

P004 GUIDELINES AND PERFORMANCE

Daniel Keenan.

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The Guidelines and performance measures allow us to reduce variation in the provision of care and to provide reassurance to all that care is optimum.

In England we continue to look at clinical performance and have focused of the three main tenants of quality; clinical effectiveness, safety and patient experience from institution down to individual. Institutional effectiveness has been looked at in relation to targets which are “must do”, such as primary angioplasty times (previously thrombolysis) and performance against standards such as time to scan for stroke. Next come such measures as the percentage of patients admitted to a dedicated stroke unit and the use of cognitive behavioural interventions. In relation to individual performance, we have looked at mortality rates following open-heart surgery. This year, under the government’s transparency agenda, individual results are to be published from additional national interventional audits. More are to follow and virtually all the national audits and registries will be published with a high degree of granularity in the next few years.

In primary care the quality and outcomes framework, which is a remuneration package for primary care physicians, is used to manage performance and has driven up the quality of the services offered. It is based on a basket of process measures, which are managed by the National Institute for Health and Care Excellence (NICE), and are renegotiated to drive increasing improvement that is evident by improved performance against the indicators.

With recent changes in government policy, increasing interest has focused on the quality of commissioning and measures have been derived from NICE Quality Standards (in effect an amalgamation of guidelines into 12 standards) to assess this. Further, with the introduction in the UK this year of medical revalidation, there is an increased emphasis on individual information to support re licensing.

Overall, therefore, we have a dual track of the increasing development of guidance and the condensation of these into easily manageable standards and the measurement of performance, at many levels, against these standards.

P005 DO GUIDELINES GUIDE THE CLINICAL PRACTICE?

Sang il Lee.

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Clinical practice guidelines and performance measures can be used to improve quality of health care. Medical review criteria and performance measures are used to determine the extent to which care has followed specified processes and whether the expected outcomes have been achieved. Recently there are increasing tendencies to release the healthcare organisations’ performance to the public and to introduce pay-for-performance in many countries.

In countries where development, dissemination, and implementation of clinical practice guidelines are relatively slow, other interventions such as claims review activities, report cards, and pay-for-performance may have stronger influence on clinical practice in the real world than guidelines. In this presentation issues around the relationship among clinical practice guidelines, performance measures, claims review criteria, and clinical

practice in the settings where guideline activities are not so active will be discussed

Plenary 3: Challenges and Solutions for Updating Guidelines**P006 UPDATING PRACTICE GUIDELINES**

Paul Shekelle (USA).

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A challenge facing all guideline developers is how to keep their guidelines up-to-date. The practice of using a fixed interval to update guidelines, such as every 3 or 5 years, may not be efficient in terms of resources or keep fast-moving guidelines sufficiently up-to-date. I will present a conceptual framework for considering when guidelines need updating, that includes periodic surveillance. Next I will present the results of a programme of surveillance of a large number of systematic reviews, a conceptually similar process. I will then relate our experience with implementing a programme of surveillance for guidelines produced by the American College of Physicians. I will conclude with thoughts and speculations about the future directions for surveillance and updating of guidelines

P007 KEEPING A PROGRAMME OF CLINICAL GUIDELINES UP-TO-DATE

Roberta James.

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Over the last 20 years, SIGN has published 132 guidelines. Of the 68 extant guidelines only 15 are under 3 years old. SIGN is committed to providing evidence based clinical practice guidelines to help accelerate the translation of new knowledge into action to meet our aim of reducing variations in practice, and improving patient-important outcomes.

SIGN has an established process of scoping, consulting on, prioritising and updating published guidelines. This process, however, is time and resource intensive and has been based heavily on the age of the guideline and the emergence of new evidence rather than on any real need from guideline users.

A full review of a guideline is equivalent to developing a new topic and takes 2–3 years. Some alternative approaches that SIGN has developed for keeping guidelines up to date in a more timely fashion include:

- a selective update based only on those key questions underpinning a guideline that are shown to identify new evidence that would change recommendations. This process takes around 15 months and topics are scoped and prioritised;
- a living guideline that is scoped and updated every year;
- a small change affecting one or two recommendations that is highlighted by a guideline user or initiated by a change in licensing, legislation or local healthcare policy. This process takes around 6 months, is more reactive and driven by guideline user need but may only be applicable to newer guidelines.

This presentation will describe the risks, benefits, success and challenges in adopting these approaches. The key lessons learned include the need to: