the efficacy of a single episode of acute care. To derive 'intelligent information' about effectiveness, whether at the level of the PCT or of a constituent practice, from a plethora of data and over a meaningful time period represents a major challenge to the health care community and to those who seek to measure its performance.

Overall, PCTs would welcome national guidance on the promotion and measurement of clinical effectiveness.

Significantly, across all the PCTs in the pilot programme, the section on Clinical Effectiveness was the fourth lowest scoring, at 4.6 on the progress scale (range 3.0 to 6.8).

As in almost all other cases, the more recently formed PCTs were likely to find the generation of evidence of clinical effectiveness even more challenging than those that had longer to begin to wrestle with it. The 25 PCTs that were under a year old when they completed the questions scored an average of 4.1 whilst the remainder scored an average of 4.9.

Almost all PCTs found the question about the robustness of the methods for monitoring and gathering evidence of the effectiveness of clinical care challenging (4.6/10). This echoed the problem Boards and PECs had in evidencing the safety of the care that they provide and that they commission (see Section 9) and points to a systemic deficit in terms of 'intelligent' clinical quality and outcome information across broad sweeps of primary and acute health care.

Discussions about clinical effectiveness with Boards and PECs within the feedback process tended to reflect the primary concern that exists to secure appropriate diagnosis and referral and/or subscribing. All of these are crucially important to the well being of patients and to the management of risks to clinicians themselves and to their organisation.

Almost all Boards and PECs did, however, recognise that little systematic attention is paid to the other aspect of the 'efficacy equation' the right drug+rightly applied. Lack of appropriate application can have as adverse an impact upon clinical effectiveness and health outcomes as inappropriate or inaccurate prescription.

Since the overwhelming majority of the primary care treatment process is dependent upon the actions of the patient (and/or their informal carers) it is perhaps surprising that so little attention has, hitherto, been paid by individual clinicians or PCTs to the well-evidenced low levels of 'concordance with treatment' and to the evidence-based steps that can help to promote concordance. Improvements in concordance have a direct and beneficial impact upon 'value for money' as well as the health outcomes secured from the massive primary care drug budget spend.

The concordance achieved by many HIV patients provides powerful evidence that, where patients are full and active partners in their own care, significant gains can accrue for the individual, the clinician and the health care system.

It is equally clear that, not least in the light of the focus of scrutiny of the new CHAI (see Section 7), Boards and PECs will need to give more systematic attention to the clinical effectiveness of the entire 'patient journey' and thus to the clinically effective management of transitions between primary and other sectors of care.

Assuring clinical effectiveness

Boards and PECs need to have in place structures that promote and monitor clinical effectiveness and compliance with evidence-based practice. This scrutiny extends beyond the immediate care provided by clinicians, to all decisions made by managers (or by the Board, the PEC or their sub-committees) that have direct or indirect clinical implications.

Clinical effectiveness, co-ordination and alignment of the elements of clinical governance

Clinical effectiveness is the product of the routine and systematic application to the care process of all elements of clinical governance that are designed to support the improvement and measurement of clinical quality. Active patient and NHS partner involvement is an integral part of all of these activities – as well as of the clinical transaction itself. Figure 15.1 illustrates some of the elements which, taken together, support, foster and continuously improve clinical effectiveness.

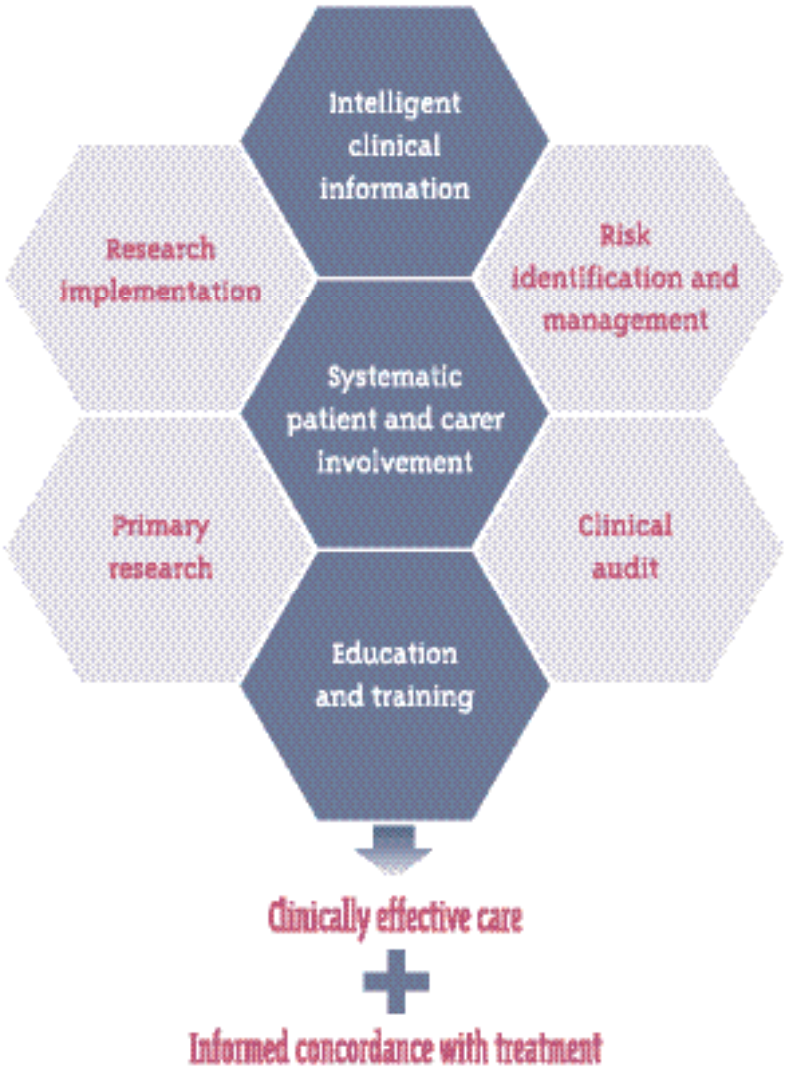

Figure 15.1 Co-ordinating and aligning the elements of clinical governance to achieve clinical effectiveness

REFLECTION

What evidence exists of systems and processes that ensure co-ordination of the elements of clinical governance so that they routinely inform and support clinical practice?

Clinical effectiveness and knowledge management

Knowledge management has a vital role to play in supporting effective clinical care. There are three core elements. PCTs must recognise the knowledge component of healthcare as an explicit concern in:

- strategy
- policy
- practice.

Clinical and other decisions and actions initiated by or on behalf of a PCT should be based upon a reliable, robust and ever-developing evidence base – at the macro as well as the micro level of provision.

'It is crucial that organisations get to grips with the growing body of evidence on the successful implementation of evidence-based change and organisational development.'

Clinical Governance Bulletin December 2001

At the micro level, clinical effectiveness needs to be grounded in 'evidence based care'. Given the ever-expanding research-driven knowledge base, Professor David Sackett calculated that a General Practitioner would need to give all of her or his time to scrutiny of the professional literature in order to stay abreast of emergent research that impacted upon one or other aspect of their patient care. For a PCT, therefore, the development of knowledge management processes needs to be a significant strategic concern.

'Knowledge management is 'a core activity for the improvement of health and healthcare', concerned with 'recognising the importance of knowledge and mobilising it in a form that professionals can apply'.'

Clinical Governance Bulletin, December 2001, vol. 2, no. 5.

The Boards and PECs need to make good use of an IM&T based infrastructure and, with the support of the SHA, must target new IM&T investment (see Section 9) to support the use of evidence in and through clinical practice. Boards and PECs need to pay particular attention to supporting systematic and routine compliance with:

- NSFs
- NICE guidance
- local clinical governance priorities.

Evidence from the pilot study suggests that Boards and PECs are currently more likely to pay attention to NSFs (which they perceive as directly 'target based') than they are to NICE guidance.

Key indicators of the ways in which a PCT demonstrates 'constantly improving the quality of care' are provided by:

- systematic application of the fruits of research and guidance
- a PCT-wide clinical audit plan that examines the delivery of clinically effective care in relation to priority clinical conditions
- intelligent collection and utilisation of clinical and other local information.

Boards and PECs should, therefore:

'support people within a learning organisation committed to: sharing best practice; implementing evidence-based change.'

Clinical Governance Bulletin December 2001, vol. 2, no. 5

It is important to ensure that active and intelligent use is made of the extensive Cochrane clinical database.

'The Cochrane Library is now available to NHS practitioners, but many still do not realise that it is available, or that help in using it is close by.'

Clinical Governance Bulletin December 2000, vol. 1, no. 3

An increasing proportion of this extensive menu maps directly against the clinical priorities of primary care practitioners.

'Examples of the thousands of topics covered:

- wound care
- social and medical treatments for depression and schizophrenia
- analgesia for osteoarthritis
- smoking prevention programmes
- treatments for adult and childhood asthma.'

Clinical Governance Bulletin, December 2000, vol. 1, no. 3.

Boards and PECs also need to ensure that there is widespread awareness and active use of:

- the Electronic Library for Health'
- PRODIGY as an evidence-based medicine tool for consultations
- PRIMIS as a nationally led electronic initiative designed to support the use of robust clinical and other information in general practices.

There needs, therefore, to be an appraisal of the accessibility to the PCT staff community of libraries, journals and the internet/intranet.

It is not enough to put structures and systems in place to disseminate knowledge; staff need the necessary skills to access it and to make intelligent and sustained use of it. PCTs need to consider the critical appraisal skills of staff in conjunction with their ICT competences. This suggests that there needs to be a transparent and effective three way connection between the clinical effectiveness agenda and the research implementation (see Section 14) and the education and training (see Section 13) components of clinical governance.

Even where these structures and support systems are put in place, it is important that PCT Boards and PECs recognise the importance of fostering a culture in which attention to evidence and to learning are firmly embedded.

''Soft' techniques that promote person-to-person communication are needed alongside effective dissemination of documented best evidence and best practice.'

Clinical Governance Bulletin December 2001, vol. 2, no. 5.

REFLECTION

To what extent is there evidence of active knowledge management across the PCT community?

How accessible are underpinning clinical knowledge support systems?

REFLECTION

What steps have been taken to ensure that staff possess the necessary range of ICT and research critiquing skills that will enable them to make the best use of the knowledge infrastructure?

REFLECTION

To what extent is the PCT culture one that promotes the systematic and routine use of evidence by managers, clinicians and by the Board itself?

Monitoring and generating evidence of clinical effectiveness

It is clear from the pilot study that this continues to pose a major clinical governance challenge to Boards, PECs and Clinical Governance Committees.

In carrying out their 'clinical effectiveness' duties and responsibilities, PCT Boards and PECs must ensure that:

- knowledge management-based support is available to the PCT clinical and managerial community
- appropriate structures and processes are in place to monitor and audit the implementation of evidence-based care
- appropriate use is made of relevant performance indicators
- processes and structures are developed that ensure continuity and co-ordination of activity between the Board, Directorates and Clinical Teams with references to the collection, use and review of clinically effective data and information
- systematic approaches to the production of integrated care pathways, protocols and guidelines are developed in order to reflect strategic priorities, promote changes in working practice and improve patient care

Boards and PECs need to identify and apply outcome measures that enable them to assess the effectiveness of care against national or local standards (where these exist).

The Primary Care Collaboratives have provided compelling evidence of the improvements in clinical effectiveness that can be achieved when a PCT community acts in concert with other key players in the local health economy to generate a systematic, coordinated and evidence based response to the management of a clinical priority topic.

'The Collaborative's approach to improving care of patients with coronary heart disease (CHD) is based around clinical evidence on the effectiveness of medication and best practice in delivering care.'

National Primary Care Development Team, 2002

They have provided a clear (and generalisable) template for the implementation of a systematic process to promote and support clinically effective practice.

'**Collaborative framework for effective secondary prevention of CHD**

- Develop and maintain a valid CHD register.
- Implement agreed protocols for care.
- Use computerised templates for collecting patient information.
- Identify systems for call and recall of patients.
- Develop nurse-led care for CHD patients.'

National Primary Care Development Team, 2002

REFLECTION

To what extent is there evidence that the PCT routinely monitors, collects and disseminates evidence of clinically effective care?

The results of this approach have exceeded expectations and have clearly evidenced benefits to their local patient populations.

'A comparison of PCTs that were part of the NPCC with those that were not involved has shown a four-fold difference in the reduction in mortality from CHD during the same period.'

National Primary Care Development Team, 2002

Boards and PECs need to scrutinise the evidence from these initiatives – and put in place similar systematic process in relation to their own clinical priorities in order to provide to CHAI and to their local communities evidence of improvements to the patient experience resulting from the implementation of evidence-based practice.

Priorities for action

Now that you have finished reading through this section, please identify three key priorities for the PCT in relation to clinical effectiveness.

1

2

3

References

Commission for Health Improvement 2002. *Emerging Themes*, December. www.chi.nhs.uk

Clinical Governance Bulletin December 2001, vol 2, no 5

Clinical Governance Bulletin December 2000, vol 1, no 3.

National Primary Care Development Team 2002. *The National Primary Care Collaborative: The First Two Years*, Manchester: NPCDT

Resources

Bandolier
www.jr2.ox.ac.uk/bandolier

Cochrane Library
www.nelh.nhs.uk/cochrane.asp

Commission for Health Improvement – CHI's aim is to improve the quality of patient care in the NHS
www.chi.nhs.uk

Doctors.net.uk – Doctors.net.uk is a peer led organisation created to improve health care through modernising medical communication throughout the UK, ensuring all doctors have access to the best medical knowledge, and reducing costs for medical organisation wishing to use the Internet to disseminate information.
www.doctors.net.uk

Effective Health Care
www.york.ac.uk/inst/crd/ehcb.htm

Information for general practice

PRIMIS is a national drive to develop use of information in general practices
www.primis.nhs.uk/pages/default.asp

PRODIGY as an evidence-based medicine tool to support GPs in their consultations
www.prodigy.nhs.uk/

National Electronic Library for Health – rapid access to reliable evidence
www.nelh.nhs.uk

NHS Centre for Reviews and Dissemination
http://agatha.york.ac.uk/

Protocol based care
An information pack has been prepared by the Modernisation Agency and NICE to support the development of protocol based care within the NHS. It aims to spread good practice and help professionals working in community, primary and secondary care by providing practical guidance on how to develop protocols – linking this into the wider agenda for service modernisation
www.modern.nhs/protocolbasedcare

University of Leicester Clinical Effectiveness Information Update

Summarises information from NICE, SIGN, Royal Colleges, Department of Health, Health Technology Assessments, Audit Commission, CHI, Medical Devices Agency, and evidence-based publications
www.le.ac.uk/li/sources/subject10/ebp/current.html

University of Leicester offers an outreach library service for primary care, community and mental health care NHS staff. Includes current awareness, document delivery, website sources
www.le.ac.uk/li/clinical/outreach/menu.htm

Rating the PCT's current stage of development

Please rate the PCT's current stage of development in relation to the following questions.

Remember to use the Response Sheet provided for your answers.

15.1 To what extent is there a strategy to develop evidence about the clinical effectiveness of PCT-delivered care?

15.2 To what extent is the effectiveness of clinical care routinely monitored and compared to national standards?

15.3 To what extent does the PCT have explicit processes for balancing the cost of treatment against its evidenced efficacy?

15.4 To what extent is attention paid to issues of concordance with treatment as well as to appropriate diagnosis and prescription?