NICE National Institute for Health and Care Excellence

bpac nz better medicine

Guidelines and Pathways

What role do they have in the United Kingdom and New Zealand Health sectors?

Murray W Tilyard

CEO

bpac^nz

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- for its internal purposes to reproduce, store and circulate the NICE Guidelines
- to put out for consultation within New Zealand draft versions of adaptations of the NICE Guidelines to working groups and committees organised by bpac^{nz}
- to create Adapted Versions, which will include the NZ Adapted Guidelines
- to reproduce and make them available in electronic or hard copy form free to NZ Clinicians in English or in the Maori language

First two Guidelines to be Contextualised

- Urinary incontinence in women: the management of urinary incontinence in women. Chaired by Prof Don Wilson
- Prescribing of antibiotics for self-limiting respiratory tract infections in adults and children in primary care. Chaired by Assoc Prof Mark Thomas

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Clinical information needs of New Zealand general practitioners and the resources they use to meet them 2006

Susan M Dovey MPH PhD, Tony J Fraser BSc PG Dip Com, Murray W Tilyard BSc MBChB FRNZCGP MD, Sonia J Ross BSc, Kaye E Baldwin and David Kane B Pharm

Types of clinical information needs by frequency of need

- Medicine Information
- Diagnostic testing information
- Evidence based guidelines
- New research common problems
- Peer comparison

Clinical information source	Frequent use (%)	Trust (%)
Contact with peers outside your own workplace	89.9	85.3
Continuing professional education	87.1	92.3
Contact with others in your own workplace	85.5	83.6
Hard copy BPAC material	81.2	93.0
Contact with hospital colleagues	79.6	94.6
Hard copy Pharmac material	60.8	69.1
Hard copy - New Zealand Guidelines Group	54.2	89.9
Hard copy Medsafe material	46.3	89.0
Libraries	9.2	74.8

Reliance on information to inform clinical practice

Publication	Mean Score (the lower the score the more it is relied upon)
Best Practice Journal– hard copy	2.51
bpac^{nz} website	2.89
Conference attendance	3.24
International Journals, e.g. BMJ	3.45
Peer advice	3.62
New Zealand Formulary	3.93
MIMS	4.03
PHO CME sessions	4.24
New Zealand Medical Journal	4.43
Magazines, e.g. NZ Doctor, Pharmacy Today, Kaitiaki	4.70
Material provided by pharmaceutical companies	5.80

bpac^{nz} Survey 2013

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BEST PRACTICE FOR SORE THROAT MANAGEMENT IN PRIMARY CARE: DECEMBER 2014

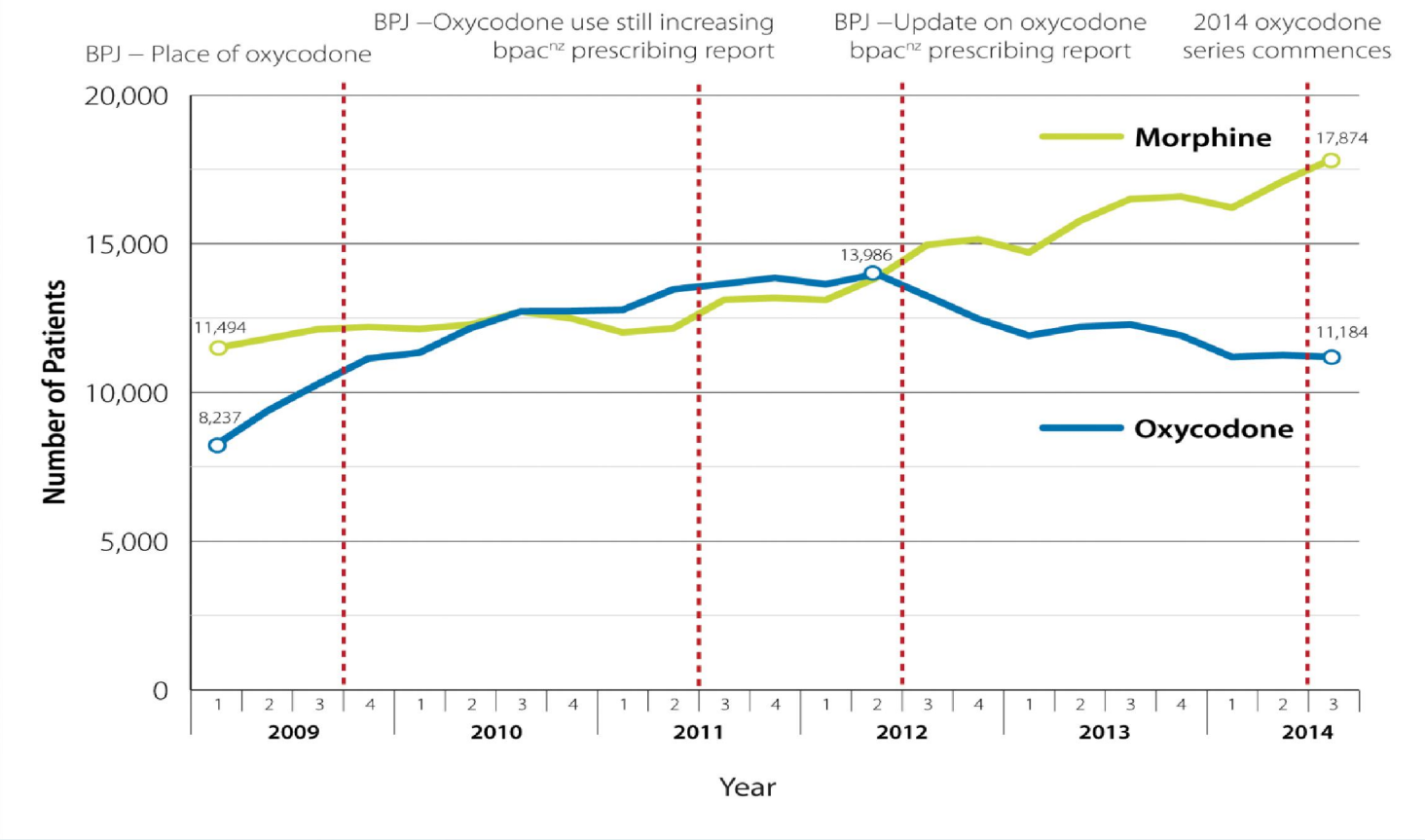
14 Guidelines + Provider Interviews

Clinical Assessment

- The health professionals interviewed made it clear that clinical assessment is an important tool used when deciding if a patient's sore throat was caused by GAS bacteria or a virus, despite many reporting using guidelines which do not recommend using clinical assessment when managing patients with sore throat.
- The NZ Primary Care Handbook, the original 2008 Heart Foundation guidelines, bpac^{nz}'s antibiotic guideline and local protocols in Tairawhiti, Waikato, Nelson-Marlborough and South Island DHBs **all recommend clinical assessment** based on either the Centor criteria or the McIsaac criteria.
- In contrast, the 2014 Heart Foundation guidelines and guidelines from the Northland DHB, the Northern regions clinical pathway and standing order, the Midland Map of Medicine pathway and the Wairarapa, Hutt Valley and Capital & Coast HealthPathway **do not recommend clinical assessment be used when determining a diagnosis.**

How bpac^{nz} battled oxycodone

Between 2007 and 2011, the number of patients dispensed oxycodone in New Zealand increased by **249%**; we needed to do something about this.



Who is prescribing oxycodone?

The **majority of oxycodone** is now initiated outside of general practice

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Guidelines, Pathways and the role of NICE in the NHS

Professor David Haslam, Chairman, NICE

February 2015

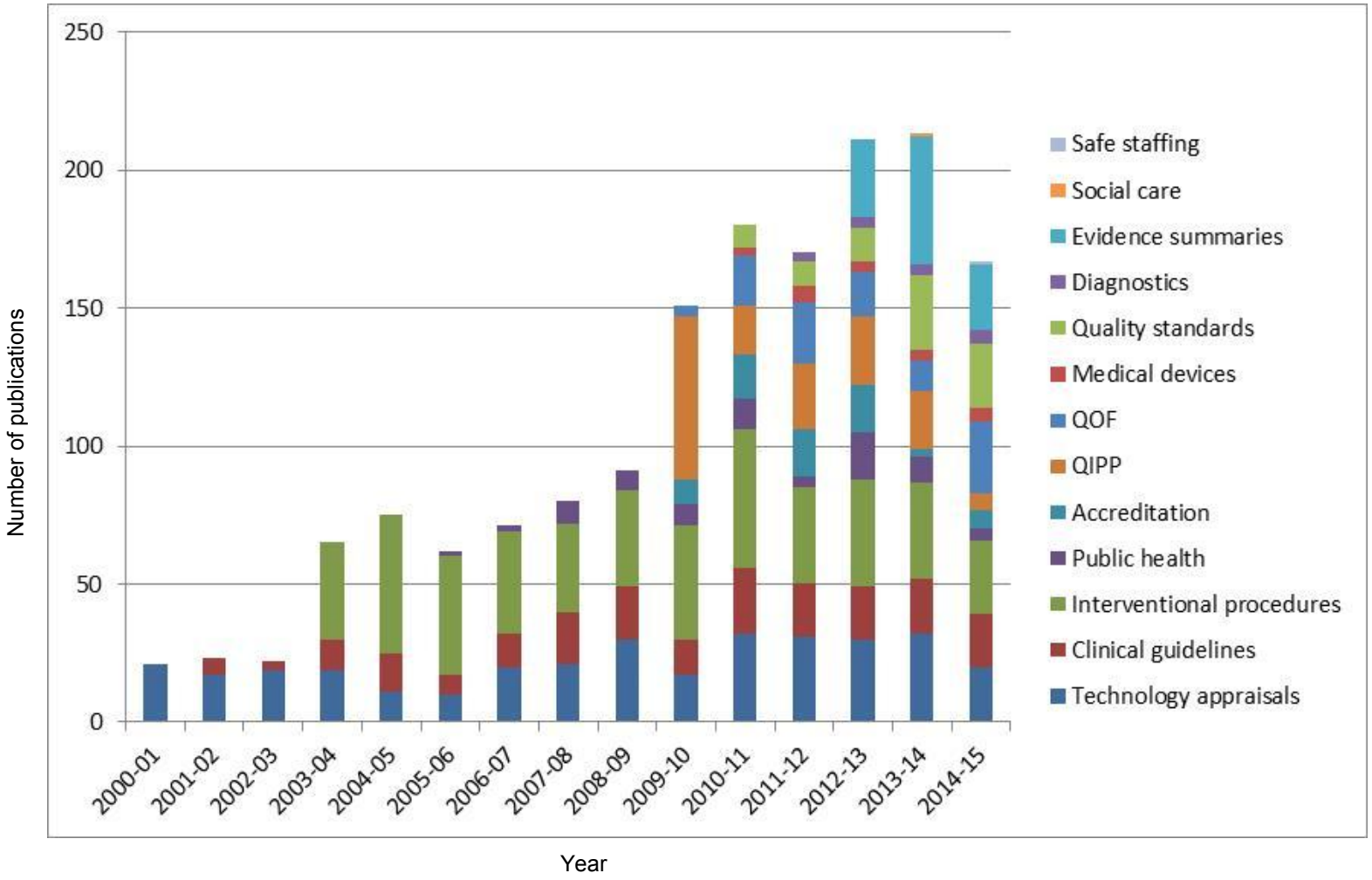
The background: why NICE was set up

- Established in 1999
- Aim: to reduce variation in the availability and quality of treatments and care (the so called ‘postcode lottery’)
- To resolve uncertainty about which medicines and treatments work best and which represent best value for money for the NHS

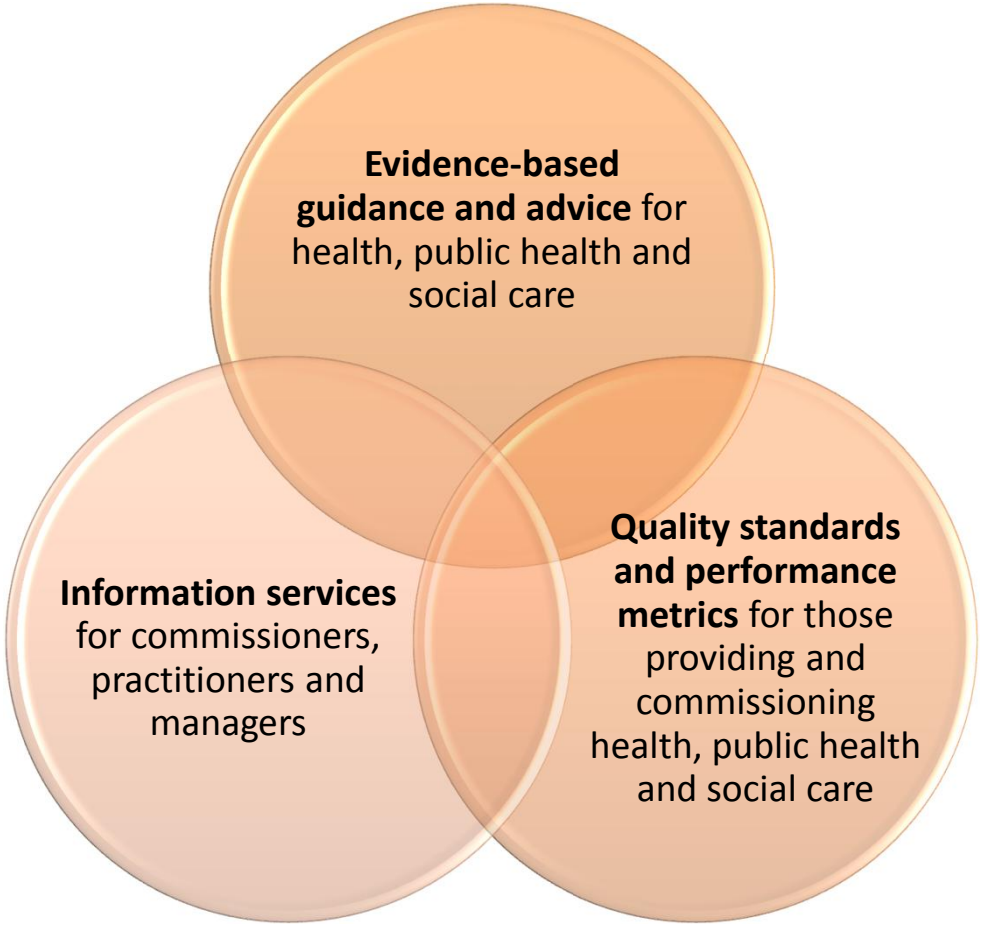
A Brief History

1999: Technology appraisals
Clinical guidelines
2002: Interventional procedures
Implementation
2005: Public health guidelines
2008 : NICE International
2009: Cost saving MedTec programme (new technologies)
Diagnostics
NHS Evidence
2011: National Prescribing Centre (now Medicines Prescribing Centre)
2013: Social care guidelines
Highly specialised technologies
2014: Safe staffing guidelines

NICE Guidance by Year



NICE: Improving outcomes for people



Core principles of NICE's work

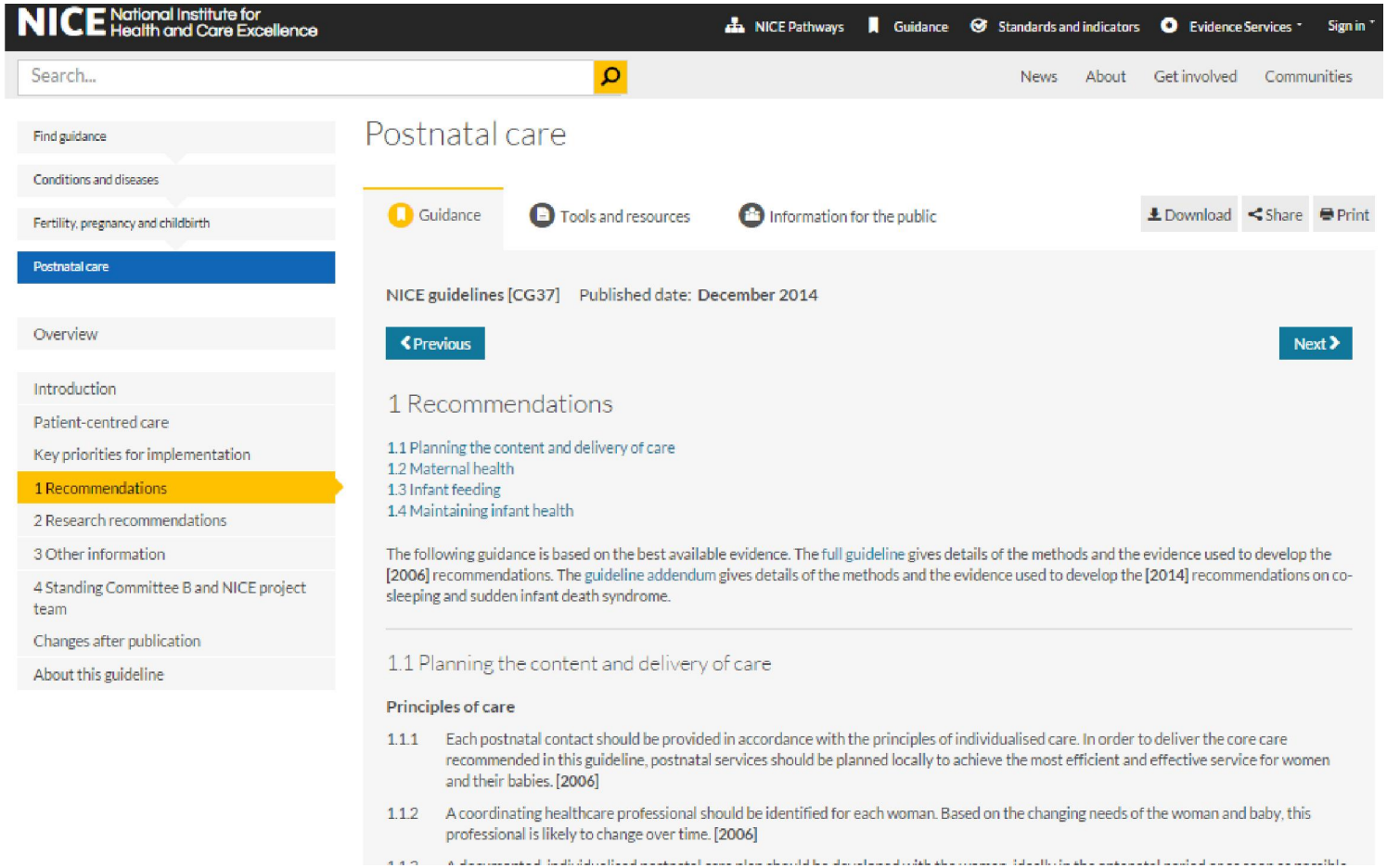
- Based on the best available evidence of what works and what it costs
- Independent and unbiased expert committees
- Patient, service user and carer involvement
- Independent advisory committees
- Genuine consultation
- Regular review
- Open and transparent process
- Social values and equity considerations

Is NICE guidance mandatory?

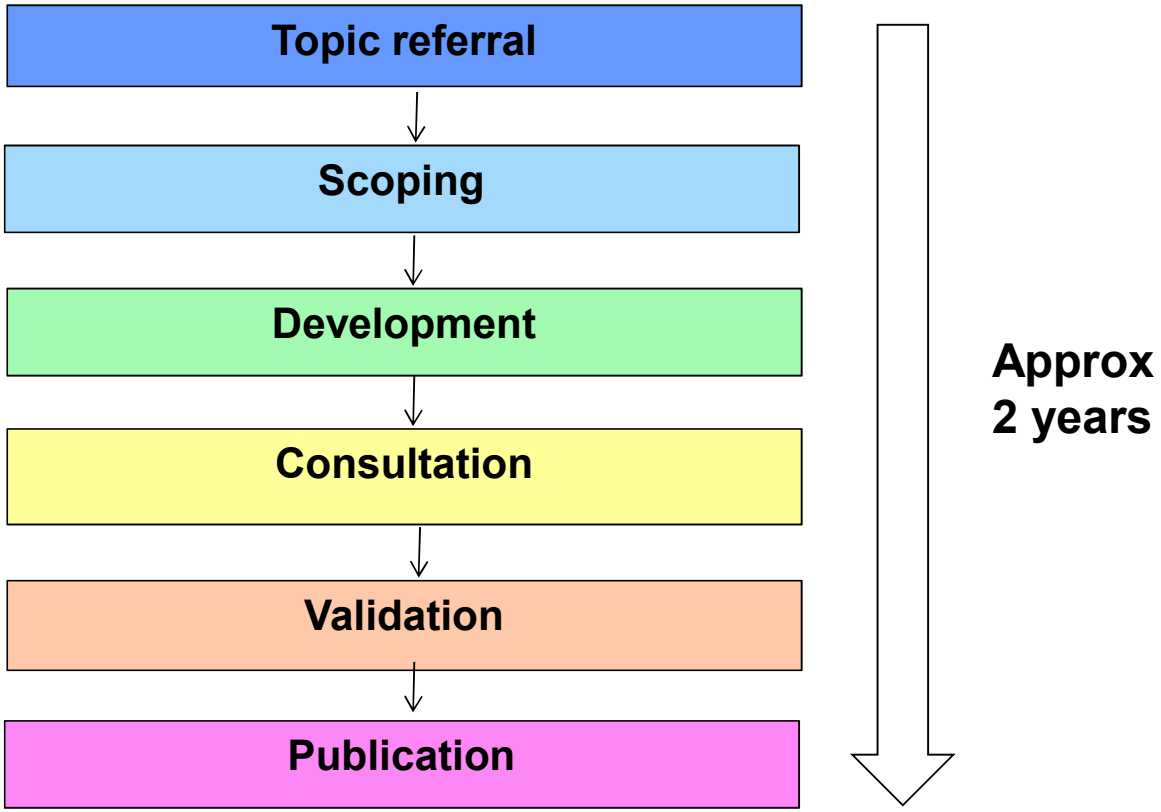
YES NHS organisations are legally required to provide access to drugs we have approved through our technology appraisal programme.

NO All other NICE guidance (clinical guidelines, public health, social care etc) is advisory, not mandatory. It is a summary of the evidence of what works, but it is not intended to replace clinical judgement.

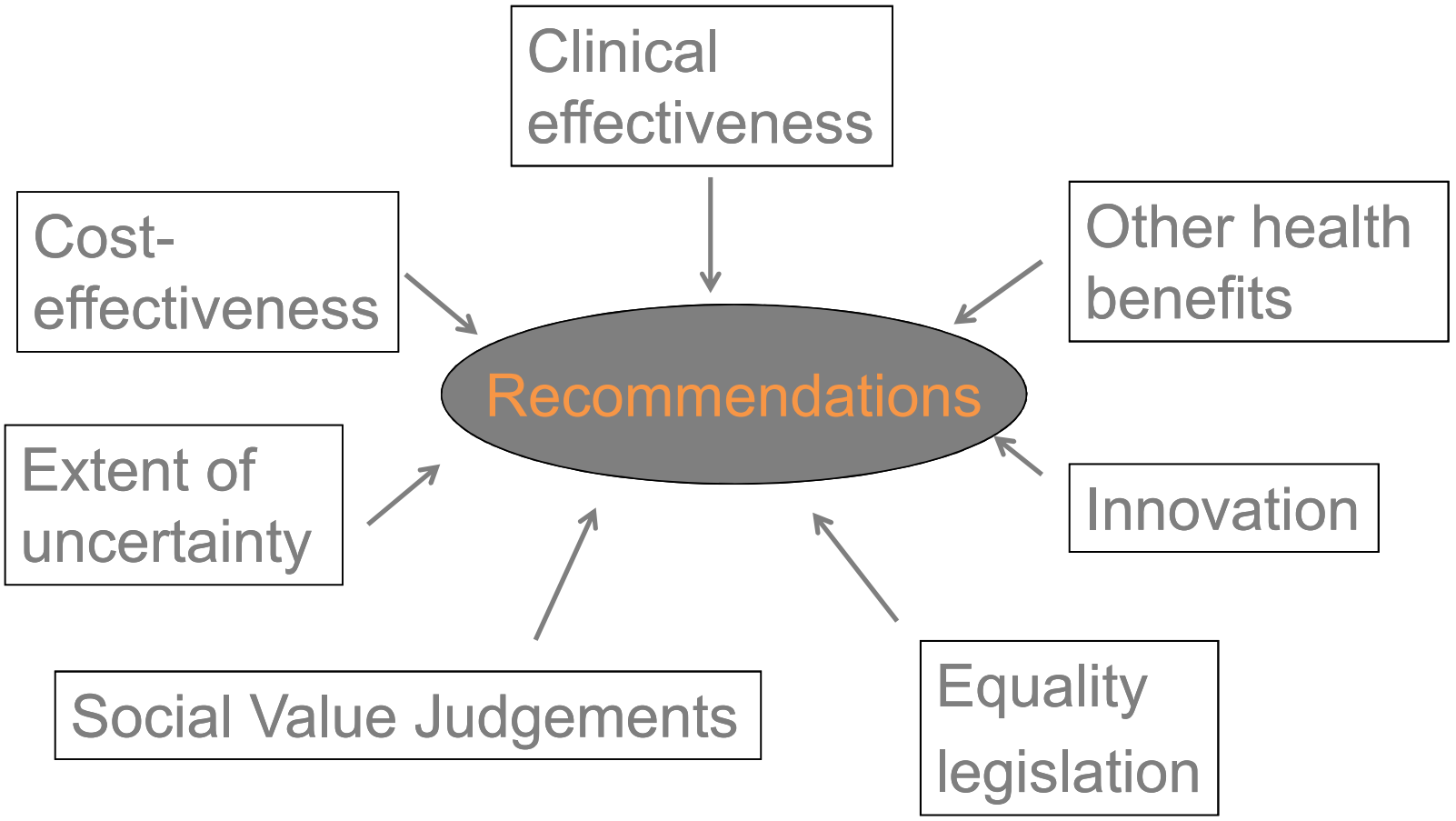
The finished product



The stages of guidance development



Committee decision making



Patient preferences

Example: kidney dialysis

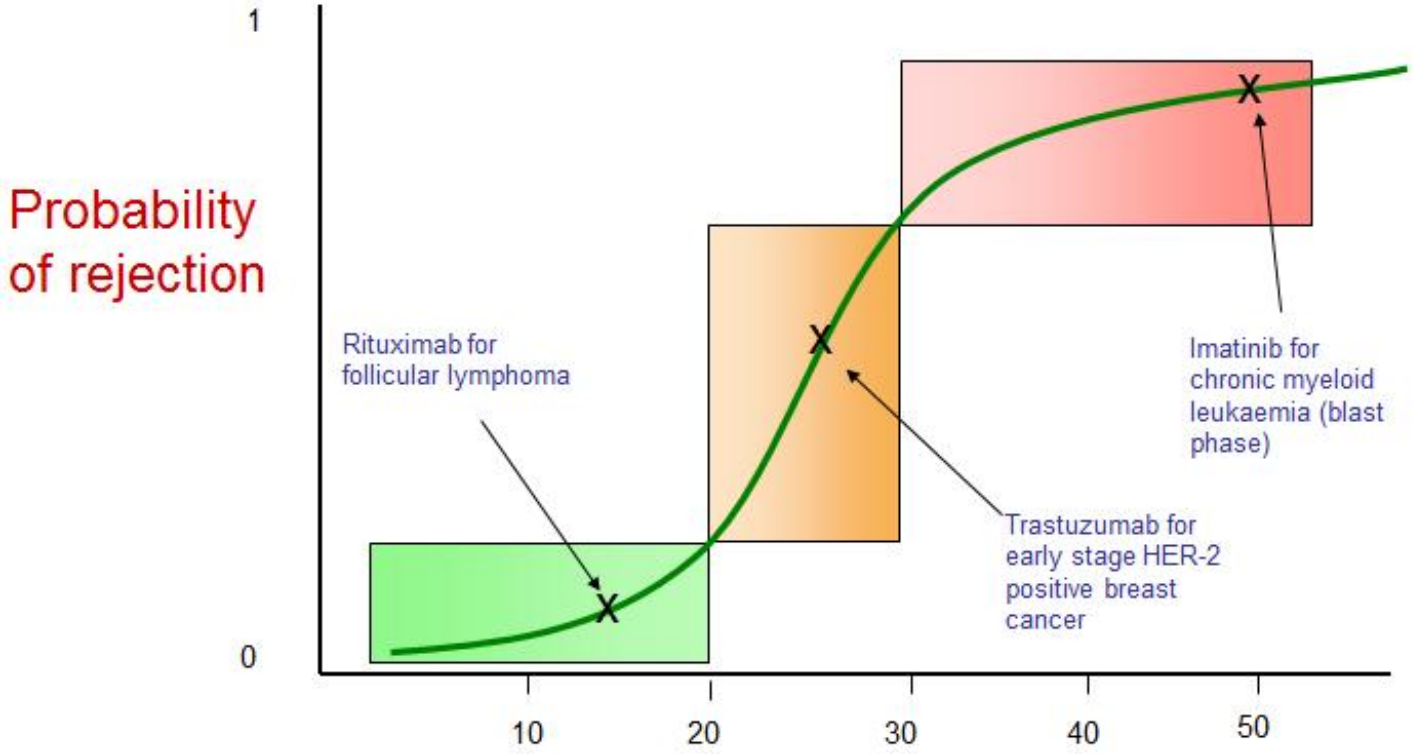
Committee assumed patients would prefer dialysis at home.

Some patients told us they disliked home machines as it meant their illness dominated their lives.

Economic evaluation of new drugs/treatments

- How well does the drug/treatment work in relation to how much it costs compared to standard practice in the NHS ?
- Recognises the reality of fixed NHS resources
- Exposes the opportunity cost of new interventions, that is if you spend money on a new healthcare intervention, you have to take away the health care from someone else
- Enables consistency and fairness across all decisions

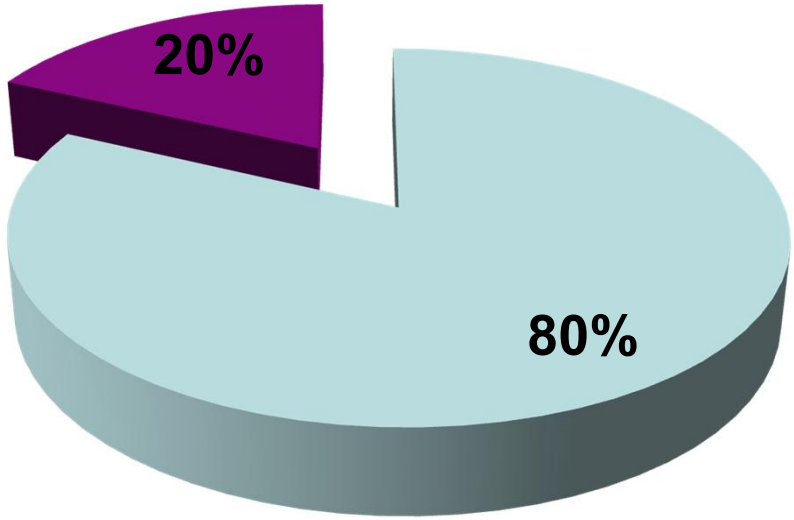
Establishing value: cost effectiveness



Breakdown of recommendations

328 drug appraisals published from 1 Mar 2000 – 31 December 2014
Containing 564 individual recommendations

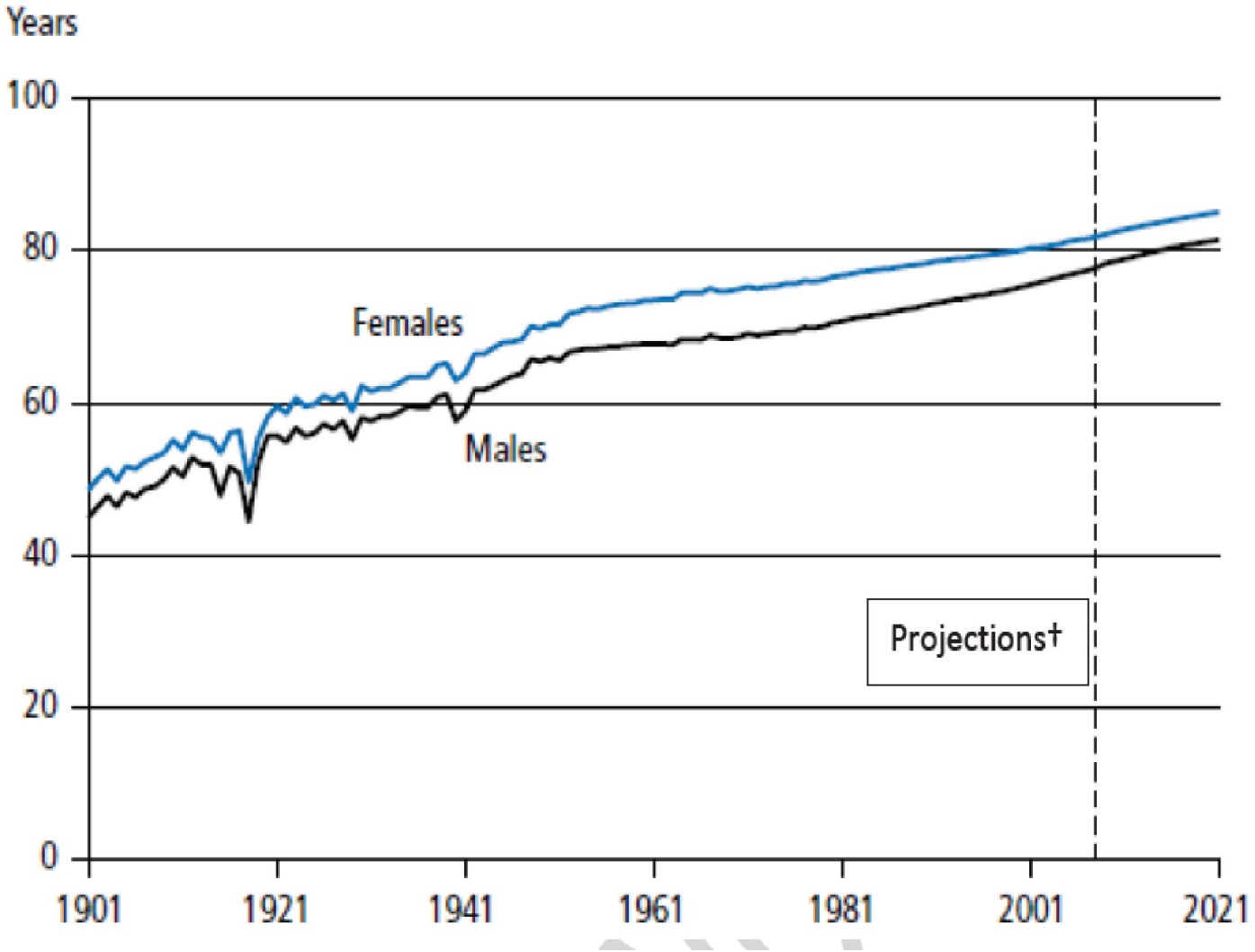
‘no’ or
‘only in research’



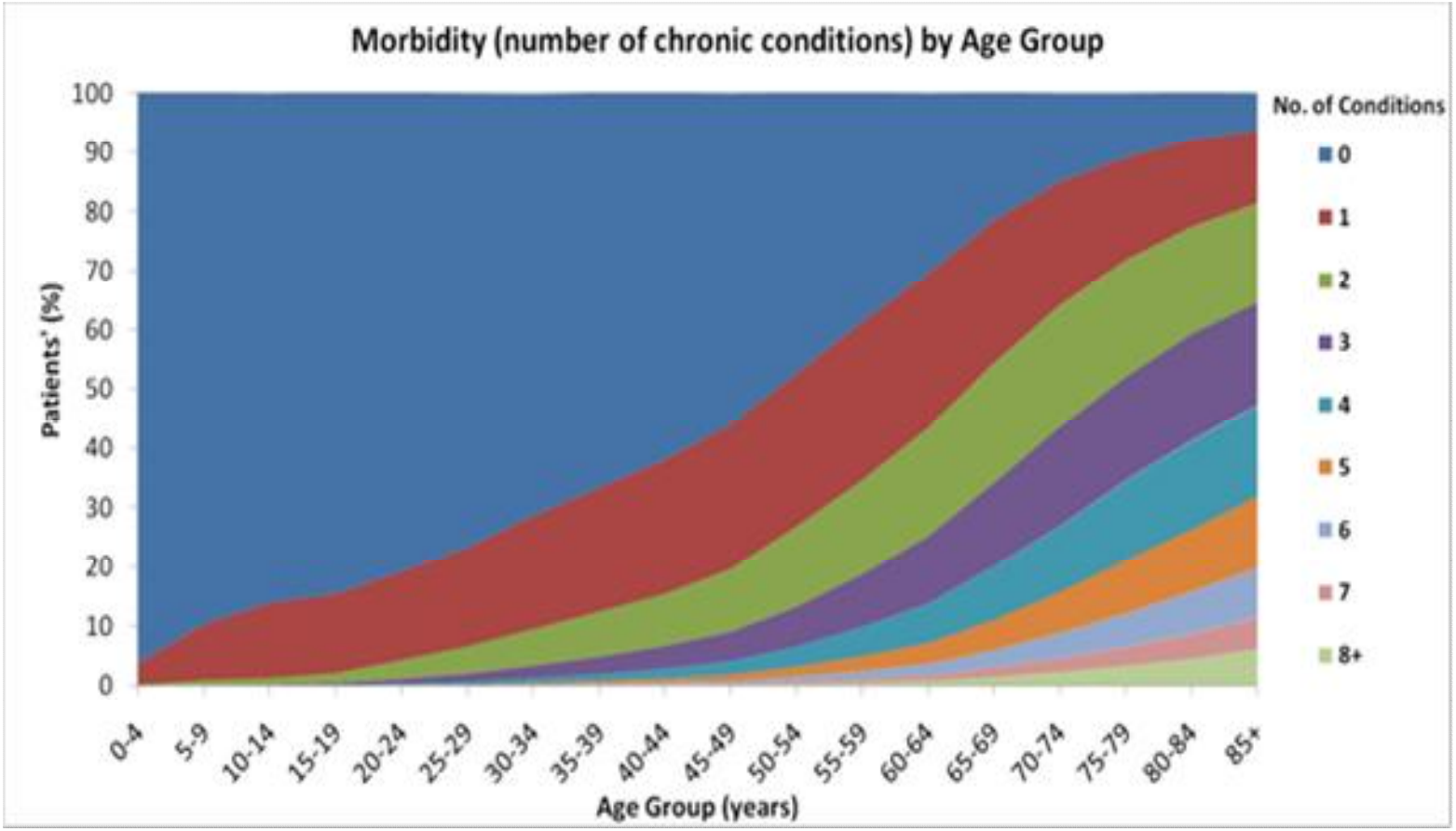
‘Yes’ recommended for routine use
or under specific circumstances

Ageing…a medical success story

Life expectancy at birth



Multimorbidity is common in Scotland



– The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions

NICE and social care

- Now working on guidelines and quality standards for social care
- A more integrated approach to supporting people, crossing health, public health and adults and children's services
- Developed in partnership with service users, carers and social care professionals

Service delivery and safe staffing

- A new area of work for NICE
- How should *services* work, rather than what treatments work
- For example: out-of-hours services. Safe staffing in maternity units.

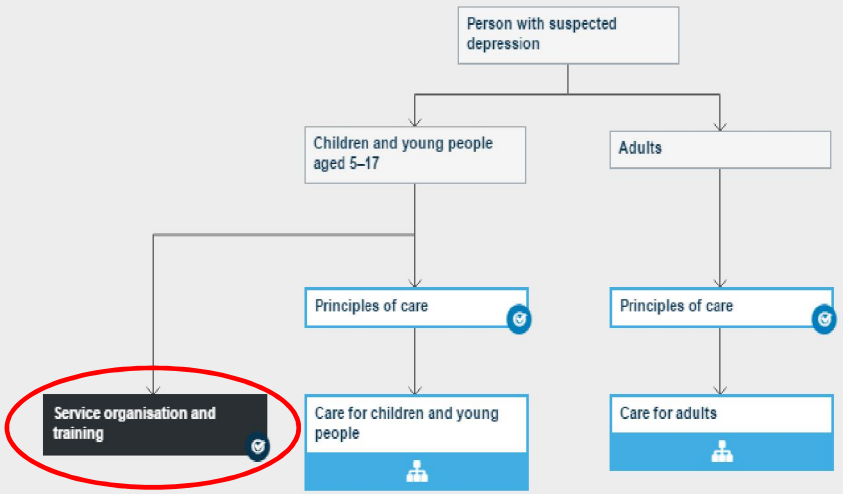
NICE Pathways- guidance at your fingertips

Pathways brings together all NICE guidance, quality standards and support in easy-to-navigate flowcharts

A different way of seeing everything NICE has said about a topic or condition that interests you

Detailed advice appears on the right

Depression overview



Depression

Service organisation and training

Organisation and planning of services

CAMHS and PCT s should:

- consider introducing a primary mental health worker (or CAMHS link worker) into each secondary school and secondary pupil referral unit as part of tier 2 provision within the locality
- routinely monitor detection, referral and treatment rates of children/young people with mental health problems from all ethnic groups in local schools and primary care
- use information about these rates to plan services, and make it available for local, regional and national comparison.

Primary mental health workers (or CAMHS link workers) should:

- establish clear lines of communication between CAMHS and tier 1 and tier 2, with named contact people in each tier/service

NICE guidance app for iPhone and Android smartphone

- Search over 750 pieces of NICE guidance.
- Download it today free from Apple's iStore and the Android Market.
- Bookmark key recommendations
- Email them to a colleague

Roles and Responsibilities of the Ministry of Health for Guidelines and Sector Performance

Dr Peter Jones

Chief Advisor, Ministry of Health

Outline

Roles & Responsibilities of the Ministry of Health

Guidelines – for whom? –for what?

Guidelines, the Ministry and central agencies

Sector Performance and Quality Improvement

Roles and Responsibilities of the Ministry of Health

Government agency for health and disability

- Responsible for delivering on Government priorities
- Responsible for managing and developing the health system

Providing leadership to ensure New Zealanders live longer, healthier and more productive lives

NZ Triple Aim

Guidelines – What For? Who For?

Certainty in an uncertain world

Bringing evidence to bear on clinical decisions

Evaluating and collating evidence

Keeping abreast of advances in knowledge

Clinicians

Planners

Funders

Auditors

Guidelines

At Best

Apply evidence to inform clinical decision making

Improve health outcomes for individuals and populations

Provide a standard of care for best use of resources

Reduce variation

Support service delivery by generalists

At Worst

Set unattainable goals given resource constraints

Open to bias and error

Multiple guidelines create confusion

Work against person centred care

A stick to beat health professionals

Potential Roles for a Government Agency in Guidance

Investment approach

- developing and maintaining guidelines
- commissioning
- endorsement

Incentive approach

- planning requirements
- performance management and quality assurance
- incentivising quality care and integration

Why the Ministry Should Not be Involved

Guidelines vulnerable to agendas, by selection of topics and content

- narrow focus on a single disease or organ
- do not answer the difficult questions or account for co-morbidity

Lack of evidence that guidelines change practice

- lack buy-in from practising clinicians in the real world
- top-down approach ‘from the centre’ is ineffective for quality improvement

Poor return on investment

- costly to produce in time and money
- costly to maintain in human and fiscal resource

Why the Ministry Should Take a Lead Role

Whole-of-system view to ensure

- government health priorities are evidence-informed
- coverage of conditions and linking of initiatives
- proliferation of guidelines in each district or organisation is minimised
- health professionals, managers and planners provide consistent care

Command and Control

- performance management
- concern for quality of health care and best use of resources

New Zealand Guidelines Group 1999-2012

Inception

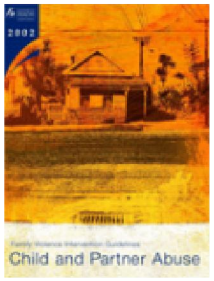
- Arose from the evidence based medicine movement
- promoted use of evidence in practice
- aimed to produce guidance, tools and implementation approaches

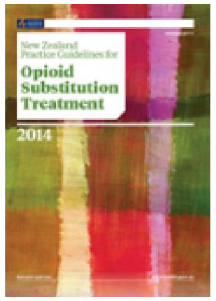
Wind up

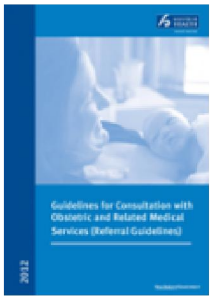
- concern over implementation
- concern over the value proposition
- changes in knowledge management

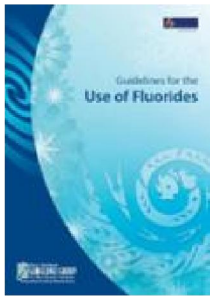
Legacy issues remain

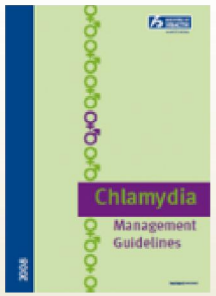
Ministry of Health Guidelines

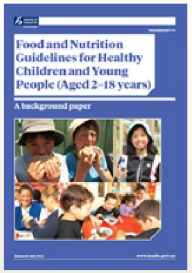












- Currently, commissioning of guidelines is done within specific work streams
- Involves expert groups, NGOs, government agencies
- Aligns with government health priorities

Current Activity by Government Agencies

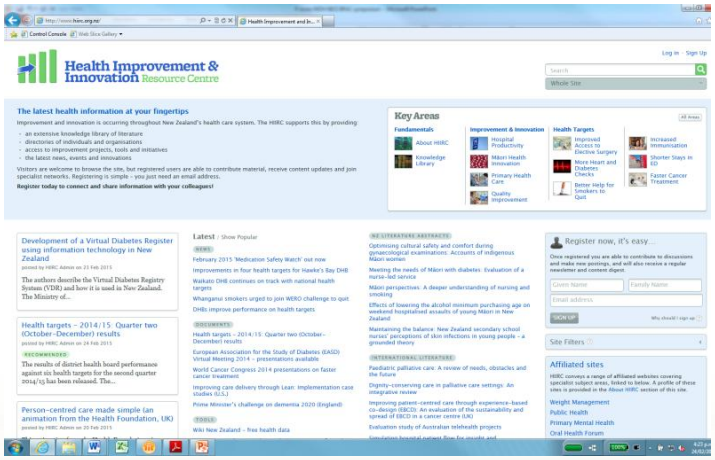
Health Quality and Safety Commission

PHARMAC

Health Improvement and Innovation Resource Centre

Ministry of Health

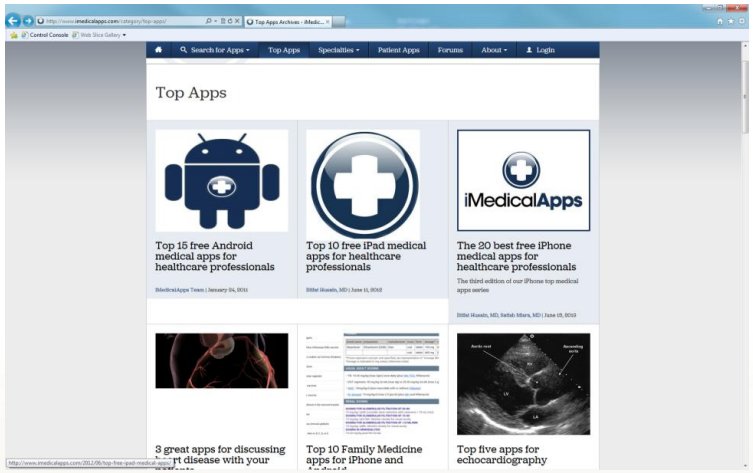
ACC



Decision Support

Proliferation of sources

- UpToDate
- Map of Medicine
- Canterbury Pathways
- BPAC
- NICE



The Answer is on the Web

- Web2 tools – blogs, wikis
- Apps for everything

Patient centred care and shared decision making

Guidelines and Performance Assessment

Top-Down

- DHB Accountability Framework
- PHO Performance Programme
- Health Targets

Shared

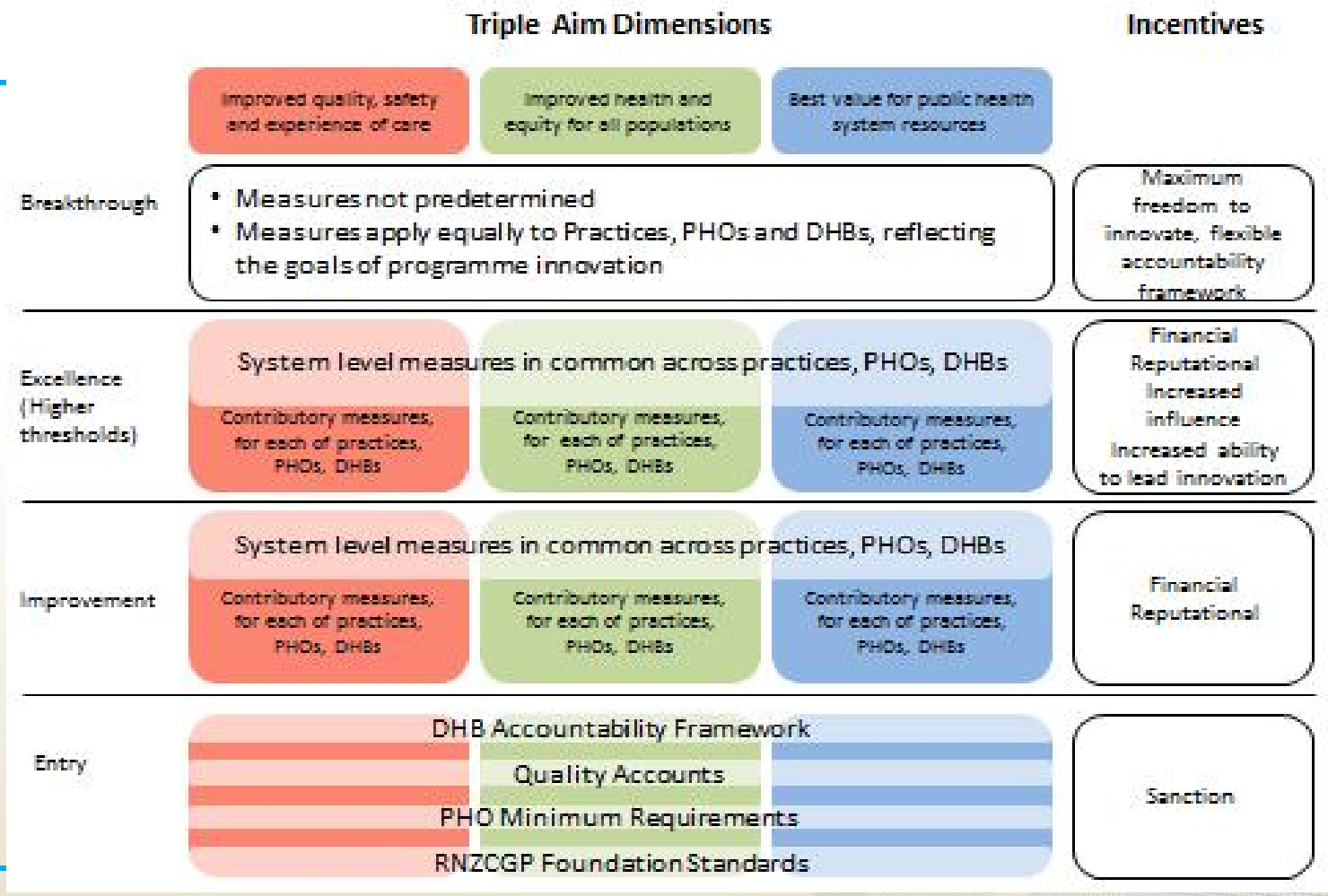
- Integrated Performance and Incentives Framework

IPIF Aims

DHBs, PHOs, primary care and patients develop a mechanism to
- lift performance
- improve clinical integration
- support and improve system sustainability
- improve quality

Encourage DHBs and PHOs to drive system integration

IPIF will provide a way to assess PHOs' readiness to undertake an increasing role in the design, delivery, and funding of services in their district.


Triple Aim Dimensions
Incentives
Improved quality, safety and experience of care
Improved health and equity for all populations
Best value for public health system resources
Breakthrough
• Measures not predetermined
• Measures apply equally to Practices, PHOs and DHBs, reflecting the goals of programme innovation
Maximum freedom to innovate, flexible accountability framework
Excellence (Higher thresholds)
System level measures in common across practices, PHOs, DHBs
Contributory measures, for each of practices, PHOs, DHBs
Contributory measures, for each of practices, PHOs, DHBs
Contributory measures, for each of practices, PHOs, DHBs
Financial
Reputational
Increased influence
Increased ability to lead innovation
Improvement
System level measures in common across practices, PHOs, DHBs
Contributory measures, for each of practices, PHOs, DHBs
Contributory measures, for each of practices, PHOs, DHBs
Contributory measures, for each of practices, PHOs, DHBs
Financial
Reputational
Entry
DHB Accountability Framework
Quality Accounts
PHO Minimum Requirements
RNZCGP Foundation Standards
Sanction

Measures Framework

System performance measures

- Nationally set
- Support high level goals of the health system
- Reflect performance of the system as a whole
- Organised according to life stages

Contributory measures

- Selected at a local level for quality improvement
- Supported by effective clinical governance
- Support achievement on system performance measures
- Measures library and guidance

IPIF Implementation

Local District Alliances (PHO, DHB)

- Selection of district level contributory measures for quality improvement
- Periodic review of district level contributory measures (relevance, efficacy etc.)
- Local level performance monitoring and allocation of incentives
- Recommendations on change of performance status
- Depends on strong clinical governance

Ministry Role

- Aligning measures of system performance with health priorities
- Providing the framework and incentives
- Supporting the sector to find solutions to difficult problems

Summary

Guidelines and guidance are helpful for decision support and quality improvement

- Guidelines are not so useful for performance assessment and QA

Guidelines can form a part of a framework to improve health and equity of outcomes, ensure sustainability of the healthcare system and improve patient safety and experience of care

Is there a place for guidelines in New Zealand?

Professor Cindy Farquhar
Co-director of Cochrane New Zealand
National Women's Health
University of Auckland

Cochrane New Zealand

Definition

- Guidelines are "*statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options*"

Institute of Medicine

Evidence based recommendations

- Evidence-based guidelines
- Evidence summaries and resources
- Care pathways
- Consumer resources and decision-aids

Institute of Medicine

The case for guidelines….

- Health care decisions are made by both policy makers and clinicians
  - How do we know that what we do as health care providers is good for our patients ?
  - How do we know what we do results in more good than harm ?
- Traditional teaching
  - Expert based “in my experience”
- A newer approach
  - Use evidence from research for clinical decisions

Failure to translate research finding into clinical practice means

- 30-40% patients do not get treatments of proven effectiveness
- 20-25% patients get care that is not needed or potentially harmful

Schuster et al 1998 Milbank Memorial Quarterly
R Grol (2001) Med Care

New Zealand examples of our need for evidence...

- Screening decisions
  - PSA – confusion persists
- Prevention
  - 30% of patients with cardiovascular risk do not get effective treatments (Selak et al, 2009)
- Cancer treatments
  - Wide variation between DHBs in protocols being used
- Primary care
  - 20% of all acute and arranged admissions were "potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting" Source: HQSC 2011-2012

When should we develop guidance?

- Variation in practice
- Uncertainty and debate about aspects of care
- When there is a gap between best practice and current practice
- When the gains are considered to be sufficient to justify the effort of developing a guideline

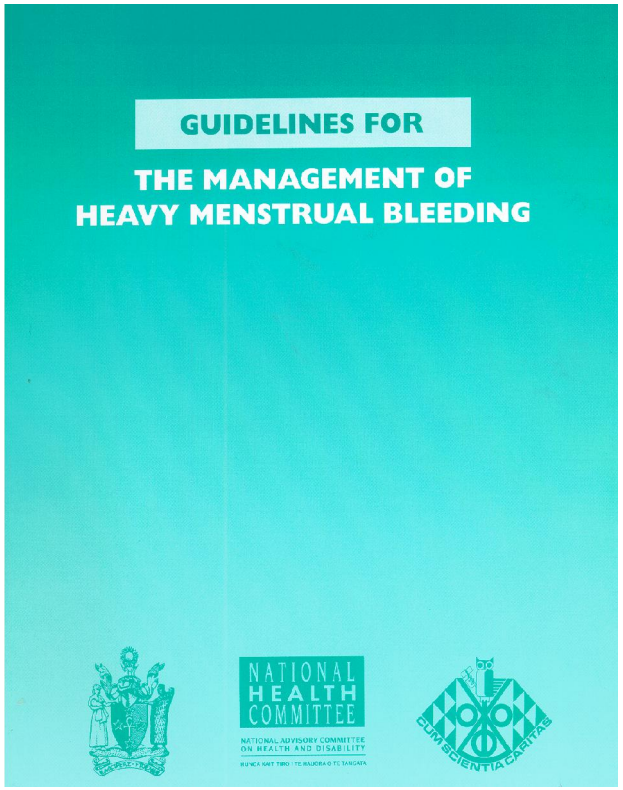
Best practice in guideline development

1. Topic selection based on priority setting
2. Guidelines focus on patient outcomes
3. Link best evidence and strength of recommendations
4. Synthesis of evidence strongest available
5. Team of multidisciplinary professionals and consumers – buy in for implementation
6. Guidelines flexible and adaptable for local conditions
7. Guidelines consider resource constraints
8. Guideline includes dissemination and implemetation plans
9. The usefulness & impact of guidelines should be evaluated

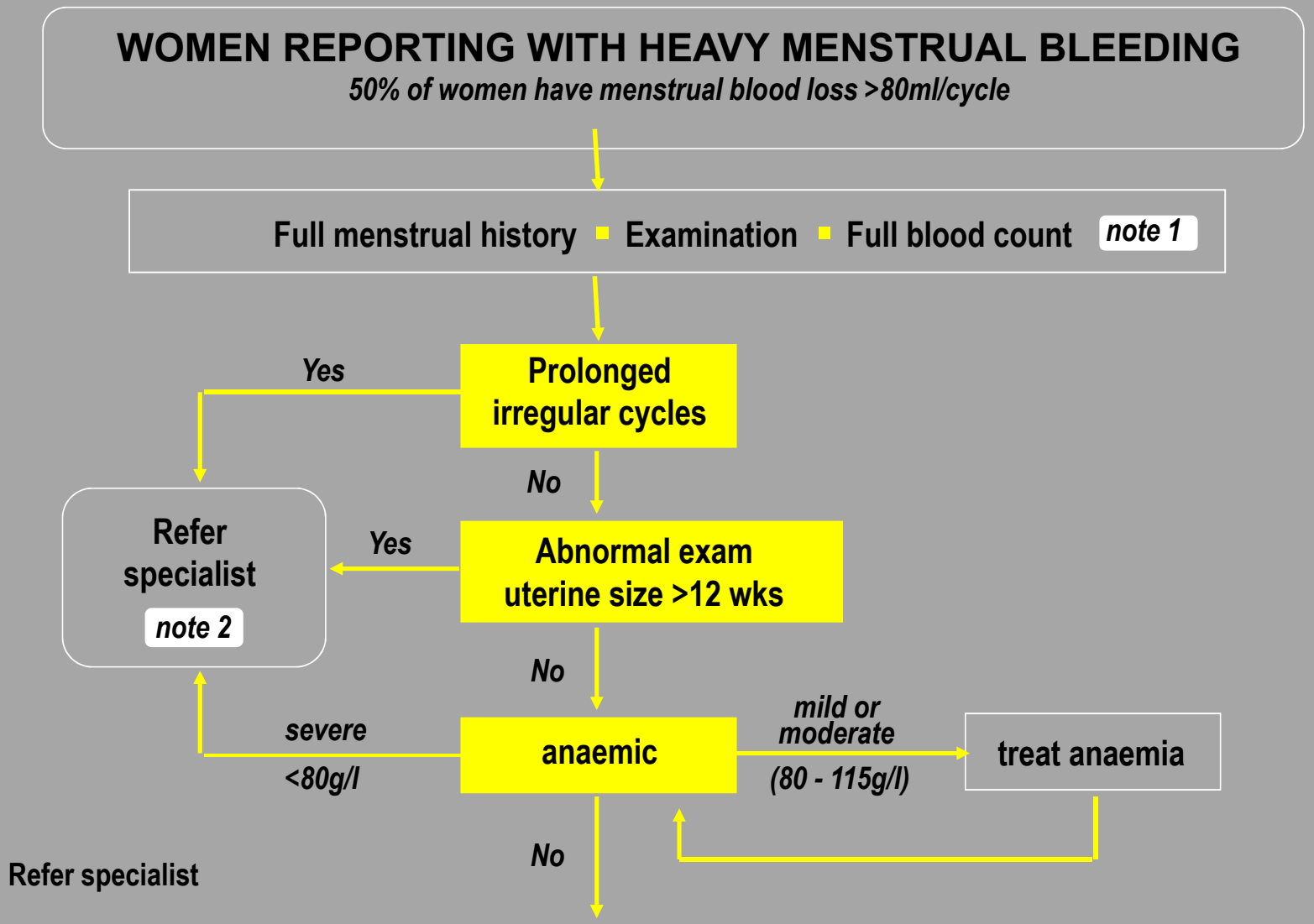
Guidelines and pathways

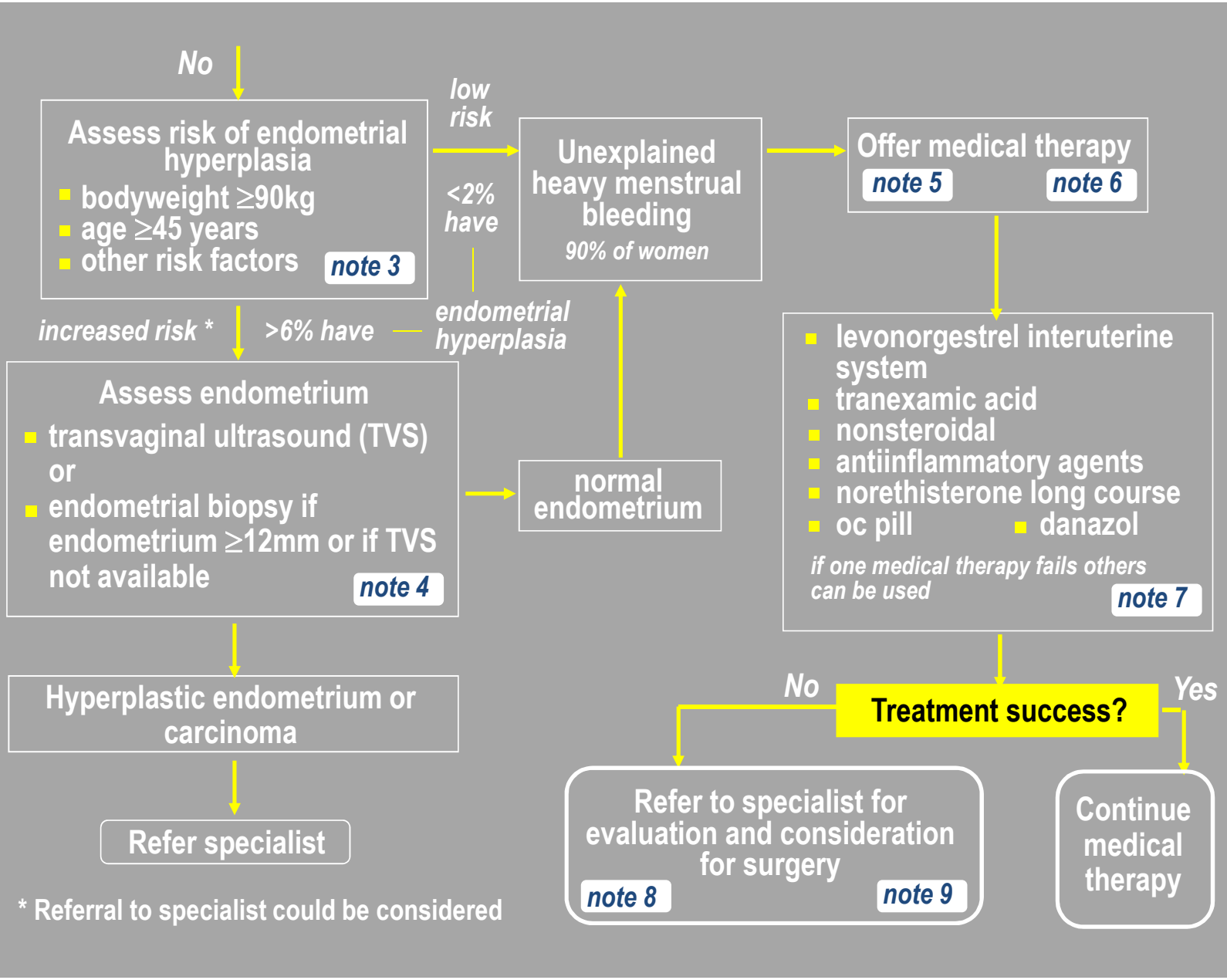
- Guidelines – usually a lengthy process, and covers a large topic
- Pathways
  - Simpler but still should be based on evidence (?guideline)
  - Usually for a clinic or a hospital or a region
  - Often a check list to enhance the referral and speed up care
  - Usually process driven, not outcome drive

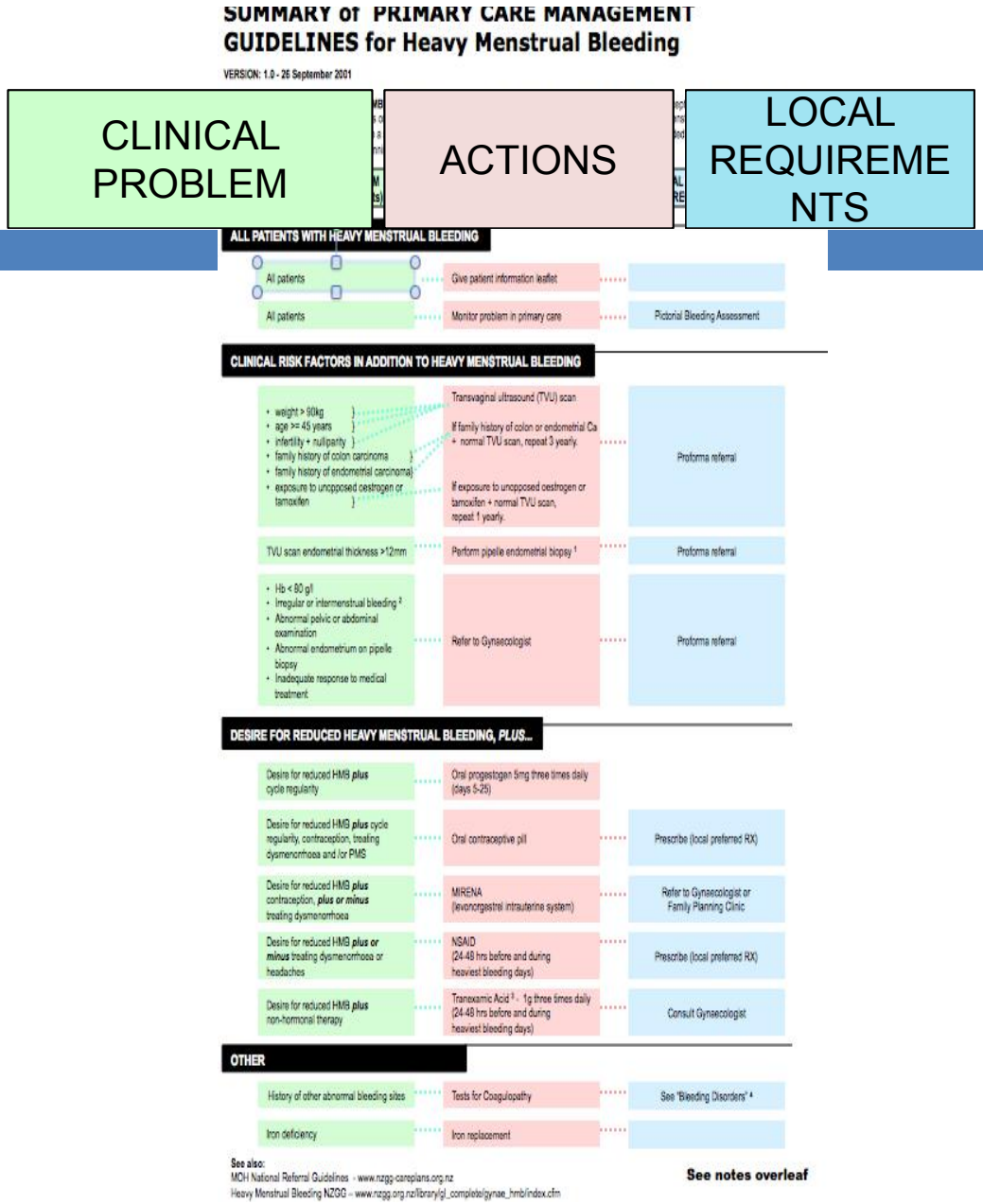
NZ Guidelines on Heavy Menstrual Bleeding 1998



- Took a year to develop
- Multidisciplinary
- 31 recommendations


WOMEN REPORTING WITH HEAVY MENSTRUAL BLEEDING
50% of women have menstrual blood loss >80ml/cycle
Full menstrual history ▪ Examination ▪ Full blood count
note 1
Prolonged irregular cycles
Yes
No
Refer specialist
note 2
Yes
Abnormal exam uterine size >12 wks
No
severe
<80g/l
anaemic
mild or moderate
(80 - 115g/l)
treat anaemia
No
Refer specialist


No
Assess risk of endometrial hyperplasia
bodyweight ≥90kg
age ≥45 years
other risk factors
note 3
low risk
<2% have
endometrial hyperplasia
Unexplained heavy menstrual bleeding
90% of women
Offer medical therapy
note 5
note 6
increased risk *
>6% have
Assess endometrium
transvaginal ultrasound (TVS) or
endometrial biopsy if endometrium ≥12mm or if TVS not available
note 4
normal endometrium
levonorgestrel interuterine system
tranexamic acid
nonsteroidal antiinflammatory agents
norethisterone long course
oc pill
danazol
if one medical therapy fails others can be used
note 7
Hyperplastic endometrium or carcinoma
Refer specialist
No
Treatment success?
Yes
Refer to specialist for evaluation and consideration for surgery
note 8
note 9
Continue medical therapy
* Referral to specialist could be considered



SUMMARY of PRIMARY CARE MANAGEMENT
GUIDELINES for Heavy Menstrual Bleeding

VERSION: 1.0 - 26 September 2001

CLINICAL PROBLEM

ACTIONS

LOCAL REQUIREMENTS

ALL PATIENTS WITH HEAVY MENSTRUAL BLEEDING

All patients	Give patient information leaflet	
All patients	Monitor problem in primary care	Pictorial Bleeding Assessment

CLINICAL RISK FACTORS IN ADDITION TO HEAVY MENSTRUAL BLEEDING

• weight > 90kg • age >= 45 years • infertility + nulliparity • family history of colon carcinoma • family history of endometrial carcinoma • exposure to unopposed oestrogen or tamoxifen	Transvaginal ultrasound (TVU) scan If family history of colon or endometrial Ca + normal TVU scan, repeat 3 yearly. If exposure to unopposed oestrogen or tamoxifen + normal TVU scan, repeat 1 yearly.	Proforma referral
TVU scan endometrial thickness >12mm	Perform pipelle endometrial biopsy [1]	Proforma referral
• Hb < 80 g/l • Irregular or intermenstrual bleeding [2] • Abnormal pelvic or abdominal examination • Abnormal endometrium on pipelle biopsy • Inadequate response to medical treatment	Refer to Gynaecologist	Proforma referral

DESIRE FOR REDUCED HEAVY MENSTRUAL BLEEDING, *PLUS...*

Desire for reduced HMB ***plus*** cycle regularity	Oral progestogen 5mg three times daily (days 5-25)	
Desire for reduced HMB ***plus*** cycle regularity, contraception, treating dysmenorrhoea and /or PMS	Oral contraceptive pill	Prescribe (local preferred RX)
Desire for reduced HMB ***plus*** contraception, ***plus or minus*** treating dysmenorrhoea	MIRENA (levonorgestrel intrauterine system)	Refer to Gynaecologist or Family Planning Clinic
Desire for reduced HMB ***plus or minus*** treating dysmenorrhoea or headaches	NSAID (24-48 hrs before and during heaviest bleeding days)	Prescribe (local preferred RX)
Desire for reduced HMB ***plus*** non-hormonal therapy	Tranexamic Acid [3] - 1g three times daily (24-48 hrs before and during heaviest bleeding days)	Consult Gynaecologist

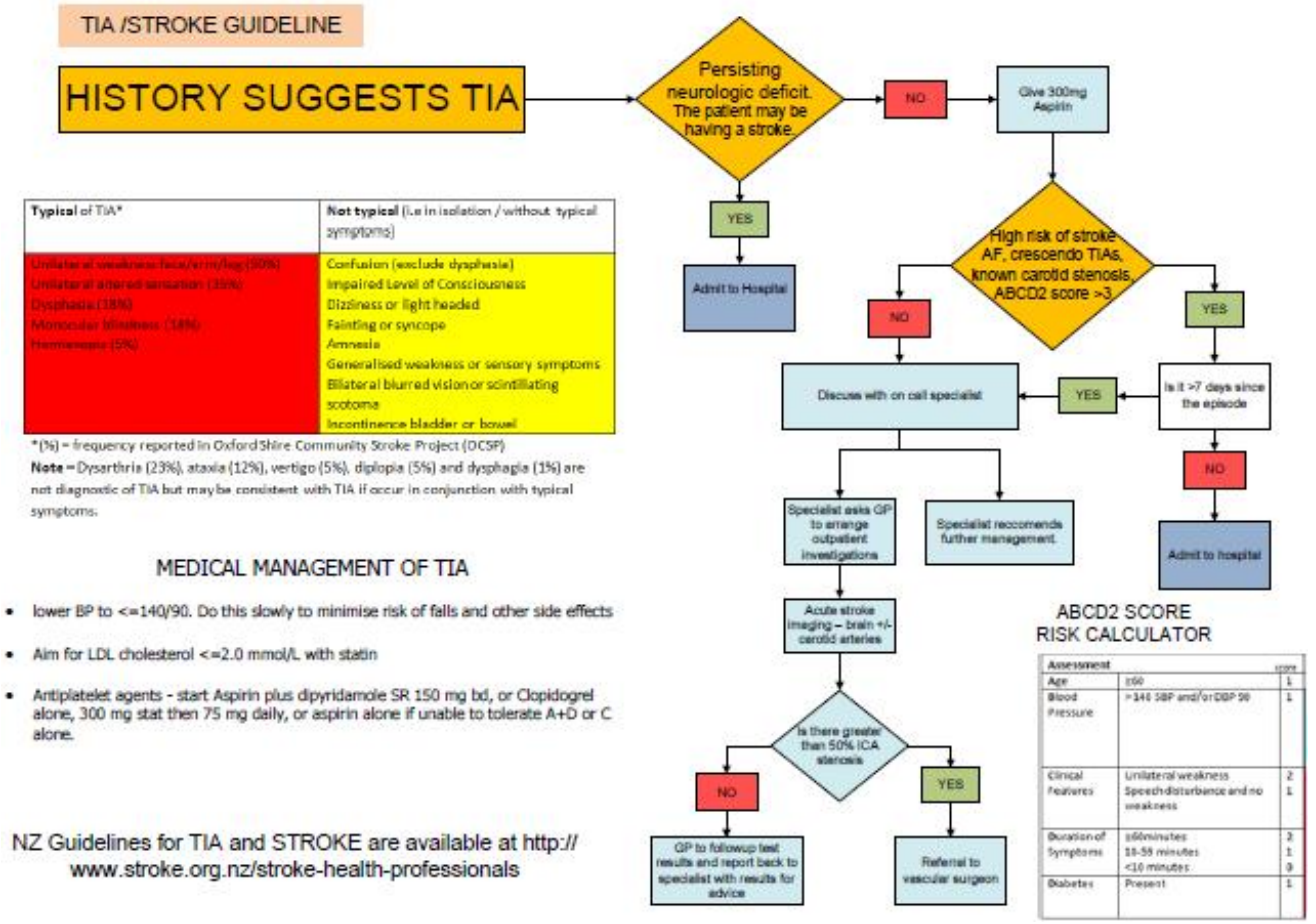
OTHER

History of other abnormal bleeding sites	Tests for Coagulopathy	See "Bleeding Disorders" [4]
Iron deficiency	Iron replacement	

See also:
MOH National Referral Guidelines - www.nzgg-careplans.org.nz
Heavy Menstrual Bleeding NZGG – www.nzgg.org.nz/library/gl_complete/gynae_hmb/index.cfm

See notes overleaf

From the guideline to the local clinical pathway Auckland region 2010…



The New Zealand Guidelines Group

- Established in 1996 by the National Health Committee of the Ministry of Health to produce national guidelines
- Incorporated society from 2000
- Funded by the Ministry of Health but independent
- Handbook developed in 2001 and updated in 2009
- Unfortunately the NZGG was not funded after 2012 so …..

The New Zealand Guidelines Group

Vision

Reduce inequalities and improve health outcomes for all New Zealanders

Mission

Lead the health and disability sectors in driving the effective use of reliable evidence

NZGG Structure

- Elected Board
  - Health care practitioners
  - Health care researchers
  - Stakeholders – consumers
- Annual budget was $3-5M – from MOH ($500K for infrastructure) and ACC for specific projects

Strengthening consumer voices SCV

- Promoted stronger consumer voices
- Consumers on the board and all guideline groups
- National umbrella organisation was under consideration

Judi Strid

NZGG record in evidence …..

- Guidelines – 30 reports
- Evidence and technical reports – 30+
- Consumer work – 1 major report on development of strengthening consumer voice
- Complementary and alternative medicine reports – 16
- Rapid reviews
- Implementation projects - 3

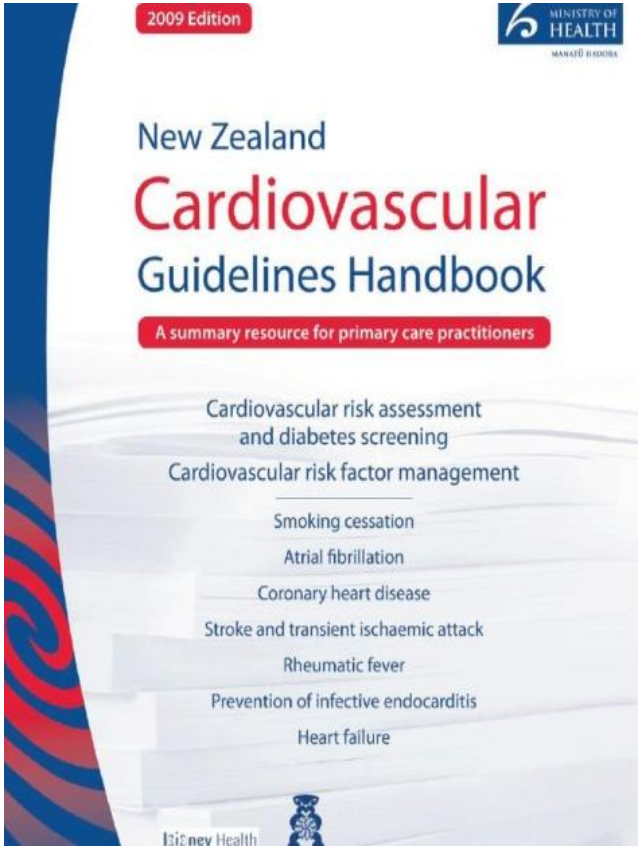
Cancer topics

- Breast cancer (2009)
- Melanoma (2009)
- Suspected cancer in primary care (2009)
- Prostate cancer (2010)
- Bowel cancer (2011)
- National Cancer Network

  (for protocols for chemotherapy)

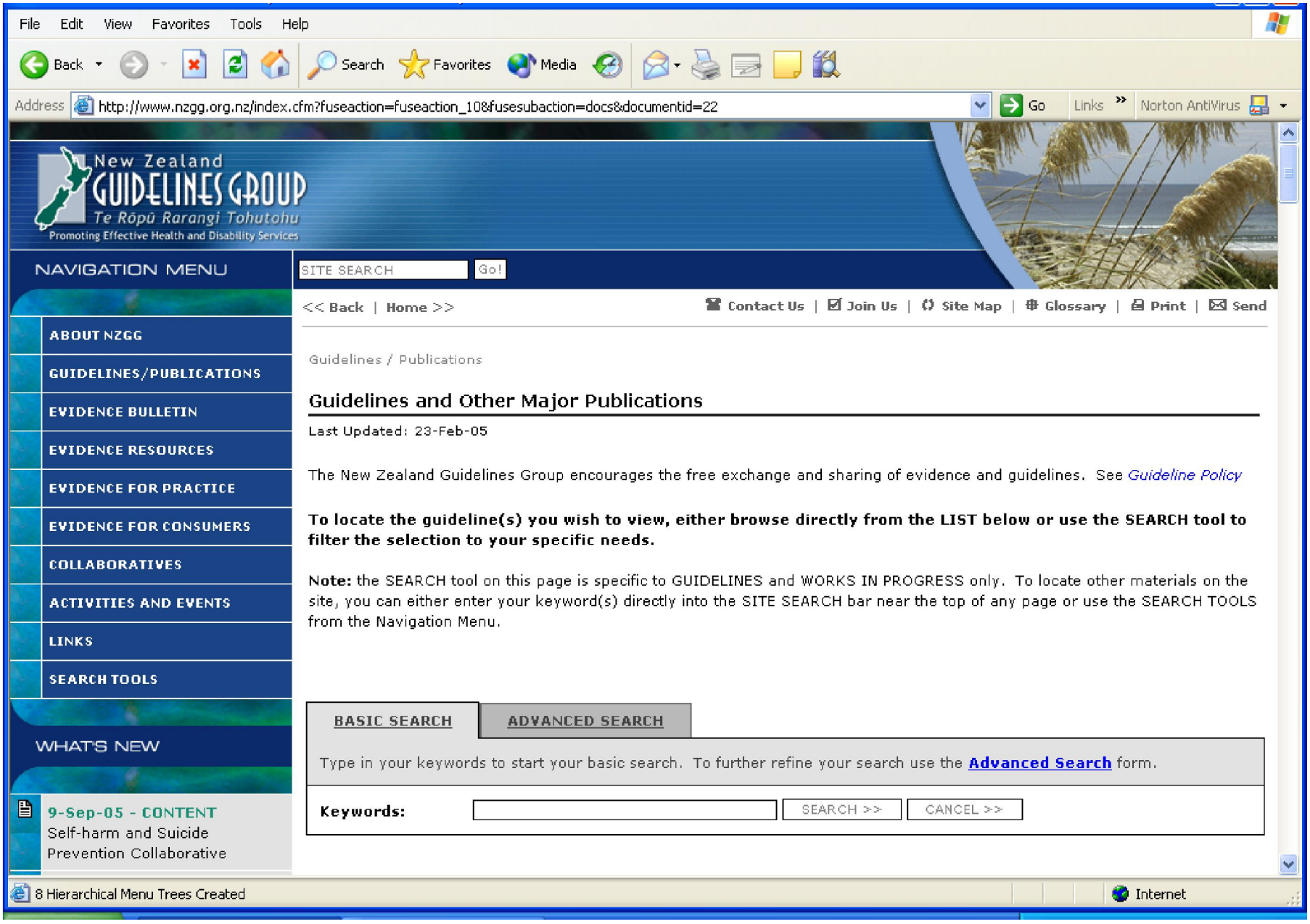
Cardiovascular guidelines: all in one place

- Cardiovascular Risk assessment and diabetes screening
- Cardiac risk factor management
- Smoking cessation
- Atrial fibrillation and flutter
- Coronary heart disease
- Stroke and transient ischaemic heart disease
- Rheumatic heart disease
- Prevention of infective endocarditis
- Heart failure



Mental Health Topics

- Suicide and self harm prevention guidelines (2004)
- Depression guidelines (2008)
- Autism Spectrum Disorders (2008)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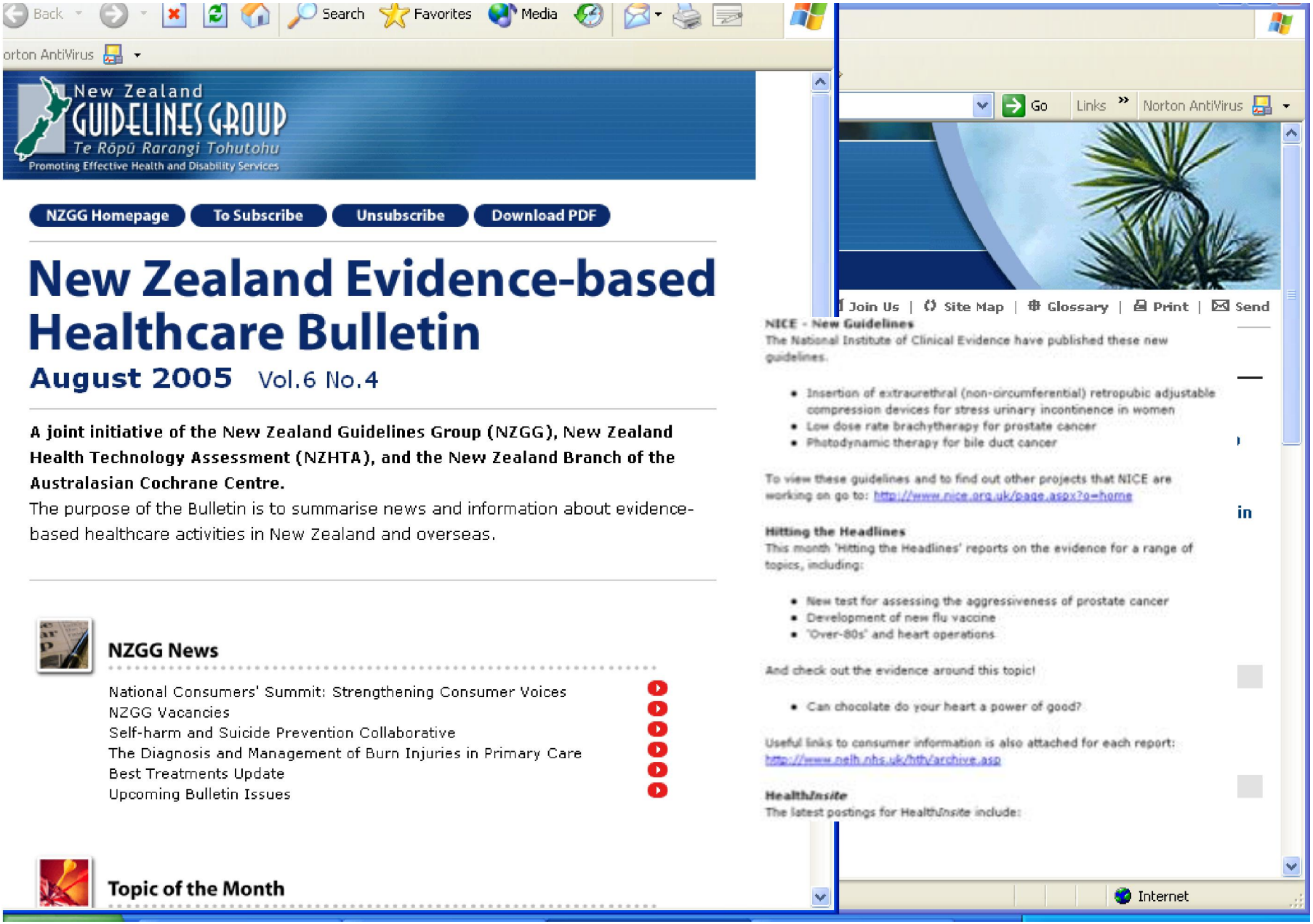
EVIDENCE RESOURCES
EVIDENCE FOR PRACTICE
EVIDENCE FOR CONSUMERS
COLLABORATIVES
ACTIVITIES AND EVENTS
LINKS
SEARCH TOOLS
WHAT'S NEW
9-Sep-05 - CONTENT
Self-harm and Suicide Prevention Collaborative
Guidelines / Publications
Guidelines and Other Major Publications
Last Updated: 23-Feb-05
The New Zealand Guidelines Group encourages the free exchange and sharing of evidence and guidelines. See Guideline Policy
To locate the guideline(s) you wish to view, either browse directly from the LIST below or use the SEARCH tool to filter the selection to your specific needs.
Note: the SEARCH tool on this page is specific to GUIDELINES and WORKS IN PROGRESS only. To locate other materials on the site, you can either enter your keyword(s) directly into the SITE SEARCH bar near the top of any page or use the SEARCH TOOLS from the Navigation Menu.
BASIC SEARCH
ADVANCED SEARCH
Type in your keywords to start your basic search. To further refine your search use the Advanced Search form.
Keywords:
SEARCH >>
CANCEL >>
8 Hierarchical Menu Trees Created
Internet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New Zealand Evidence-based Healthcare Bulletin
August 2005 Vol.6 No.4
A joint initiative of the New Zealand Guidelines Group (NZGG), New Zealand Health Technology Assessment (NZHTA), and the New Zealand Branch of the Australasian Cochrane Centre.
The purpose of the Bulletin is to summarise news and information about evidence-based healthcare activities in New Zealand and overseas.
NZGG News
National Consumers' Summit: Strengthening Consumer Voices
NZGG Vacancies
Self-harm and Suicide Prevention Collaborative
The Diagnosis and Management of Burn Injuries in Primary Care
Best Treatments Update
Upcoming Bulletin Issues
Topic of the Month
Go
Links
Norton AntiVirus
Join Us | Site Map | Glossary | Print | Send
NICE - New Guidelines
The National Institute of Clinical Evidence have published these new guidelines.
Insertion of extraurethral (non-circumferential) retropubic adjustable compression devices for stress urinary incontinence in women
Low dose rate brachytherapy for prostate cancer
Photodynamic therapy for bile duct cancer
To view these guidelines and to find out other projects that NICE are working on go to: http://www.nice.org.uk/page.aspx?o=home
Hitting the Headlines
This month 'Hitting the Headlines' reports on the evidence for a range of topics, including:
New test for assessing the aggressiveness of prostate cancer
Development of new flu vaccine
'Over-80s' and heart operations
And check out the evidence around this topic!
Can chocolate do your heart a power of good?
Useful links to consumer information is also attached for each report:
http://www.nelh.nhs.uk/hth/archive.asp
HealthInsite
The latest postings for HealthInsite include:
Internet

NZGG's Implementation Approach

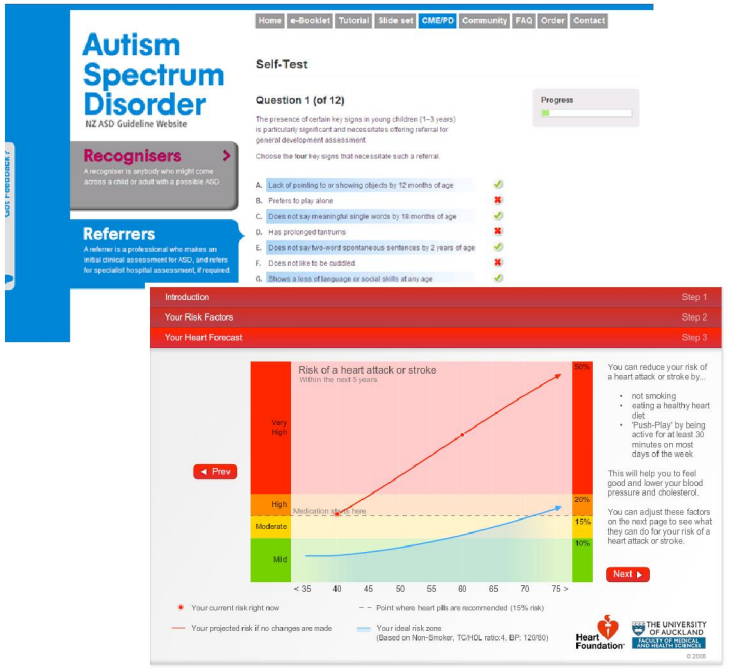
- Identify key themes to promote
- Identify the range of audiences – and find out how they want to learn about the messages
  - Primary care, Specialists, Allied health practitioners
  - Consumers and the media
  - Policy makers and funders
  - Software vendors

Then considered…

- Barriers to implementation
- Workforce requirements
- Cost implications
- Identify incentives that could encourage uptake of the guideline

NZGG implementation examples

- Whakawhanuatanga – implementing the suicide and self harm guidelines in emergency departments
- Autistic spectrum guidelines
- Cardiovascular guidelines with collaboration with National Heart Foundation and University of Auckland
- BPAC and Goodfellow Unit have used NZGG guidelines



What did stakeholders say?

Original Scientific Paper

'Really simple, summary, bang! That's what I need.'

– Clinical information needs of New Zealand general practitioners and the resources they use to meet them

Susan M Dovey MPH PhD, Tony J Fraser BSc PG Dip Com, Murray W Tilyard BSc MBChB FRNZCGP MD, Sonia J Ross BSc, Kaye E Baldwin and David Kane B Pharm

www.nzgg.org.nz
Your Trusted Evidence Site !

"it is a real gap.
The GPs hate that it's gone. "
Dovey 2015

Clinical information source	Frequent use (%)	Trust (%)
Contact with peers outside your own workplace	89.9	85.3
Continuing professional education	87.1	92.3
Contact with others in your own workplace	85.5	83.6
Hard copy BPAC material	81.2	93.0
Contact with hospital colleagues	79.6	94.6
General web searches, e.g. google	63.1	31.5
Hard copy Pharmac material	60.8	69.1
Hard copy – New Zealand Guidelines Group	54.2	89.9
Contact with pharmacists	49.8	65.7
Drug reps	49.5	7.8
PHO material	49.3	72.1
Hard copy Medsafe material	46.3	89.0
Unsolicited advertisements	34.5	2.6
New Zealand Guidelines Group website	33.7	89.3

What NZGG was good at….

- Comprehensive guidelines in different packages
- Strong collaborative approach
- Governance structure
- Depth of experience and expertise
- Value for money
- Strong credibility nationally and internationally
- Sector relationships – Colleges, DHBs, NGOs, Healthcare Practitioners, Māori, Pacific, Consumers

The challenges

- Our guidelines were big
  - Tension between quality, affordability and usefulness
- Lack of knowledge about where the true evidence-practice gaps are
  - Lack of national data
  - Lack of insight into the bigger/national practice issues
- Electronic platforms for guidelines
  - Many available
  - But costly….

What happened?

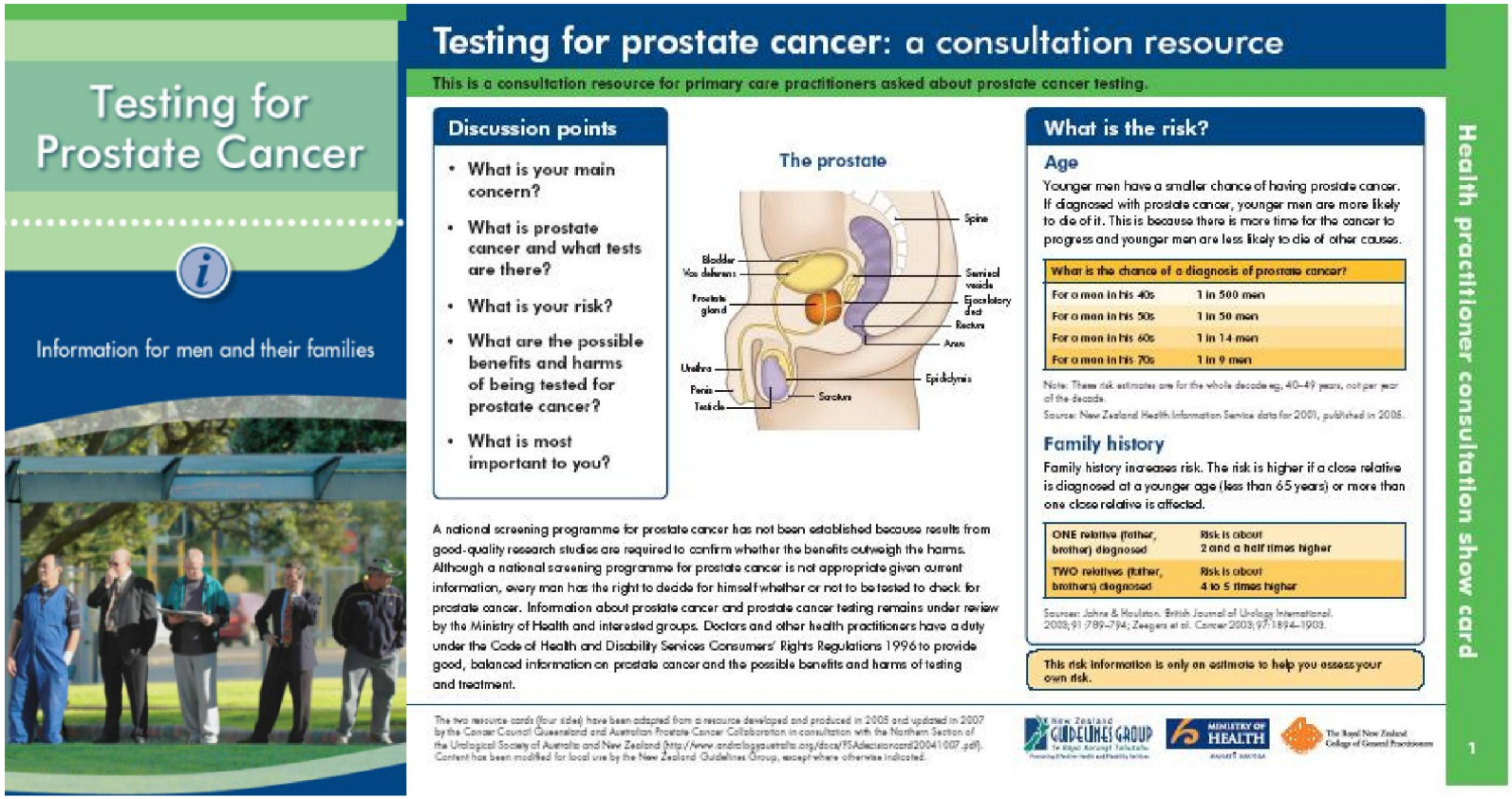
Ministry of Health reduced its staff by 30% in 2009-2010

- No new guidelines commissioned for 12 months in 2011
- Planned to stop base funding in 2012

What's happening now?

- Fragmented
- Expert guidance is back!
  - GOBSAT
  - Lack of independence
  - Lack of skilled workforce in evidence processes

An example NZGG Prostate Screening



Testing for Prostate Cancer

Information for men and their families

Testing for prostate cancer: a consultation resource

This is a consultation resource for primary care practitioners asked about prostate cancer testing.

Discussion points

- What is your main concern?
- What is prostate cancer and what tests are there?
- What is your risk?
- What are the possible benefits and harms of being tested for prostate cancer?
- What is most important to you?

The prostate

A national screening programme for prostate cancer has not been established because results from good-quality research studies are required to confirm whether the benefits outweigh the harms. Although a national screening programme for prostate cancer is not appropriate given current information, every man has the right to decide for himself whether or not to be tested to check for prostate cancer. Information about prostate cancer and prostate cancer testing remains under review by the Ministry of Health and interested groups. Doctors and other health practitioners have a duty under the Code of Health and Disability Services Consumers' Rights Regulations 1996 to provide good, balanced information on prostate cancer and the possible benefits and harms of testing and treatment.

What is the risk?

Age

Younger men have a smaller chance of having prostate cancer. If diagnosed with prostate cancer, younger men are more likely to die of it. This is because there is more time for the cancer to progress and younger men are less likely to die of other causes.

What is the chance of a diagnosis of prostate cancer?	
For a man in his 40s	1 in 500 men
For a man in his 50s	1 in 50 men
For a man in his 60s	1 in 14 men
For a man in his 70s	1 in 9 men

Note: These risk estimates are for the whole decade eg, 40–49 years, not per year of the decade.

Source: New Zealand Health Information Service data for 2001, published in 2005.

Family history

Family history increases risk. The risk is higher if a close relative is diagnosed at a younger age (less than 65 years) or more than one close relative is affected.

ONE relative (father, brother) diagnosed	Risk is about 2 and a half times higher
TWO relatives (father, brothers) diagnosed	Risk is about 4 to 5 times higher

Sources: Johns & Houlston. British Journal of Urology International. 2003;91:789–794; Zeegers et al. Cancer 2003;97:1894–1903.

This risk information is only an estimate to help you assess your own risk.

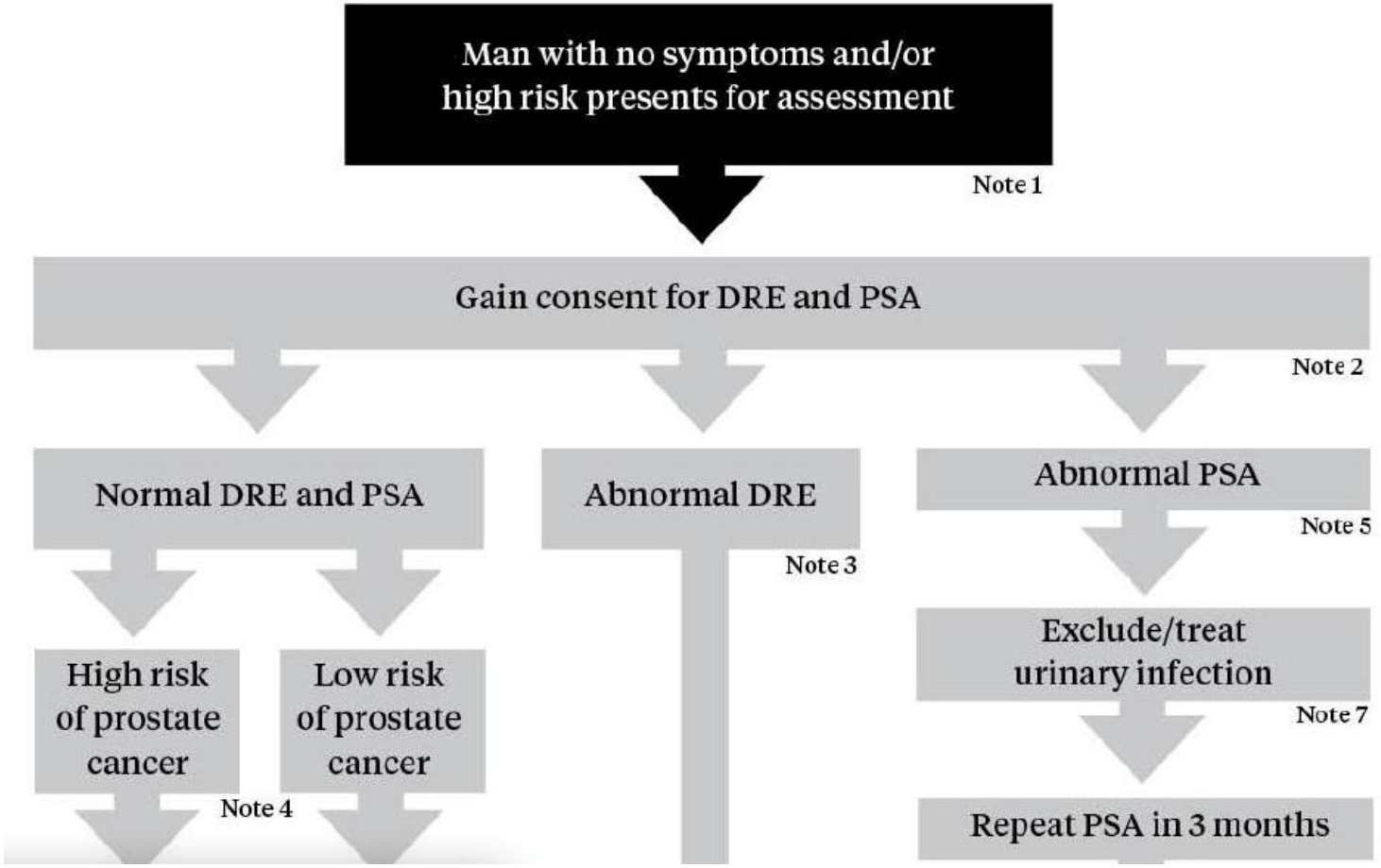
The two resource cards (four sides) have been adapted from a resource developed and produced in 2005 and updated in 2007 by the Cancer Council Queensland and Australian Prostate Cancer Collaboration in consultation with the Northern Section of the Urological Society of Australia and New Zealand (http://www.andrology.australia.org/docs/PSAdecisioncard20041007.pdf). Content has been modified for local use by the New Zealand Guidelines Group, except where otherwise indicated.

New Zealand Guidelines Group | Ministry of Health | The Royal New Zealand College of General Practitioners

Health practitioner consultation show card

1

Draft current guidance for prostate screening



Where do you go to find evidence now?

Search results

asthma

Search

Results 1 - 10 of 87 for asthma

Sort by:

Date

Relevance

Filter results by:

Audience

Consumers (39)
Health sector (48)

Content type

Consumer information (41)
News and media (3)
Page content (20)
Publication (23)

Category

About the Ministry (2)
Addiction (3)
Disability (1)
Diseases & conditions (27)
Emergency management (2)

Asthma

An asthma attack makes it hard to breath. Find out about managing asthma, asthma medication, treating asthma attacks, and more.

Consumer information - 08 April 2014

Asthma in children

Learn how to recognise asthma in your child and find tips on how to manage it.

Consumer information - 10 October 2014

Asthma and women

Learn about how menstruation, pregnancy and menopause can affect your asthma, and advice for if you're worried about it affecting your baby.

Consumer information - 16 May 2014

des and standards (3)
earch (2)
tistical publications (11)

vs type

vs article (3)

Consumer information - 10 January 2014

Diagnosis and treatment of adult asthma: Summary

Summary of the evidence-based guideline for the diagnostic management and treatment options available for asthma in adults.

Publication - 02 September 2002

Diagnosis and treatment of adult asthma

An evidence-based guideline for the diagnostic management and treatment options available for asthma in adults. The guideline seeks to assist adults with asthma and their health care providers evaluation the latest evidence and make informed decisions to improve health outcomes.

Publication - 02 September 2002

Respiratory disease (various ages)

Respiratory disease indicators for Māori and non-Māori (various ages) by gender. Morbidity and mortality rates for asthma and chronic obstructive pulmonary disease.

Publication - 03 October 2014

The opportunities

- New Zealand has a well developed primary care sector
- 2009 “better, sooner, more convenient health care” – connecting primary and secondary health care
- 2011 Health Quality and Safety Commission
- 2011 National Health Committee started to evaluate new technologies
- Local initiatives can develop into national projects

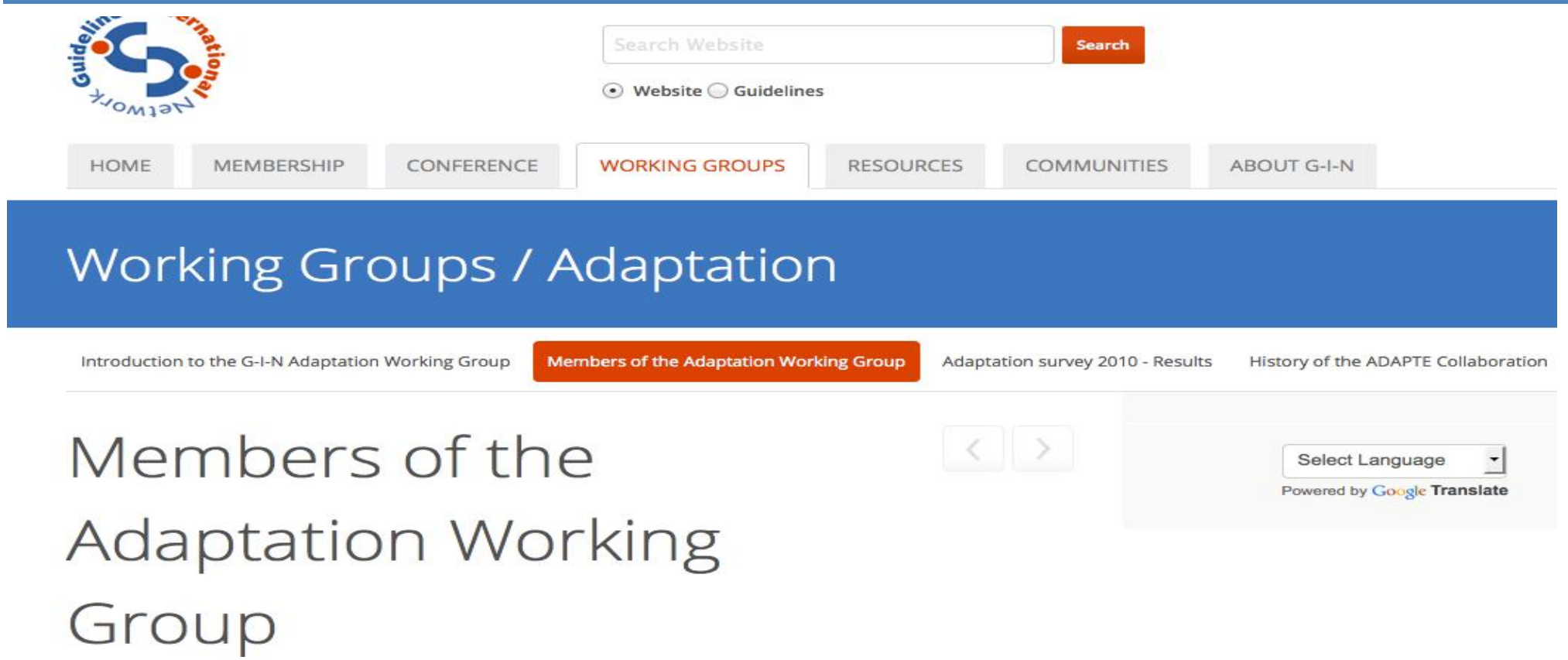
A national evidence programme?

- We are too small for local guideline initiatives
  - Duplication, waste of resources
- Colleges are generally not broad in their focus
  - Not well funded, don’t have all the stake holders
- We need a whole of system approach
  - Primary care and secondary care is intertwined and care should be seamless

Adapting guidelines

- Adapting international guidelines is one approach
- NZGG had relationships with SIGN, NICE and NHMRC to use evidence tables
- Followed the ADAPT metholodology
  - NZGG held 2008 National ADAPT Workshop

ADAPT collaboration



Adapting international guidelines

- Pros
  - Save time
  - Save resources
  - Simple
- Cons
  - Still need to understand the evidence
  - Difficult to get local engagement
  - Needs consumer input
  - Needs Maori and Pacific perspective
  - Needs to consider national/local issues
  - Often takes as long as a national guideline

Who is developing national guidelines/evidence resources in New Zealand now?

- Universities
- Colleges
- DHBs/PHOs
- Foundations/charities eg BPACNZ, NHF
- Government sector
  - NHC, MOH, ACC

- Is this the best approach?
  - Lack of independence
  - High cost
  - Fragmentation
  - Quality concerns
  - Implementation
  - Conflicts
  - Capacity
  - Ownership

Diabetes in Pregnancy Guidelines

- RPF April 2012, awarded in Oct 2012
- 4 GDT meetings, 20 experts, supported by research team
- 34 recommendations
- Implementations for DHBs, education, powerpoints etc
- Delivered on time October 2013
- In ministry processes until released December 2014
- Implementation – DHBs responsibility

What could a national evidence platform/programme look like?

- Not just guidelines
  - summaries, tools, algorithms, topic reviews, pathways etc.
- Topic prioritisation process
- Using best evidence
- Multidisciplinary
- Engaged with stakeholders eg. Consumers, Maori and Pacific representation
- Independent
- Integrated implementation
- Links to international to evidence sources
- National standards

Weighing the benefits and harms of guidelines and pathways as we move towards a more integrated health system

Les Toop March 2015

Department of General Practice,
University of Otago, Christchurch
& Pegasus Health

Interest statement

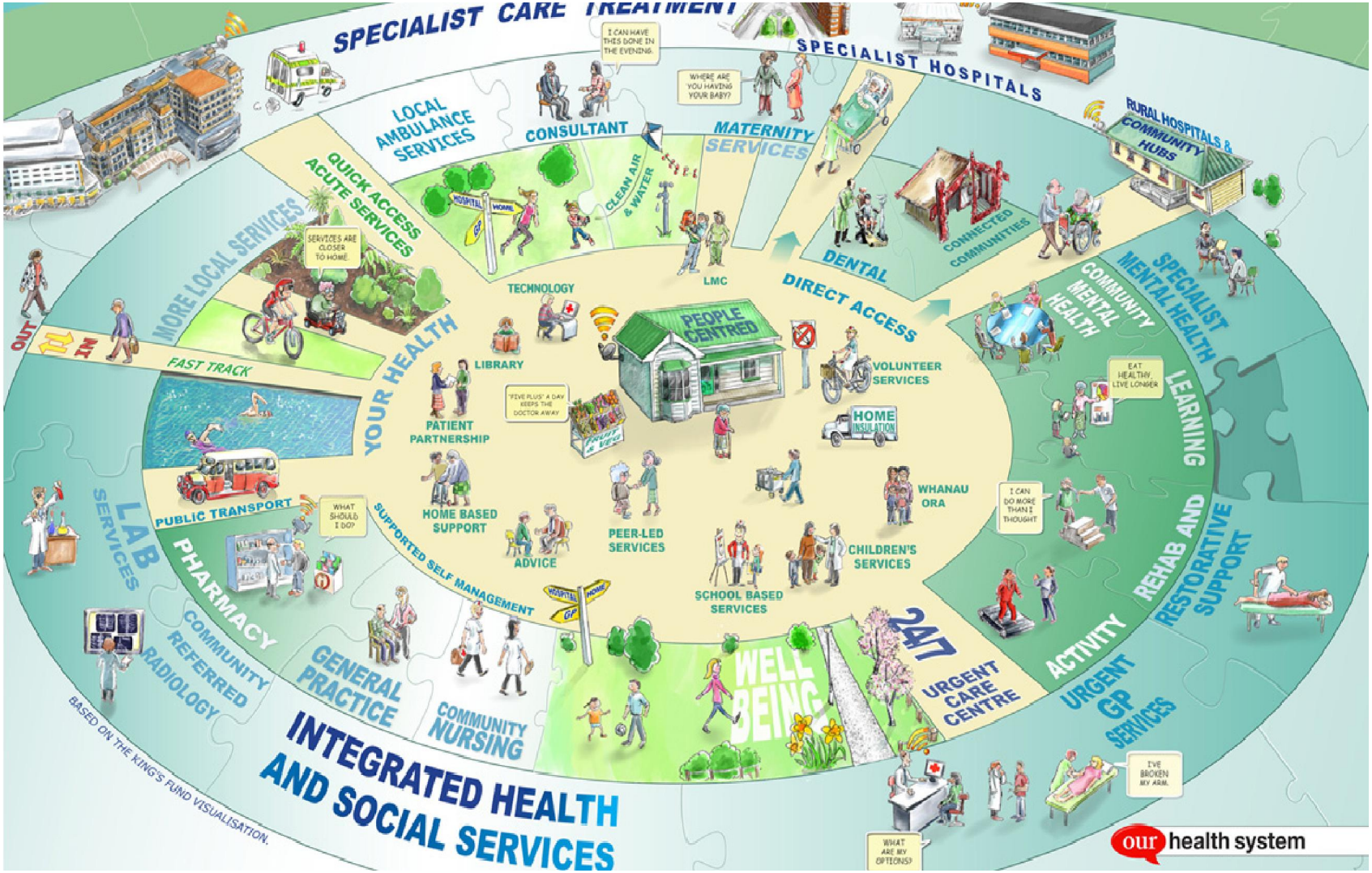
Today's clinicians need an understanding of and access to independent evidence and advice. Armed with this knowledge they need the critical and cognitive skills, attitudes and time to translate and individualise that evidence for their patients (including discussing the inevitable uncertainties). Armed with this shared understanding, they can together make informed decisions about important lifelong lifestyle and treatment choices

The Menu for the Next 20 Minutes

- Integration, Evidence and our reality
- Multimorbidity & complexity is the new norm
- When is guidance necessary?
- Guidelines, benefits and harms
- Health pathways benefits and harms
- Some examples
- Where to from here?

In 2007 Canterbury's health system was fragmented.

An increasingly joined up system



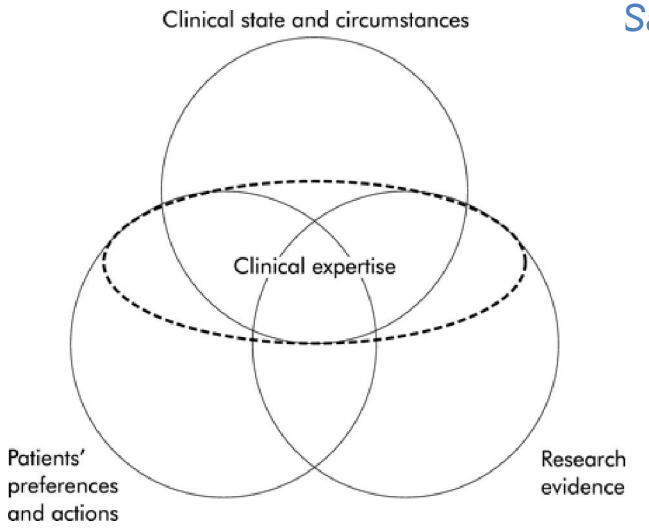
What (If Any) Are The Constant Truths About Evidence

- There is an awful lot of it about
- Experts rarely agree about its meaning
- Meta analyses aren't always helpful
- Absolute truth does not exist
- The half life or relative truth (today's evidence) is shorter than we would like
- Evidence evangelism is dangerous
- One size rarely if ever fits all

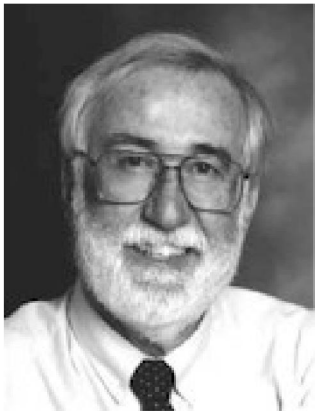
We will continue to get it wrong

- Anti arrhythmics & lipid lowering agents that killed more than they saved
- HRT for CV protection
- COX 2s are safer
- Aspirin great for primary prevention
- Steroids good for acute spinal injury
- High flow oxygen for ACS
- Need to bypass and paralyse heart for CABG
- Steroid injections for tennis elbow
- Etc.

Evidence-based medicine is the integration of **best research evidence** with **clinical expertise** and **patient values**



Sackett & Straus BMJ 1996;312:71-2.



Dave Sackett

Jump ahead to 2015 (BJGP April)

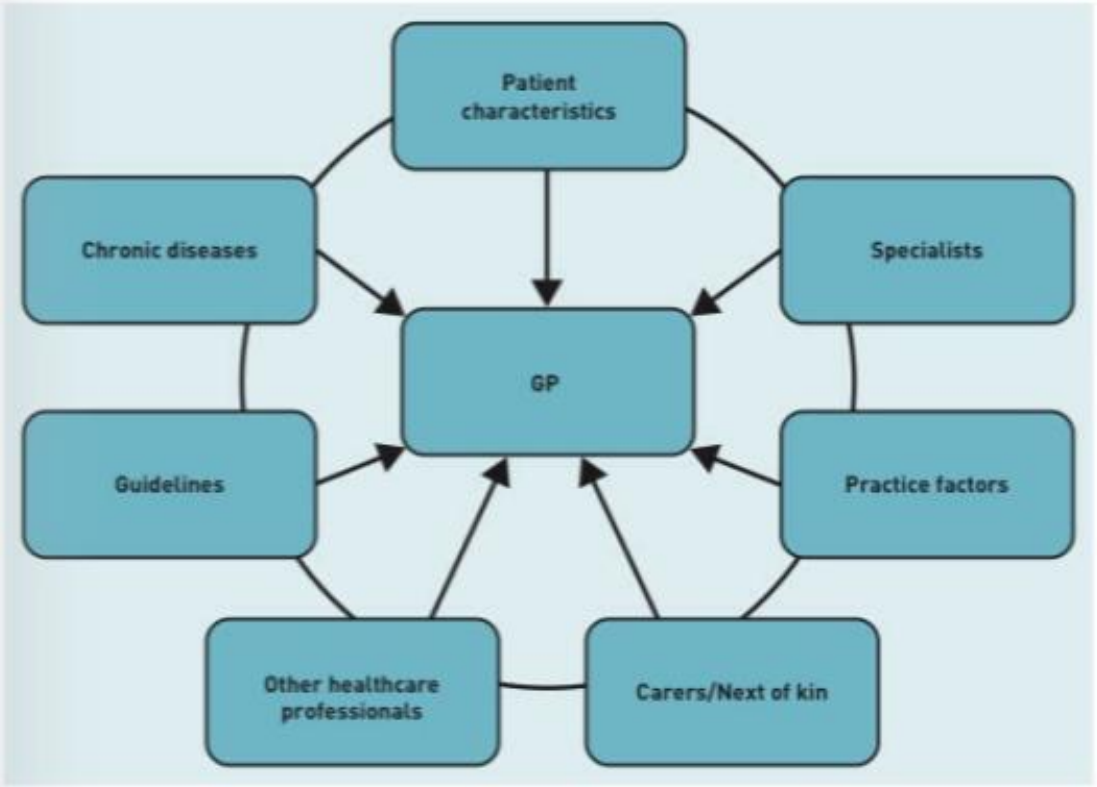


Figure 1. Influences on GPs' decision making in multimorbidity.

based on best practice guidelines, in many cases years before. Proactive changes in

National Guidelines

Potential Benefits

- Standardise guidance
- Thorough evidence review
- Evidence graded
- Comprehensive
- Reassuring for those with single disease or system focus
- Manna from heaven for accountability industry

Potential Harms

- Expensive
- Generally single disease
- Poor applicability in patients with multimorbidity
- Overly inclusive and indigestible
- Often long gestation, and out of date when published
- End users often under represented in design
- Subject to hijack and misuse as performance measures

Guidelines cont.

Potential Benefits

- Guideline fans add you own here

Potential Harms

- Contain too many acronyms
- COI of KOLs who sit around table
- Taken as gospel by junior clinicians - stifle critical thought
- Rarely involve meaningful patient choice. Paternalistic
- May lead to litigation
- Very hard to change quickly

thebmj

BMJ 2014;349:g5210 doi: 10.1136/bmj.g5210 (Published 29 August 2014)

ANALYSIS

Perioperative β blockade: guidelines do not reflect the problems with the evidence from the DECREASE trials

The trials underpinning initiation of perioperative blockers in patients with ischaemic heart disease having high risk surgery have largely been discredited, and the remaining evidence points to an increased risk of death. However, changes to the European guidelines have been slow. **Graham Cole** and **Darrel Francis** call for improvements to permit guideline experts to perform rapid amendments when required

Graham D Cole *academic clinical fellow*, Darrel P Francis *professor*

International Centre for Circulatory Health, National Heart and Lung Institute, Imperial College London, London W2 1LA

Pathways

Potential Benefits

- Consensus driven
- Evidence informed
- Local and “owned”
- Relevant
- Immediate (through PMS)
- Concise
- Consistent
- Incorporate agreed referral criteria
- Opportunity for feedback
- Nimble, easily updated

Potential Harms

- Can be captured by one or two “experts”
- Can be too rigid when used as rationing tool
- Don’t always reflect the importance of clinical experience can stifle critical thought
- Relies on the collective wisdom which may or may not be current
- May stray too far beyond original intent of referral pathways

Two Recent Guideline Examples

- Atrial fibrillation
- CV risk assessment and treatment

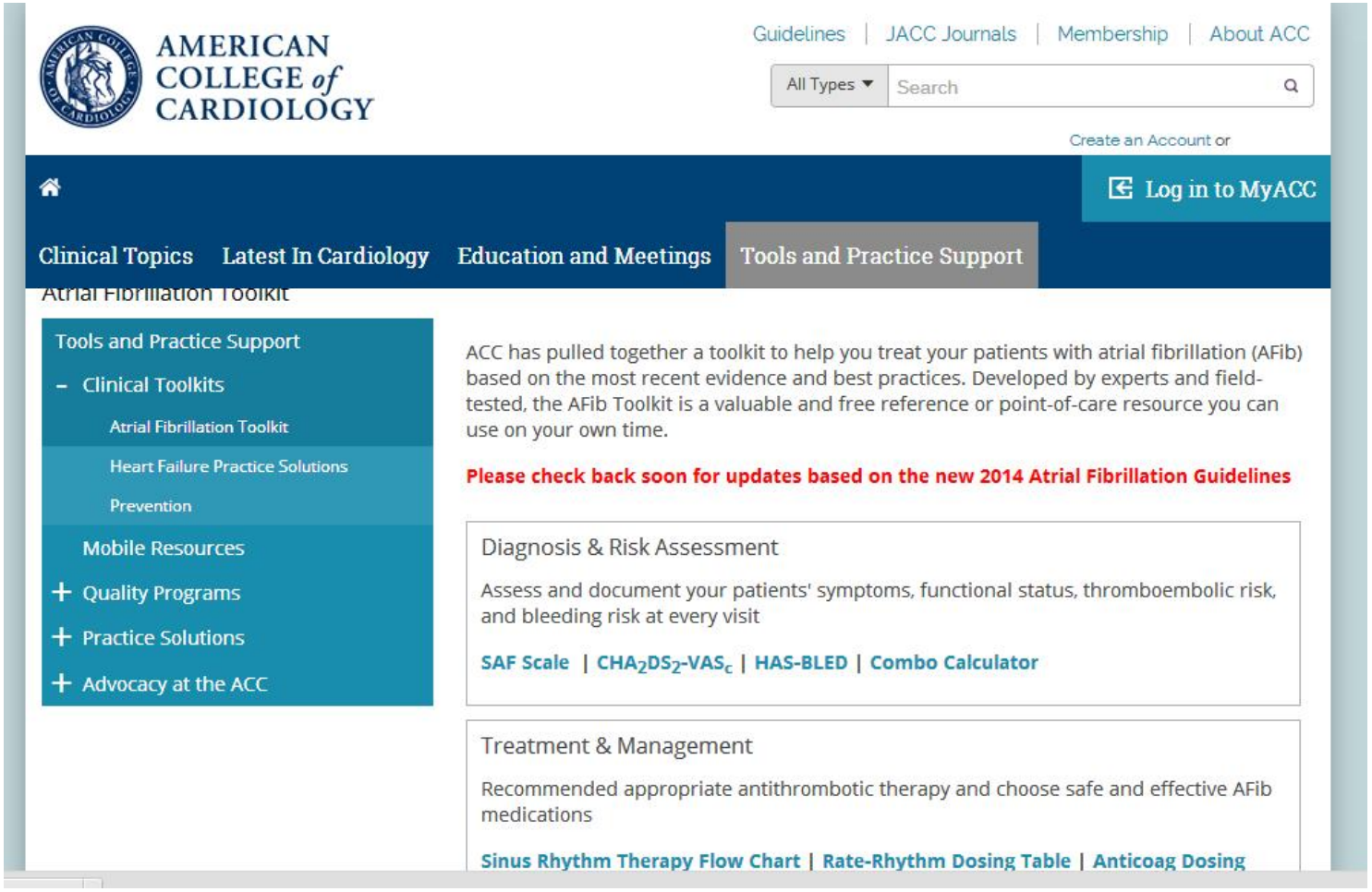
Nice latest AF guideline

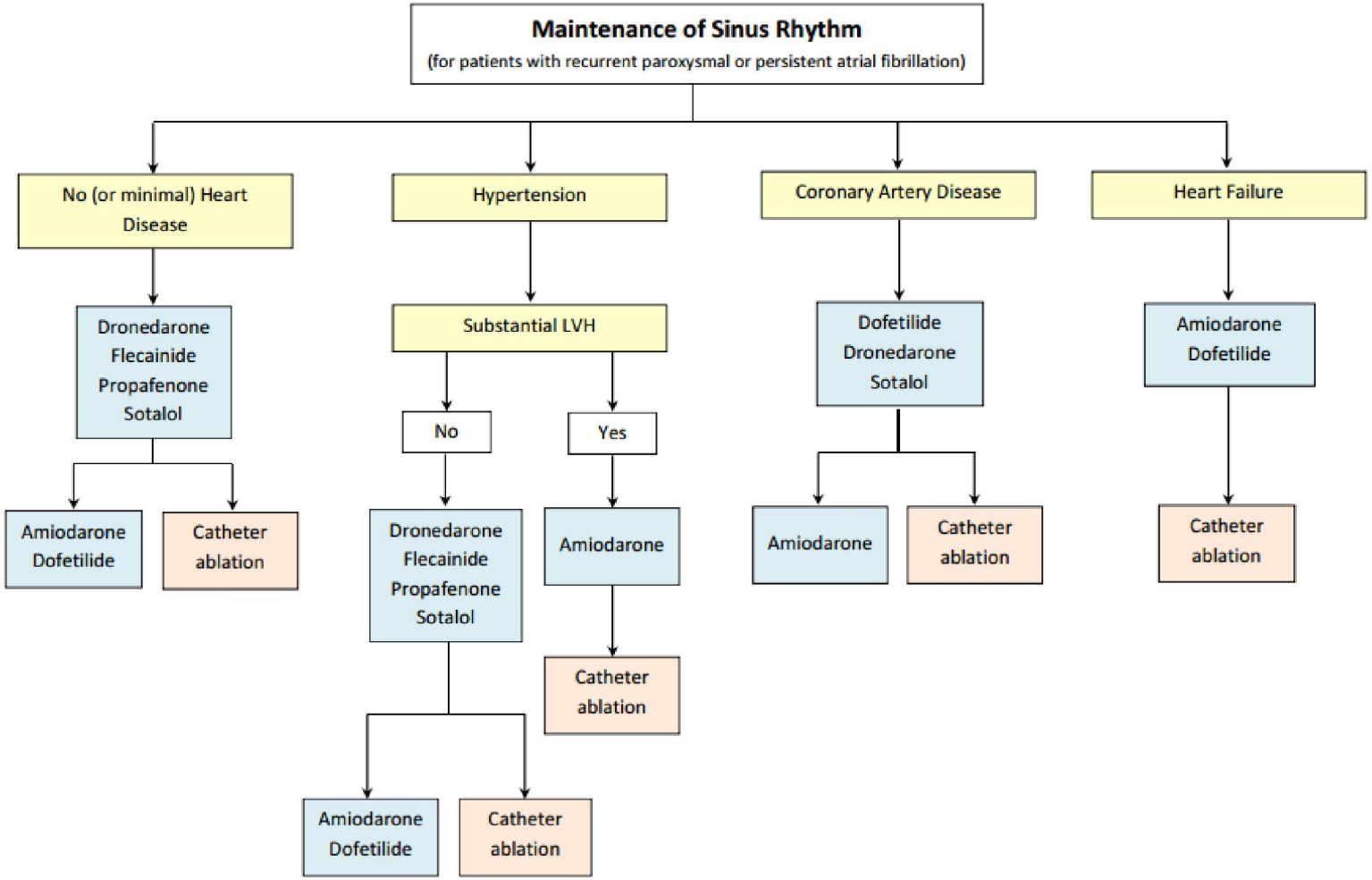
- 1.6.4 If monotherapy does not control symptoms, and if continuing symptoms are thought to be due to poor ventricular rate control, consider combination therapy with any 2 of the following:
- a beta-blocker
- diltiazem
- digoxin. **[new 2014]**
- 1.6.5Do not offer amiodarone for long-term rate control. **[new 2014]**

And

- Assess the need for drug treatment for long-term rhythm control, taking into account the person's preferences, associated comorbidities, risks of treatment and likelihood of recurrence of atrial fibrillation. **[new 2014]**
- 1.6.11If drug treatment for long-term rhythm control is needed, consider a standard beta-blocker (that is, a beta-blocker other than sotalol) as first-line treatment unless there are contraindications. **[new 2014]**

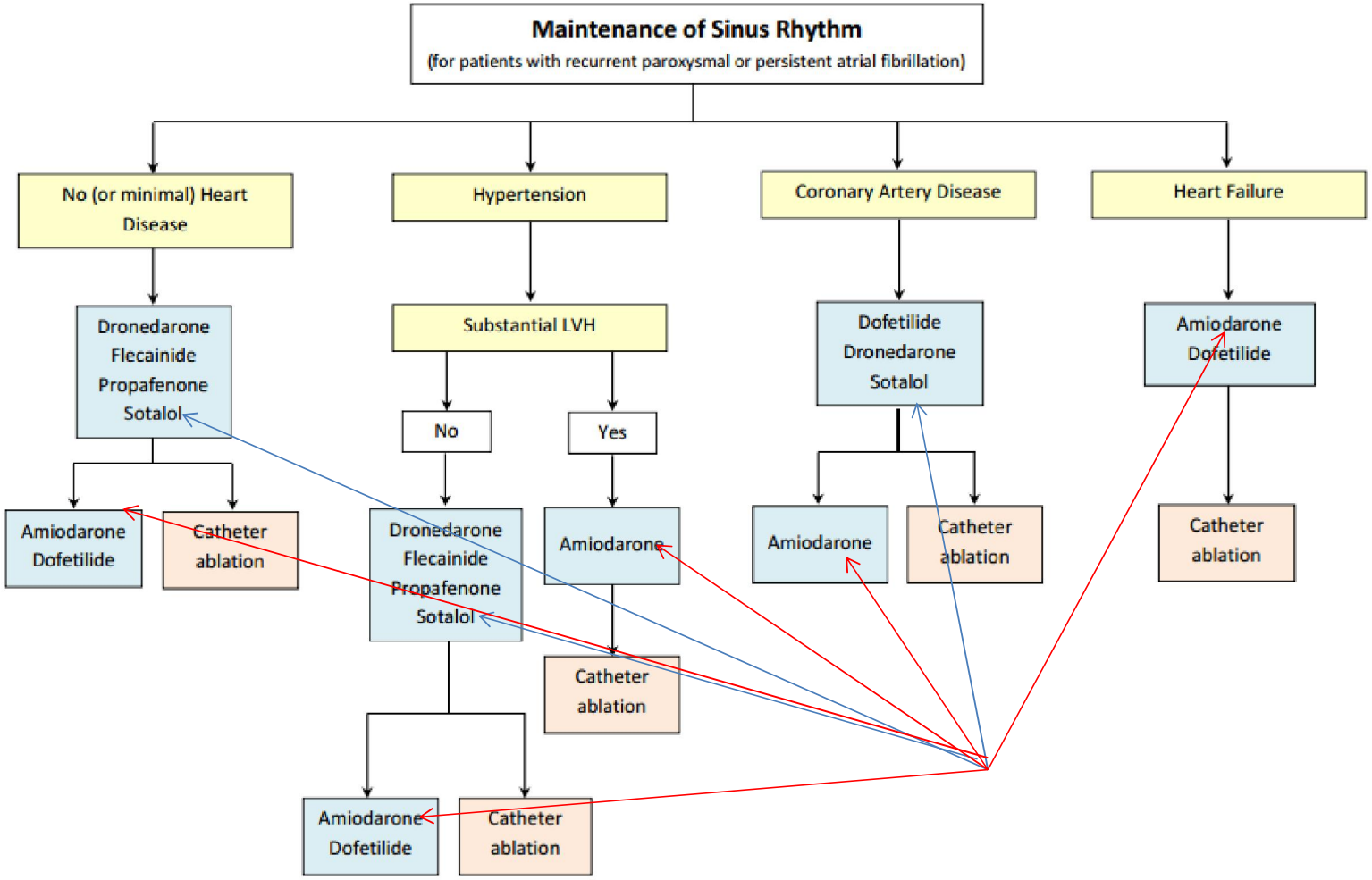
Accessed 3/3/2015





Note: Drugs are listed alphabetically and not in order of suggested use. The seriousness of heart disease progresses from left to right, and selection of therapy in patients with multiple conditions depends on the most serious condition present. LVH indicates left ventricular hypertrophy.

Modified from Fuster et al. (2) (formerly Figure 15 from 2006 Section 8.3.3).



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Modified from Fuster et al. (2) (formerly Figure 15 from 2006 Section 8.3.3).

NEW ZEALAND GUIDELINES GROUP
Promoting Effective Health and Disability Services

Heart Foundation
The Heart of Our Nation

EVIDENCE-BASED BEST PRACTICE GUIDELINE

Cardiovascular Risk Assessment and Management Guideline

December 2003

CV Risk Guideline 2003
What was new ---

- Integrated previous advice on smoking, BP, lipids and diabetes into one assessment
- Required bloods (lipids and fasting glucose)
- Recommended assessment of specific age groups
- Recommended all treatment decisions be based on absolute cardiovascular risk - CHD and stroke risk combined
- **Recommended intervention for individuals with CV risk above 15% 5 year level as practical and cost effective**

The beginnings of the CVRA Health Target

- In 2007 PHO Performance Programme (PPP) introduced
- PHOs would be incentivised to meet certain targets
- Including CV risk assessment (5 year risk) and diabetes checks on most of the adult population with a view to incentivising the 2003 National Guideline

PHO Performance Programme

DHB and PHO Presentation

September 2007

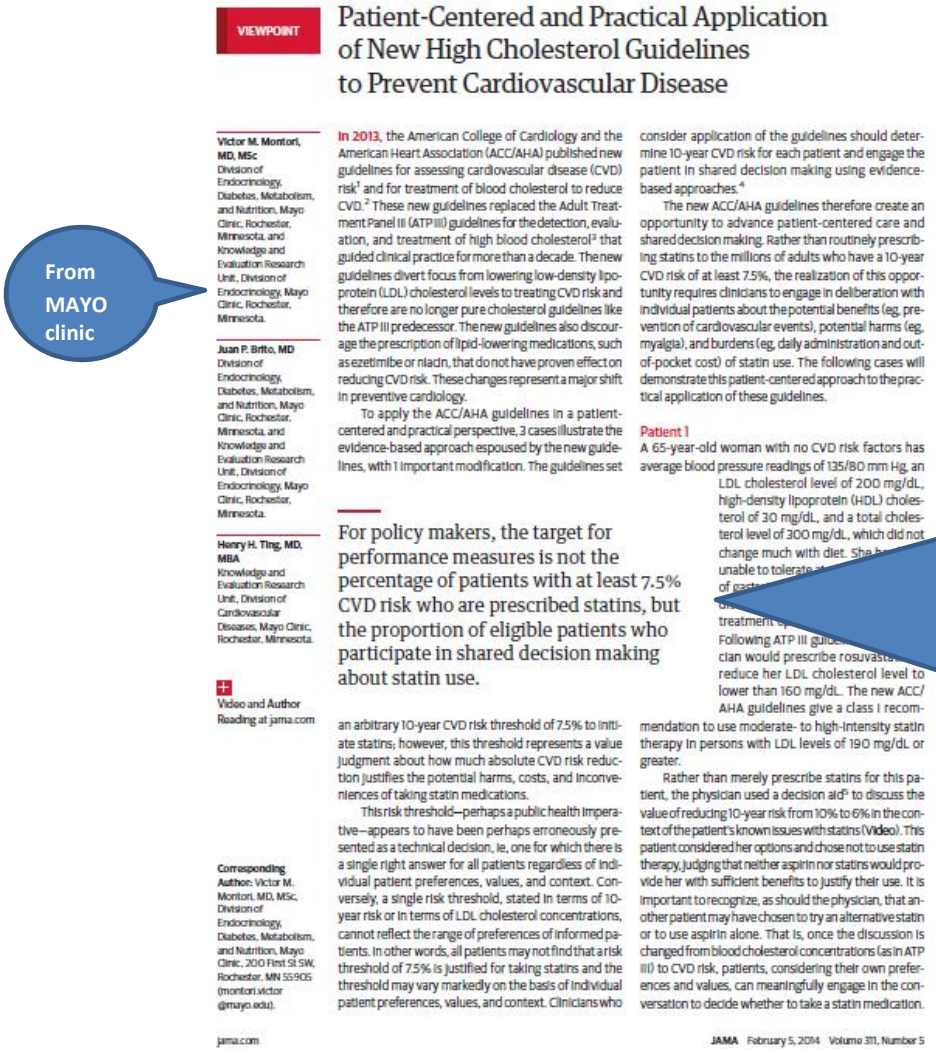
Intermediate Phase (continued)

- % of patients coded CVRA>15% (x) and on a statin (y) (High Need and Total Population)
- % of patients coded CVRA>15% (x) and on anti-thrombotic (y) (High Need and Total Population)
- % of patients coded CVRA>15% (x) and on a blood pressure lowering agent (y) (High Need and Total Population)

plus ça change, plus c'est la même chose

The recommended interventions, goals and follow-up based on cardiovascular risk assessment

Cardiovascular risk	Lifestyle	Drug therapy	Follow-up
Established CVD	Intensive lifestyle advice (diet, physical activity, smoking cessation) simultaneously with drug treatment	Strong evidence of benefit from BP-lowering, statins and antiplatelet therapy in this group	Risk factor monitoring initially at 3 months, then as clinically indicated
CVD risk calculated >20%	Intensive lifestyle advice (diet, physical activity, smoking cessation) simultaneously with drug treatment	Strong evidence of benefit from BP-lowering, statins and antiplatelet therapy in this group	Annual review or as clinically indicated
10% to 20%	Specific individualised lifestyle advice (diet, physical activity, smoking cessation)	Good evidence demonstrating benefit from BP-lowering and/or statin therapy in this group. The absolute benefits will be smaller at lower levels of combined risk, with increasing benefit of treating both BP and lipids for those with higher five-year combined risk Shared decision-making approach to consider benefits and harms of drug treatment of modifiable risk factors	As clinically indicated, with a more intensive focus for higher combined risk patients If patient not on drug treatment, offer CVD risk assessment at reassessment – at one year for 15% to 20% risk and every two years for 10% to 15% risk
<10%	Lifestyle advice (diet, physical activity, smoking cessation)	Evidence of benefit from BP-lowering and statin therapy in this group is unclear; use a shared decision-making approach to consider benefits and harms of treatment of modifiable risk factors	Offer further CVD risk assessment in 5 to 10 years



VIEWPOINT

Patient-Centered and Practical Application of New High Cholesterol Guidelines to Prevent Cardiovascular Disease

Victor M. Montori, MD, MSc
Division of Endocrinology, Diabetes, Metabolism, and Nutrition, Mayo Clinic, Rochester, Minnesota, and Knowledge and Evaluation Research Unit, Division of Endocrinology, Mayo Clinic, Rochester, Minnesota.

Juan P. Brito, MD
Division of Endocrinology, Diabetes, Metabolism, and Nutrition, Mayo Clinic, Rochester, Minnesota, and Knowledge and Evaluation Research Unit, Division of Endocrinology, Mayo Clinic, Rochester, Minnesota.

Henry H. Ting, MD, MBA
Knowledge and Evaluation Research Unit, Division of Cardiovascular Diseases, Mayo Clinic, Rochester, Minnesota.

Video and Author Reading at jama.com

Corresponding Author: Victor M. Montori, MD, MSc, Division of Endocrinology, Diabetes, Metabolism, and Nutrition, Mayo Clinic, 200 First St SW, Rochester, MN 55905 (montori.victor@mayo.edu).

In 2013, the American College of Cardiology and the American Heart Association (ACC/AHA) published new guidelines for assessing cardiovascular disease (CVD) risk[1] and for treatment of blood cholesterol to reduce CVD.[2] These new guidelines replaced the Adult Treatment Panel III (ATP III) guidelines for the detection, evaluation, and treatment of high blood cholesterol[3] that guided clinical practice for more than a decade. The new guidelines divert focus from lowering low-density lipoprotein (LDL) cholesterol levels to treating CVD risk and therefore are no longer pure cholesterol guidelines like the ATP III predecessor. The new guidelines also discourage the prescription of lipid-lowering medications, such as ezetimibe or niacin, that do not have proven effect on reducing CVD risk. These changes represent a major shift in preventive cardiology.

To apply the ACC/AHA guidelines in a patient-centered and practical perspective, 3 cases illustrate the evidence-based approach espoused by the new guidelines, with 1 important modification. The guidelines set an arbitrary 10-year CVD risk threshold of 7.5% to initiate statins; however, this threshold represents a value judgment about how much absolute CVD risk reduction justifies the potential harms, costs, and inconveniences of taking statin medications.

For policy makers, the target for performance measures is not the percentage of patients with at least 7.5% CVD risk who are prescribed statins, but the proportion of eligible patients who participate in shared decision making about statin use.

This risk threshold—perhaps a public health imperative—appears to have been perhaps erroneously presented as a technical decision, ie, one for which there is a single right answer for all patients regardless of individual patient preferences, values, and context. Conversely, a single risk threshold, stated in terms of 10-year risk or in terms of LDL cholesterol concentrations, cannot reflect the range of preferences of informed patients. In other words, all patients may not find that a risk threshold of 7.5% is justified for taking statins and the threshold may vary markedly on the basis of individual patient preferences, values, and context. Clinicians who consider application of the guidelines should determine 10-year CVD risk for each patient and engage the patient in shared decision making using evidence-based approaches.[4]

The new ACC/AHA guidelines therefore create an opportunity to advance patient-centered care and shared decision making. Rather than routinely prescribing statins to the millions of adults who have a 10-year CVD risk of at least 7.5%, the realization of this opportunity requires clinicians to engage in deliberation with individual patients about the potential benefits (eg, prevention of cardiovascular events), potential harms (eg, myalgia), and burdens (eg, daily administration and out-of-pocket cost) of statin use. The following cases will demonstrate this patient-centered approach to the practical application of these guidelines.

Patient 1

A 65-year-old woman with no CVD risk factors has average blood pressure readings of 135/80 mm Hg, an LDL cholesterol level of 200 mg/dL, high-density lipoprotein (HDL) cholesterol of 30 mg/dL, and a total cholesterol level of 300 mg/dL, which did not change much with diet. She h… unable to tolerate … of gast… treatment. … Following ATP III guid… clinician would prescribe rosuvast… reduce her LDL cholesterol level to lower than 160 mg/dL. The new ACC/AHA guidelines give a class I recommendation to use moderate- to high-intensity statin therapy in persons with LDL levels of 190 mg/dL or greater.

Rather than merely prescribe statins for this patient, the physician used a decision aid[5] to discuss the value of reducing 10-year risk from 10% to 6% in the context of the patient's known issues with statins (Video). This patient considered her options and chose not to use statin therapy, judging that neither aspirin nor statins would provide her with sufficient benefits to justify their use. It is important to recognize, as should the physician, that another patient may have chosen to try an alternative statin or to use aspirin alone. That is, once the discussion is changed from blood cholesterol concentrations (as in ATP III) to CVD risk, patients, considering their own preferences and values, can meaningfully engage in the conversation to decide whether to take a statin medication.

From MAYO clinic

For policy makers, the target for performance measures is not the percentage of patients with at least 7.5% CVD risk who are prescribed statins, but the **proportion of eligible patients who participate in shared decision making about statin use.**

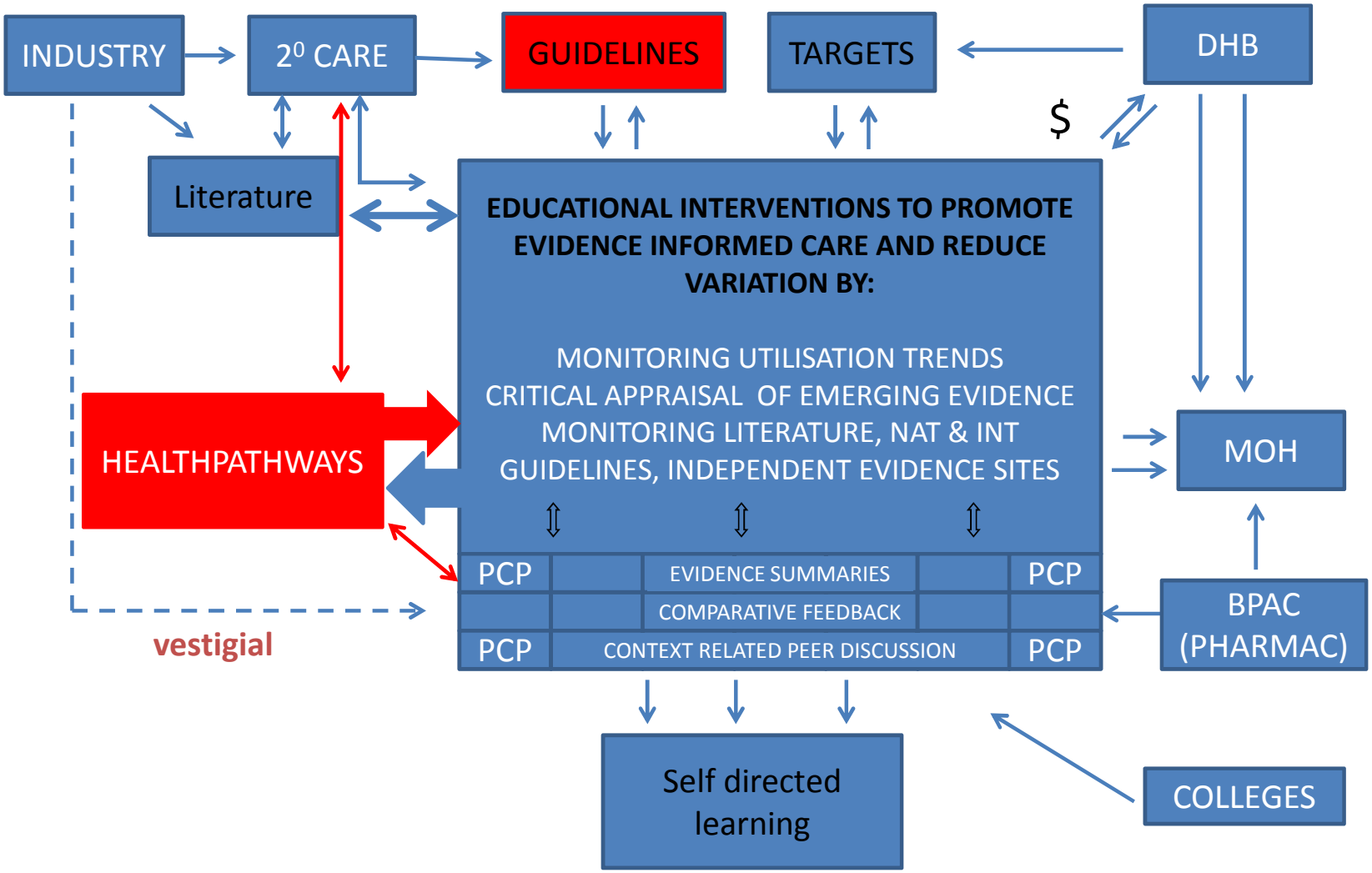
JAMA February 5, 2014 Volume 311, Number 5

HealthPathways is for Clinicians

Today's Clinicians

Need an understanding of and access to independent evidence and advice. Armed with this knowledge they need the critical and cognitive skills, attitudes and time to translate and individualise that evidence for their patients (including discussing the inevitable uncertainties). Armed with this shared understanding, they can together make informed decisions about important lifelong lifestyle and treatment choices

Current Canterbury Model



NICE National Institute for Health and Care Excellence

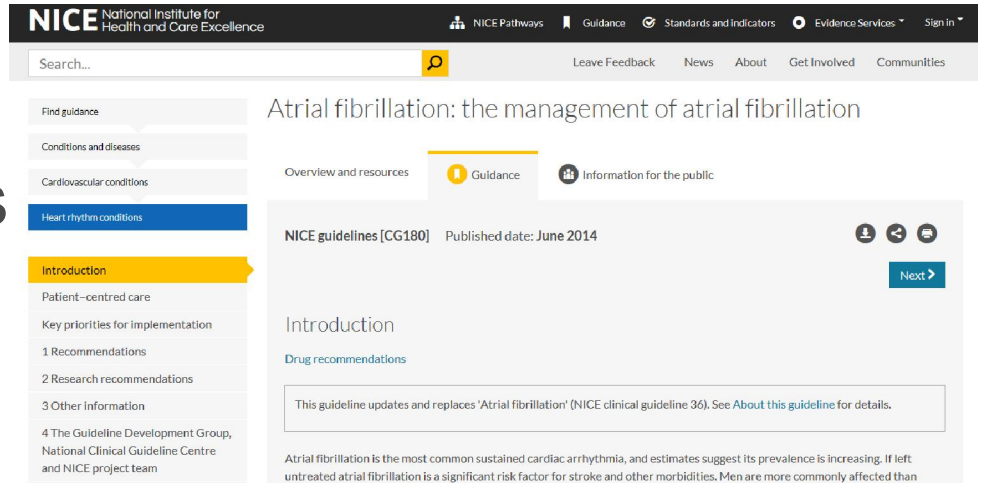
Overview of guideline development and updating process

Christine Carson, Programme Director, Centre for Clinical Practice, NICE

February 2015

NICE's clinical guidelines

The NICE Centre for Clinical Practice develops clinical guidelines on the treatment and care of people with specific diseases and conditions within the NHS, and service delivery



NICE clinical guideline programme

- The largest publicly-funded national guidelines programme in the world
- 196 guidelines published since 2002, 65-70 in development and 28 waiting to be commissioned
- Involving over 1000 people (most on a voluntary basis)
- Includes areas of public health, social care and service delivery..

What are clinical guidelines?

- Broad guidance covering all or specific aspects of the management of a particular condition
- Take account of clinical and cost effectiveness, and patient/carer perspective
- Incorporates other NICE guidance for example, technology appraisal, where relevant
- Recommendations are **advisory only** but can be used to develop quality standards to assess clinical practice and inform commissioning

Why have guidelines?

- Ensure **efficient investment** of limited public resources towards interventions that produce the greatest return
- **Improve health** and patient satisfaction; **reduce variation and inequities** of access across the country
- **Support healthcare professionals'**
- Identify **research gaps** and drive high-priority research
- Inform **performance metrics** that underlie regulation, accreditation and incentive schemes

Clinical guidelines do:

- Describe the treatment and care of individuals by health and social care professionals
- Consider service delivery
- Take account of patients' perspectives

Clinical guidelines do not:

- Replace clinical judgement
- Take the place of a 'wish list'
- Provide a textbook – cannot cover everything

What makes NICE Clinical Guidelines special?

Robust methodology and evidence-base

- Scientific approach to evaluating evidence
- Multidisciplinary topic experts consider applicability
- Cost-effectiveness is a central consideration

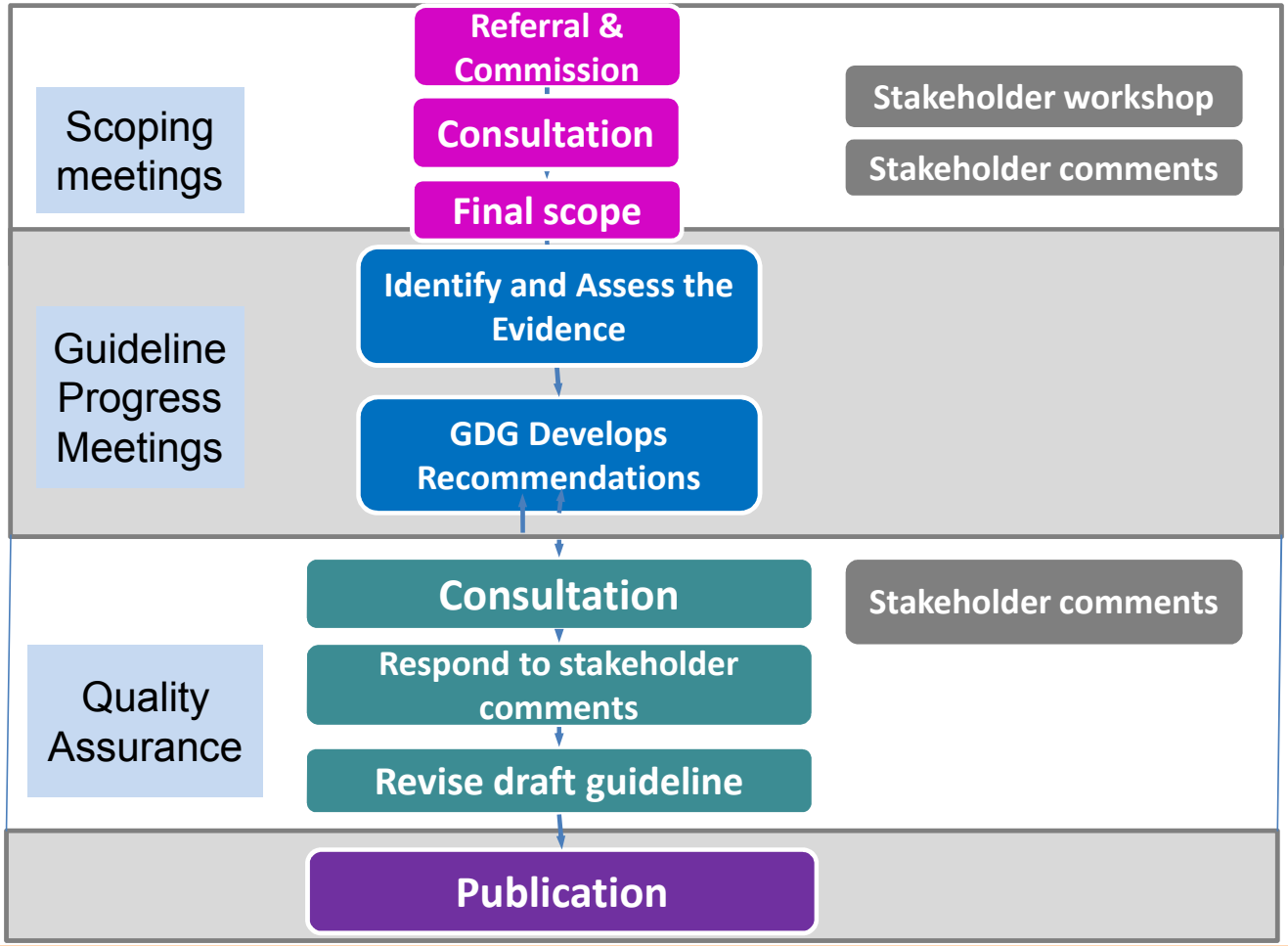
Deliberative, inclusive, transparent process

- Multidisciplinary participation, including patients and carers
- Independent from vested interests..
- Actively engage stakeholders through public consultation
- All proceedings and outputs freely published

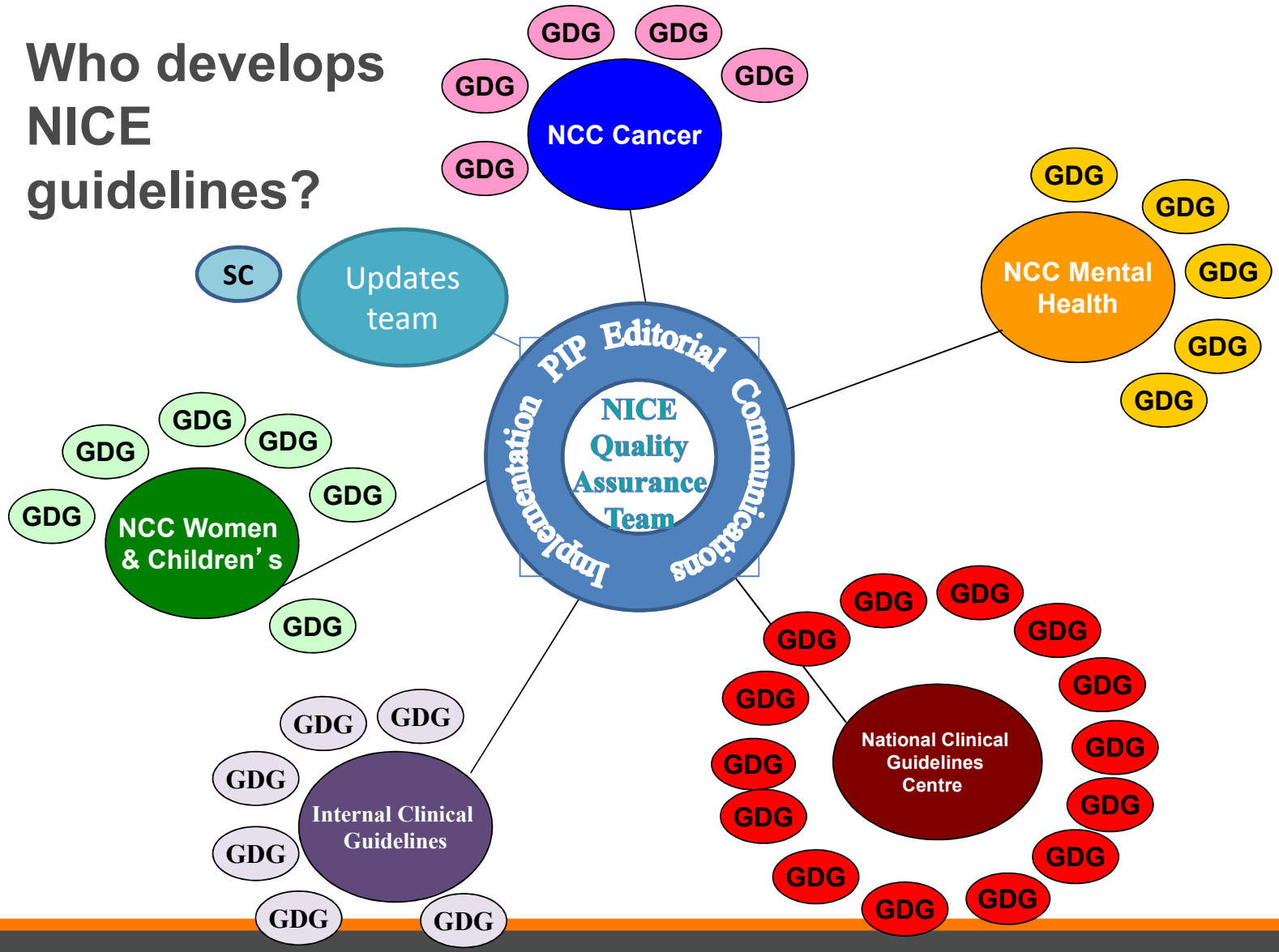
What are the key principles?

- The guideline needs to be useful to the NHS
- improve clinical decisions and hence patients' outcomes
- promote the cost-effective use of NHS resources
- focuses on key areas of known variation or uncertainty
- based on best available evidence & GDG consensus
- systematic and transparent process

Guideline development process



Who develops NICE guidelines?



Each Guideline Committee comprises experts in the field

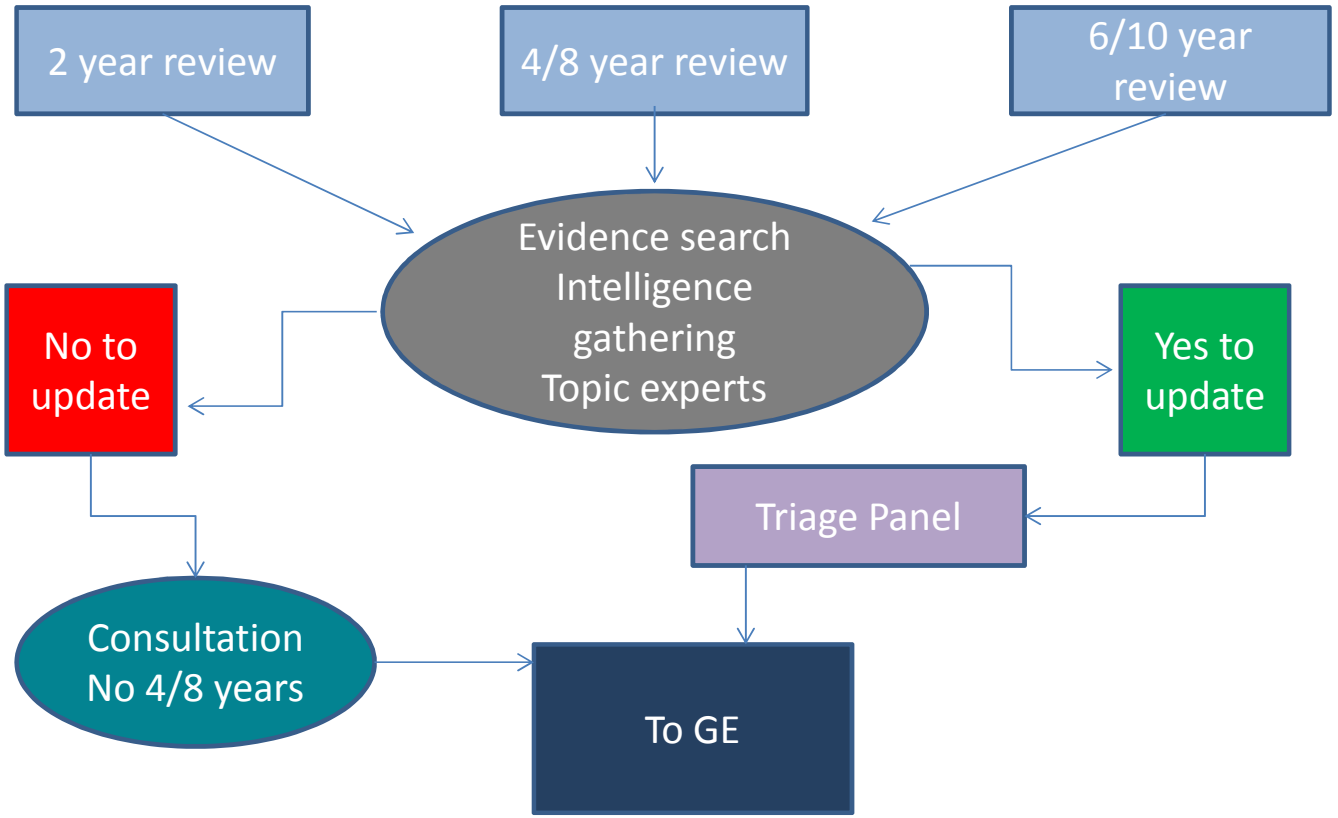
- Patients/carers
- Clinicians
- Researchers
- Commissioner
- Health economist
- Social care

Updating our guidelines
Keeping up to date with new evidence

Maintaining a catalogue of 196 published guidelines:

- Surveillance reviews
- Ability to update discrete areas of guideline

Surveillance reviews process



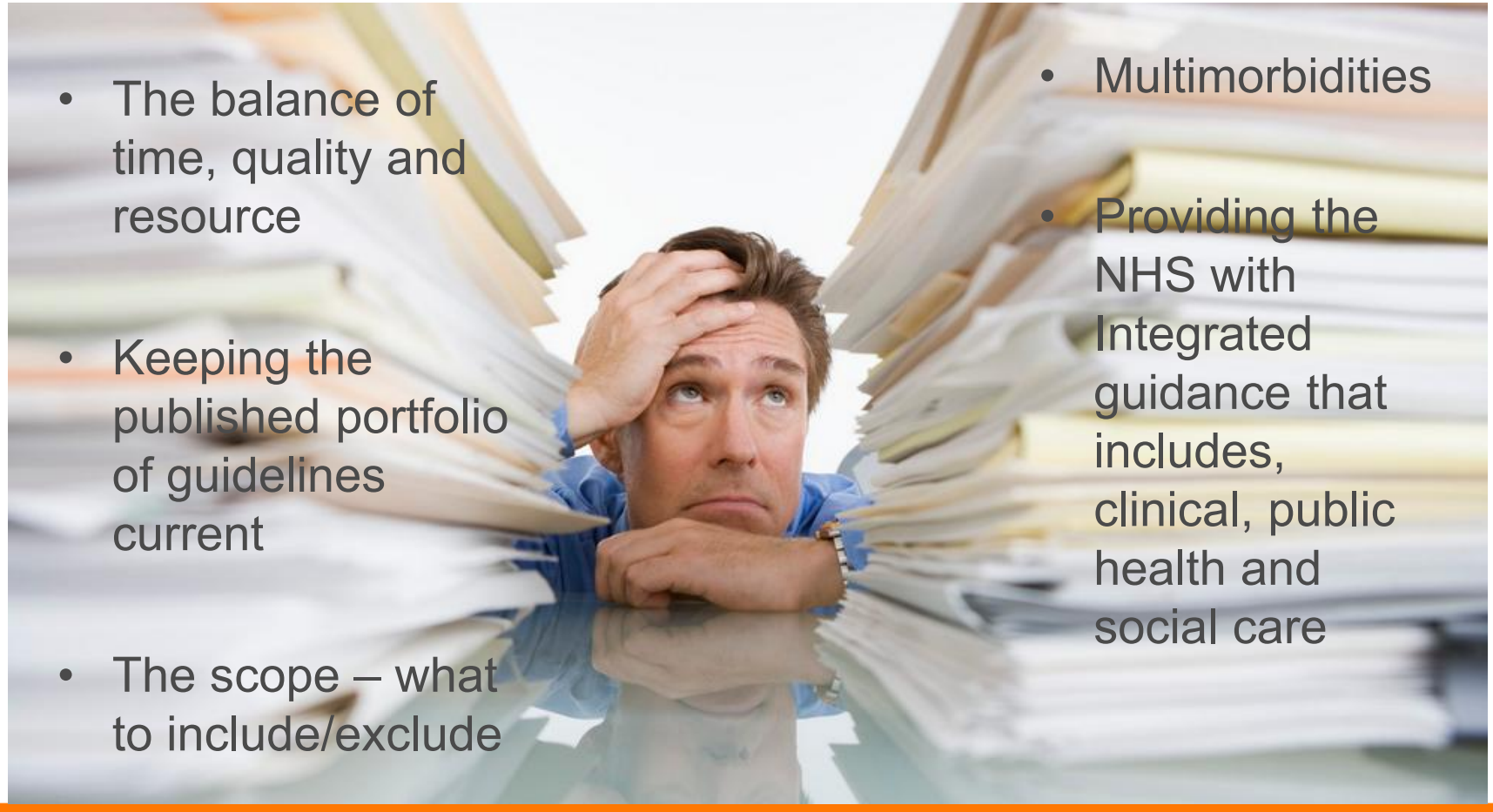
Demand for guidelines increasing

- Being asked to do more ‘rapid reaction’ guidelines to address specific clinical problems

Department of Health

NHS England

A major challenge for NICE's guidelines team

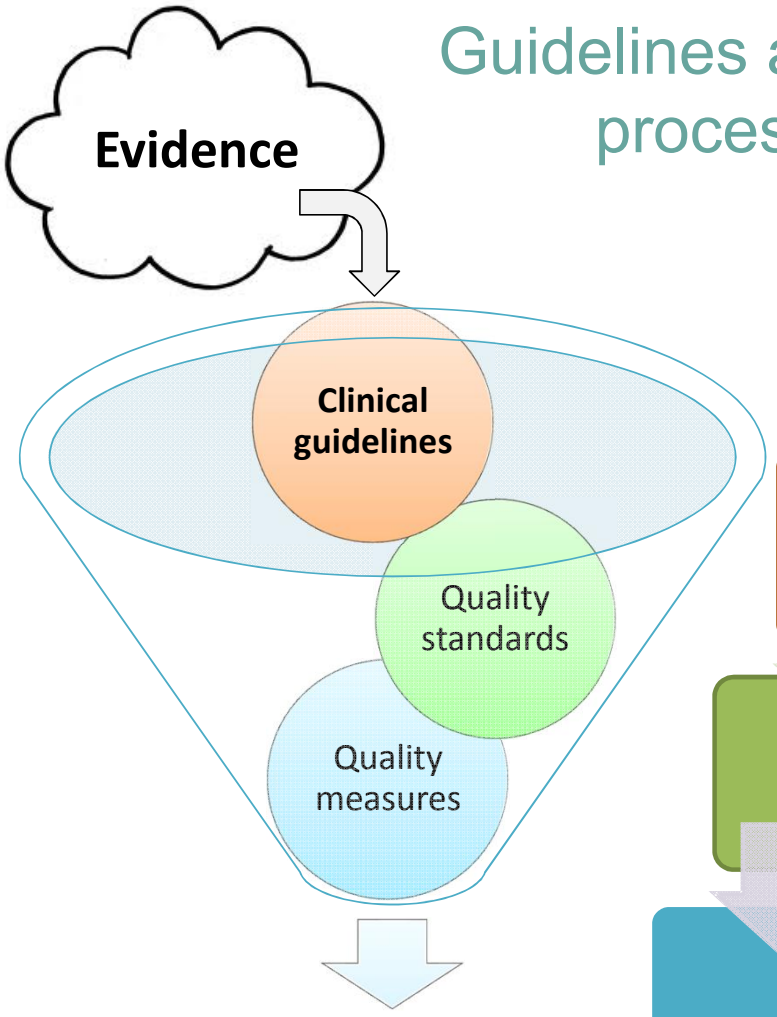


- The balance of time, quality and resource
- Keeping the published portfolio of guidelines current
- The scope – what to include/exclude
- Multimorbidities
- Providing the NHS with Integrated guidance that includes, clinical, public health and social care

Plus: Supporting the NHS in providing efficient services
Increased emphasis on service design

- **Who** delivers services, **when** and **how**?
- New Methods
- Paucity of evidence
- New experts

Guidelines are a key part of evolutionary process to drive improvement



The starting point is the evidence base (clinical trials, health economics)

Evidence is distilled to produce **clinical guidelines**

Quality standards are derived from evidence-based clinical guidelines

QS indicators and measures can inform quality initiatives and financial incentives.

Implementation support available from NICE includes…

- Regional field team for personal support
- Audit tools
- Costing templates
- Patient Decision Aids

UNIVERSITY of OTAGO
Te Whare Wānanga o Otāgo
NEW ZEALAND

NICE guidance into action: Getting guidelines embedded in health systems

Tim Stokes

Elaine Gurr Professor of General Practice, Dunedin School of Medicine

GP Mornington Health Centre, Dunedin

Overview

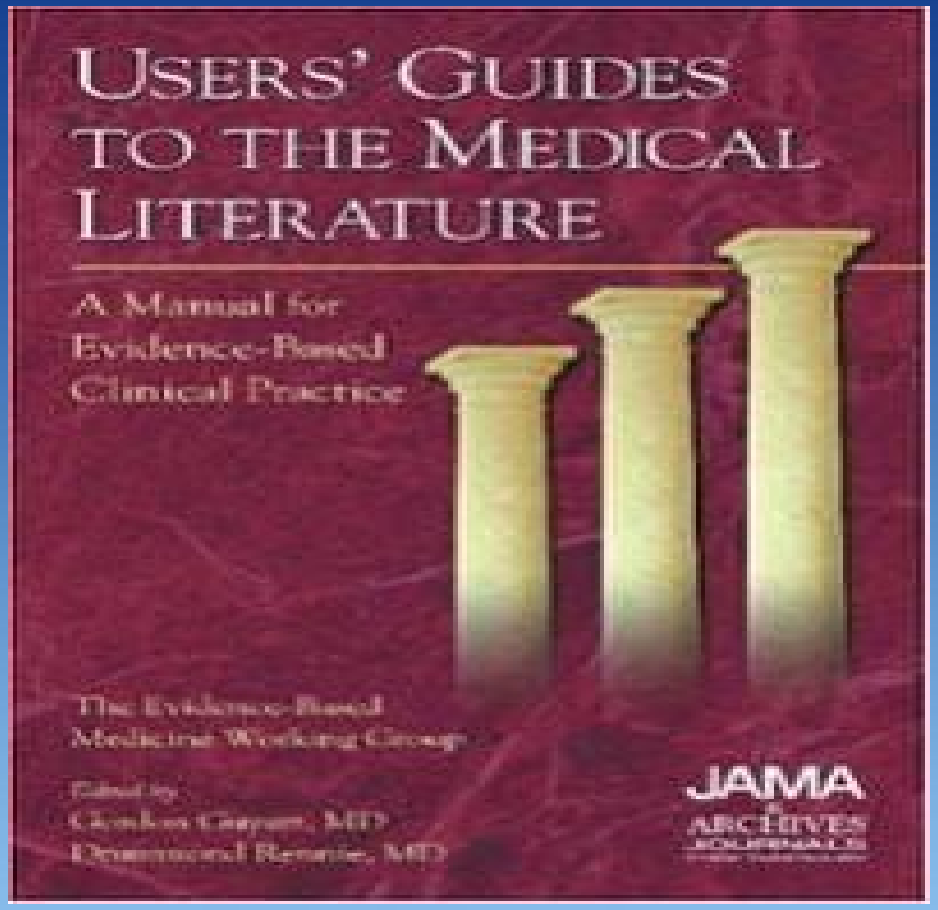
- The two ages of guidelines
- The problems with clinical guidelines
- The third age of clinical guidelines?
  - Getting guidelines embedded in health systems
  - The UK NICE experience
- Concluding reflections

The “first age” of clinical guidelines

- 1970s & 80s:
  - Consensus statements on care
- Key features:
  - Evidence:
    - Not systematic
  - Evidence translation into recommendations:
    - GOBSAT (Good old boys sitting around the table)
    - Secondary care dominated

The “second age” of clinical guidelines

- Late 1980s:
  - The Evidence Based Medicines Movement (EBM)
- The “second age” of clinical guidelines



The “second age” of clinical guidelines

- Key features
  - Definition
  - “systematially developed statements to assist practitioner and patient decisions about appropriate health care for specific circumstances”
  - Field & Lohr US IOM 1990
  - Evidence:
    - Clinical question focus
    - systematic reviews of the evidence
    - Assessment / quantification of benefits and harms
  - Evidence translation into recommendations
    - Multidisciplinary groups
      - GPs; non medical health professionals; lay members
    - Small group processes

The “second age” of clinical guidelines

Family Practice
© Oxford University Press 1999

Vol. 16, No. 3
Printed in Great Britain

Evidence-based guidelines for the management of genital chlamydial infection in general practice

Tim Stokes, Paul Schober[a], Janet Baker[b], Anita Bloor[c], Isabel Kuncewicz[d], Jenny Ogilvy[e], Adrian French[f], Carol Henry[e] and Judith Mears[c] (Leicestershire Chlamydia Guidelines Group)

Stokes T, Schober P, Baker J, Bloor A, Kuncewicz I, Ogilvy J, French A, Henry C and Mears J. Evidence-based guidelines for the management of genital chlamydial infection in general practice. *Family Practice* 1999; **16:** 269–277.

Background. Valid clinical guidelines can be effective in improving patient care. Genital *Chlamydia trachomatis* infection is the commonest curable sexually transmitted disease (STD) in England and Wales and is an important cause of pelvic inflammatory disease (PID), tubal infertility and ectopic pregnancy. No published guidelines exist on managing genital chlamydial infection in British general practice.

Objective. We aimed to develop valid guidelines for the management of genital chlamydial infection for use in British general practice.

Methods. A district-wide postal questionnaire survey was used to document current clinical practice. A critical review of the evidence concerning the management of genital chlamydial infection as it relates to British general practice was performed. The information gained from the critical review and survey was used to develop evidence-based guidelines within a multidisciplinary guideline recommendation group.

Results. The guidelines covered the diagnosis, investigation, drug treatment and referral of adult male and female patients with genital chlamydial infection in general practice.

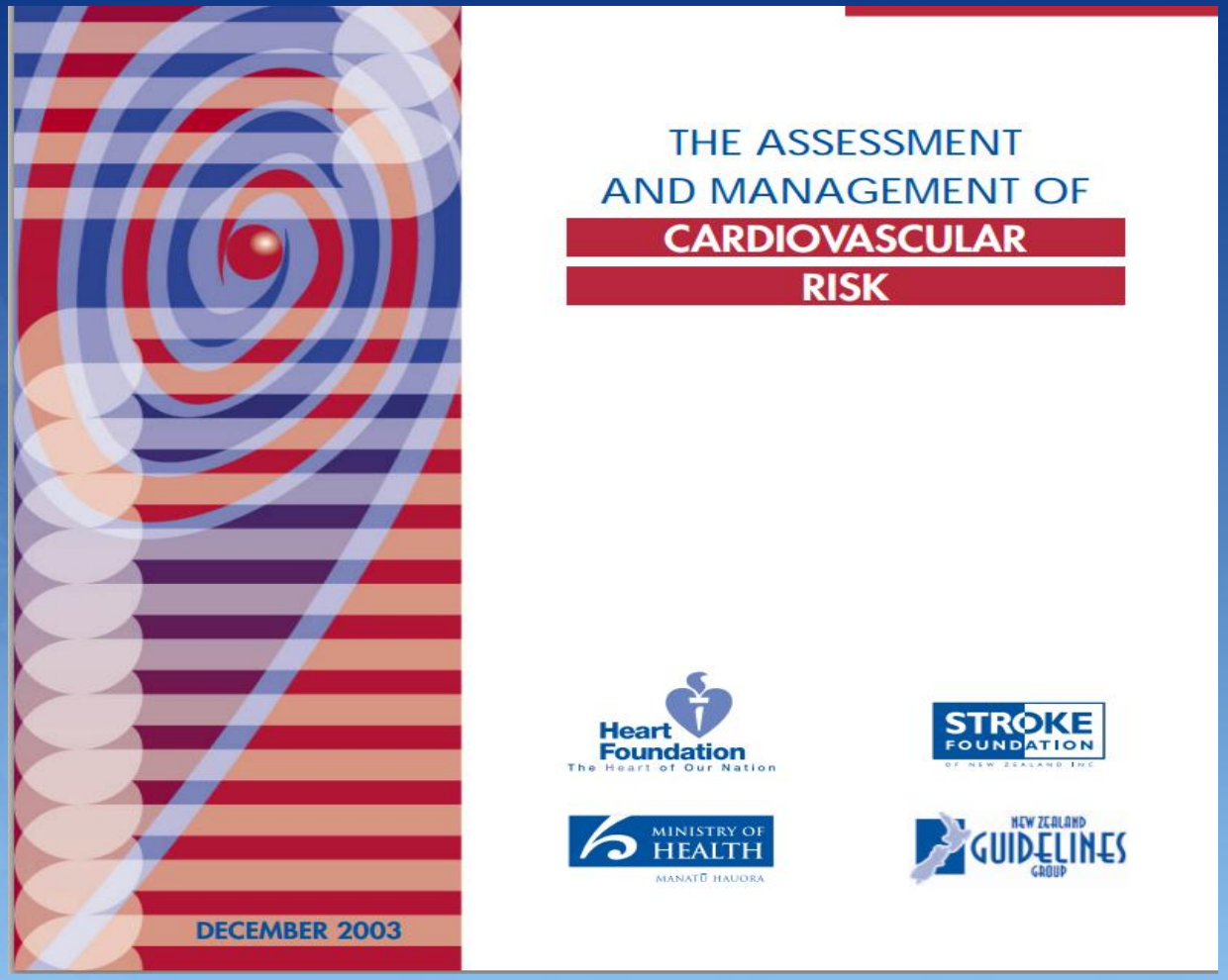
Conclusion. Valid guidelines for the management of genital chlamydial infection have been developed for use in British general practice. Appropriate dissemination and implementation of the guidelines should lead to earlier detection and treatment of men and women with chlamydial infection and thereby reduce the incidence of PID, tubal infertility and ectopic pregnancy in women.

Keywords. *Chlamydia trachomatis*, general practice, guidelines.

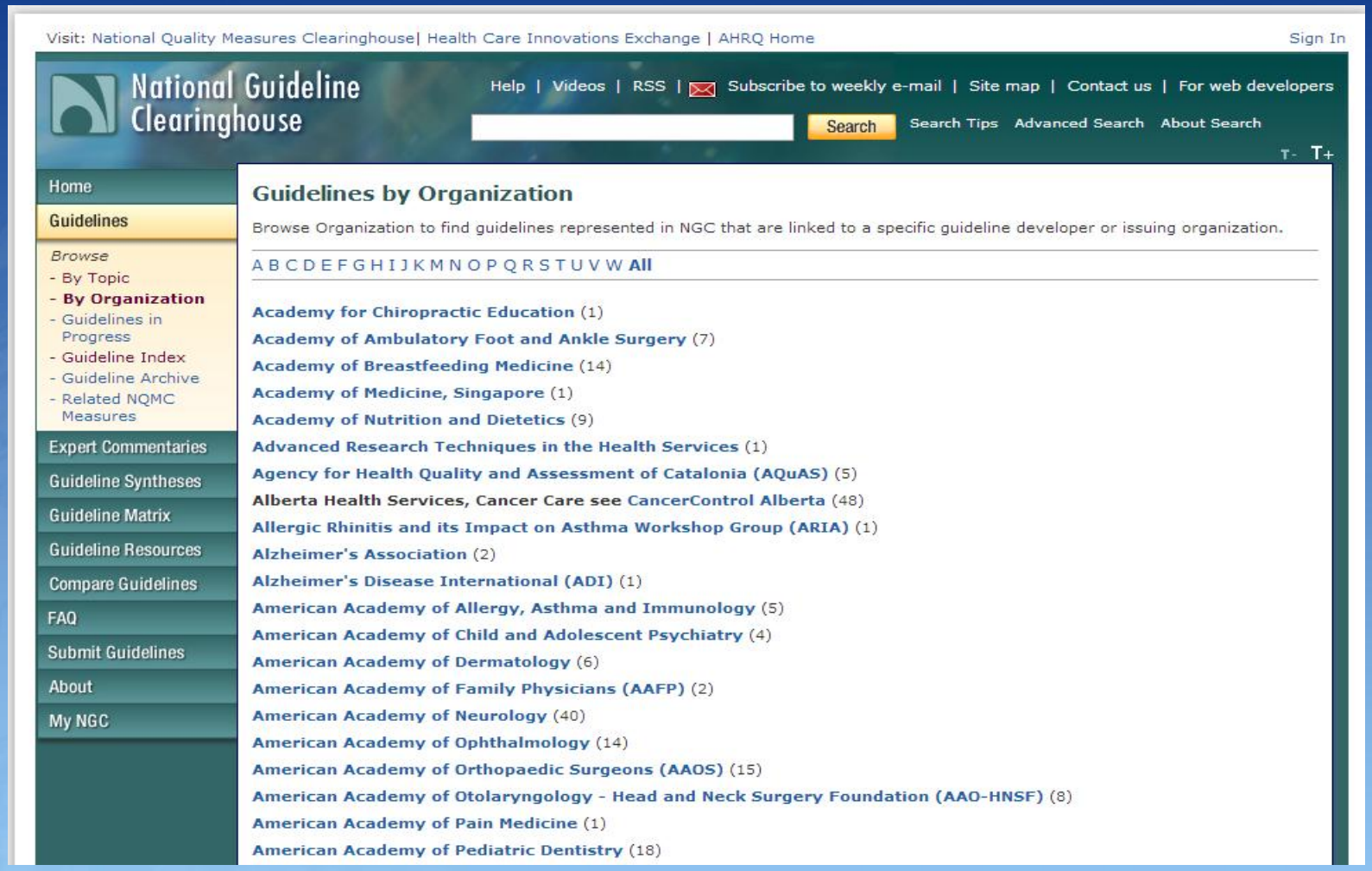
The emergence of the guidelines industry

- Late 1990s onwards:
  - National guidelines ‘take off’
    - Scottish intercollegiate guidelines group (SIGN) (1995-)
    - New Zealand Guidelines Group (1999-2012)
    - National Institute for Health and Clinical Excellence (2002 -)
      - » Early guidelines published by medical royal colleges
      - » Collegiate

Clinical Guidelines



The guidelines industry 2014



The guidelines industry 2014

- National Guideline Clearinghouse (US)
  - 337 organisations producing clinical guidelines
    - Professional societies
  - 2635 guidelines
  - Significant cost to health system
    - NICE 2013/14 annual report
      - £18.4 (NZD 36.8) million spent on clinical guidelines
      - 27% of total NICE expenditure (£68.5 million)
    - What is the cost internationally per year??

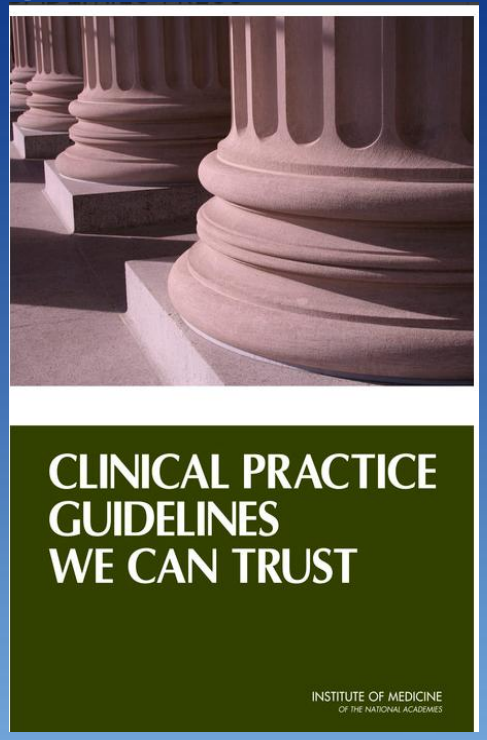
www.guideline.gov/

The problems with clinical guidelines

- 1. Problems with the EBM model
  - The evidence based “quality mark” has been misappropriated by vested interests
    - Everything needs to be “evidence based” ….

Vested interests and clinical guidelines

- Conflicts of interest
  - Pecuniary
  - Nonpecuniary
  - Big pharma
  - Specialist Medical Societies
  - Other health care organisations



Farquhar C, Stokes T, Grey A, Jeffery M, Griffin P. Let the Sunshine in – making industry payments to New Zealand doctors transparent NZMJ 2015 *in press*

Graham T, Alderson P, Stokes T. Managing conflicts of interest in the UK National Institute for Health and Care Excellence (NICE) Clinical Guidelines Programme: qualitative study PLOS ONE 2015 *in press*

The problems with clinical guidelines

- 1. Problems with the EBM model
  - The evidence based “quality mark” has been misappropriated by vested interests
  - The volume of evidence, especially clinical guidelines, has become unmanageable

1998:
All guidelines in 7 years
Number = 855
Height = 68 cm
Weight = 28 kg

Hibble A, Kanka D, Pencheon, Pooles F. Guidelines in general practice: the new Tower of Babel? *BMJ* 1998;317:862

Pile of 855 guidelines in general practices in the Cambridge and Huntingdon Health Authority

2012:
NICE primary care guidelines in 2 years
Number = 31
Height = 236 cm
Weight = 111 kg

Abdelhamid, A., Howe A., Stokes T., Qureshi N., Steel N. Primary care evidence in clinical guidelines: a mixed method study of practioners' views *British Journal of General Practice* 2014 64:e719-e727

Steel N., Abdelhamid A., Stokes T., Edwards H., Fleetcroft R., Howe A., Qureshi N.
A review of clinical practice guidelines found that they were often based on evidence of uncertain relevance to primary care patients. *Journal of Clinical Epidemiology* 2014 67: 1251-1257

The problems with clinical guidelines

- 1. Problems with the EBM model
  - The evidence based “quality mark” has been misappropriated by vested interests
  - The volume of evidence, especially clinical guidelines, has become unmanageable
  - Statistically significant benefits may be marginal in clinical practice
  - Inflexible rules and technology driven prompts may produce care that is management driven rather than patient centred
  - Evidence based guidelines often map poorly to complex multimorbidity

Greenhalgh T, Howick J, Maskrey N BMJ 2014;348:g3725 doi: 10.1136/bmj.g3725

The problems with clinical guidelines

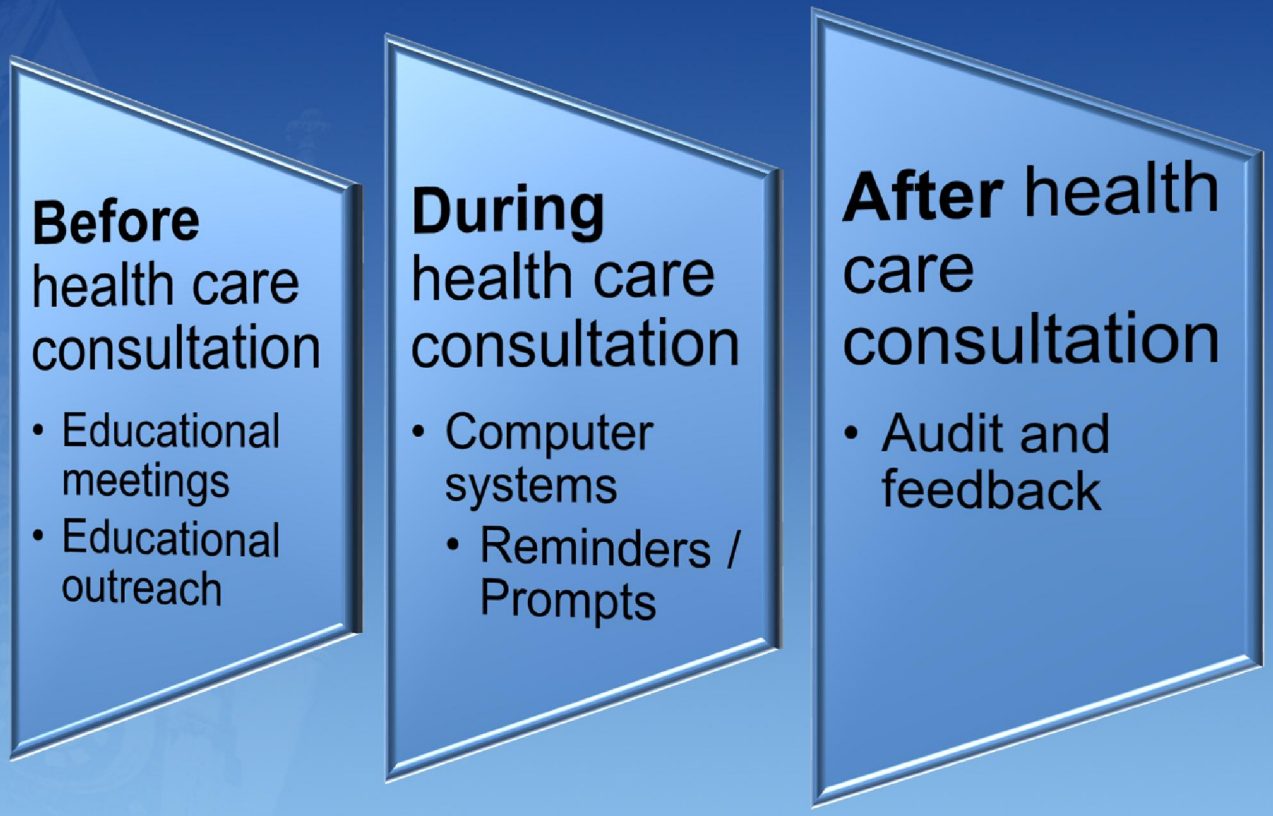
- 2. A means to an end or an end in themselves?
  - The challenge of changing clinical practice
- Grimshaw and Russell 1993/4
  - **Achieving health gain through clinical guidelines. I: Developing scientifically valid guidelines**
    - **Constant evolution …. GRADE movement**
  - **Achieving health gain through clinical guidelines II: Ensuring guidelines change medical practice**
    - **The implementation research agenda**

Grimshaw J, Russell I. Quality in Health Care 1993; 2: 243–248 and 1994;3:45-52.

The problems with clinical guidelines

- 1. Problems with the EBM model
- 2. A means to an end or an end in themselves?
  - The challenge of changing clinical practice
- 3. Limited focus on implementation approaches used
  - Collegiate approaches
    - Education / Audit
  - Implementation at the level of:
    - Individual doctors
    - Practice team

Individual health professional – changing behaviour

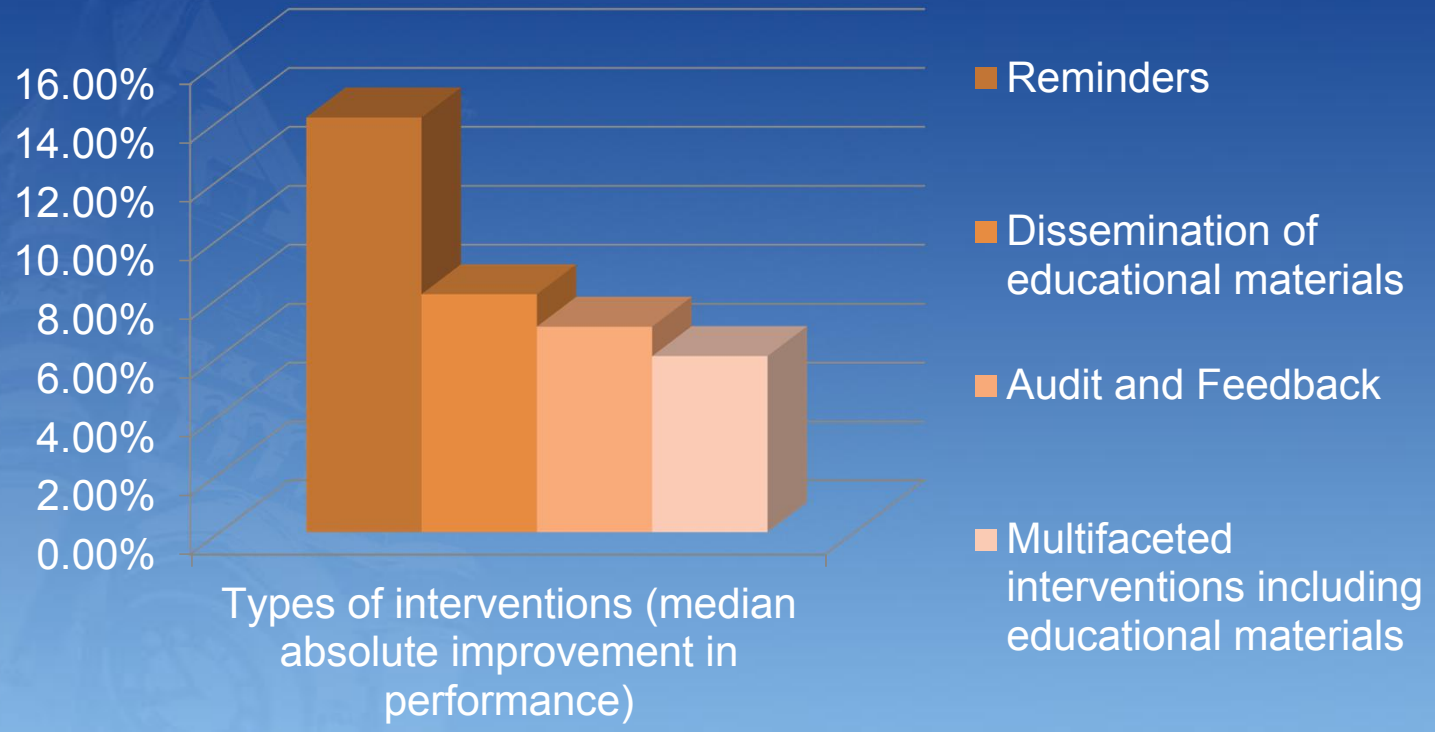


The problems with clinical guidelines

- 3. Limited focus on implementation approaches
  - Collegiate approaches
  - Implementation at the level of:
    - Individual doctors
    - Practice team
  - Does change practice
    - Size of change
    - Sustainability

Effectiveness of guideline dissemination and implementation strategies

Grimshaw et al 2006



Grimshaw, J., Eccles, M., Thomas, R., MacLennan, G., Ramsay, C., Fraser, C. and Vale, L. (2006), Toward Evidence-Based Quality Improvement. Journal of General Internal Medicine, 21: S14–S20

Clinical guidelines need to ….

- 1. Refocus on being a means to an end, not an end in themselves
  - We have valid guidelines … the challenge remains changing practice .... So:

Clinical guidelines need to ….

- 1. Refocus on being a means to an end, not an end in themselves
  - We have valid guidelines … the challenge remains changing practice … so:
  - Aim for efficiencies in guideline production
  - Development needs to be sustainable
    - Sharing of evidence reviews
      - Evidence is international
    - Tailor recommendations to one own health care system
      - Guidance is national

Clinical guidelines need to ….

- 2. Become fully integrated into GP computer systems
  - Full use of recommendations in the consultation
  - Use within and shape the practitioner – patient encounter
- 3. Become embedded in all levels of the health system
  - Not just focus on changing practice in the consultation and within one's own GP practice

Levels of implementation

Ferlie EB, Shortell SM. Improving the quality of health care in the United Kingdom and the United States: a framework for change. Milbank Q. 2001;79(2):281-315

The independent UK organisation responsible for providing national evidence-based guidance advice and standards on the most effective ways to prevent, diagnose and treat disease

NICE National Institute for Health and Care Excellence

The Telegraph

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Nice-approved drugs banned by quarter of health authorities

Cutting-edge drugs are being blacklisted by a quarter of local health authorities, even though they have already been approved by the NHS funding watchdog.

By Stephen Adams, Medical Correspondent
6:30AM GMT 24 Nov 2011

Follow

2 Comments

GPs are being told not to prescribe the drugs, which trials have shown are extremely effective in preventing heart attacks and strokes, as well as fighting cancer, to help make budget savings.

At least 14 drugs previously approved by the National Institute for Health and Clinical Excellence (Nice) have been put on "black" or "double-red" lists by primary care trusts (PCTs).

That is despite the fact that a Nice approval should mean GPs are free to prescribe them to appropriate patients.

A quarter of PCTs that responded to freedom of information requests from *GP magazine* - 19 of 71 - admitted to putting Nice-approved drugs on such lists.

This effectively bans GPs from prescribing them, and the family doctors can be penalised for doing so.

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Health News

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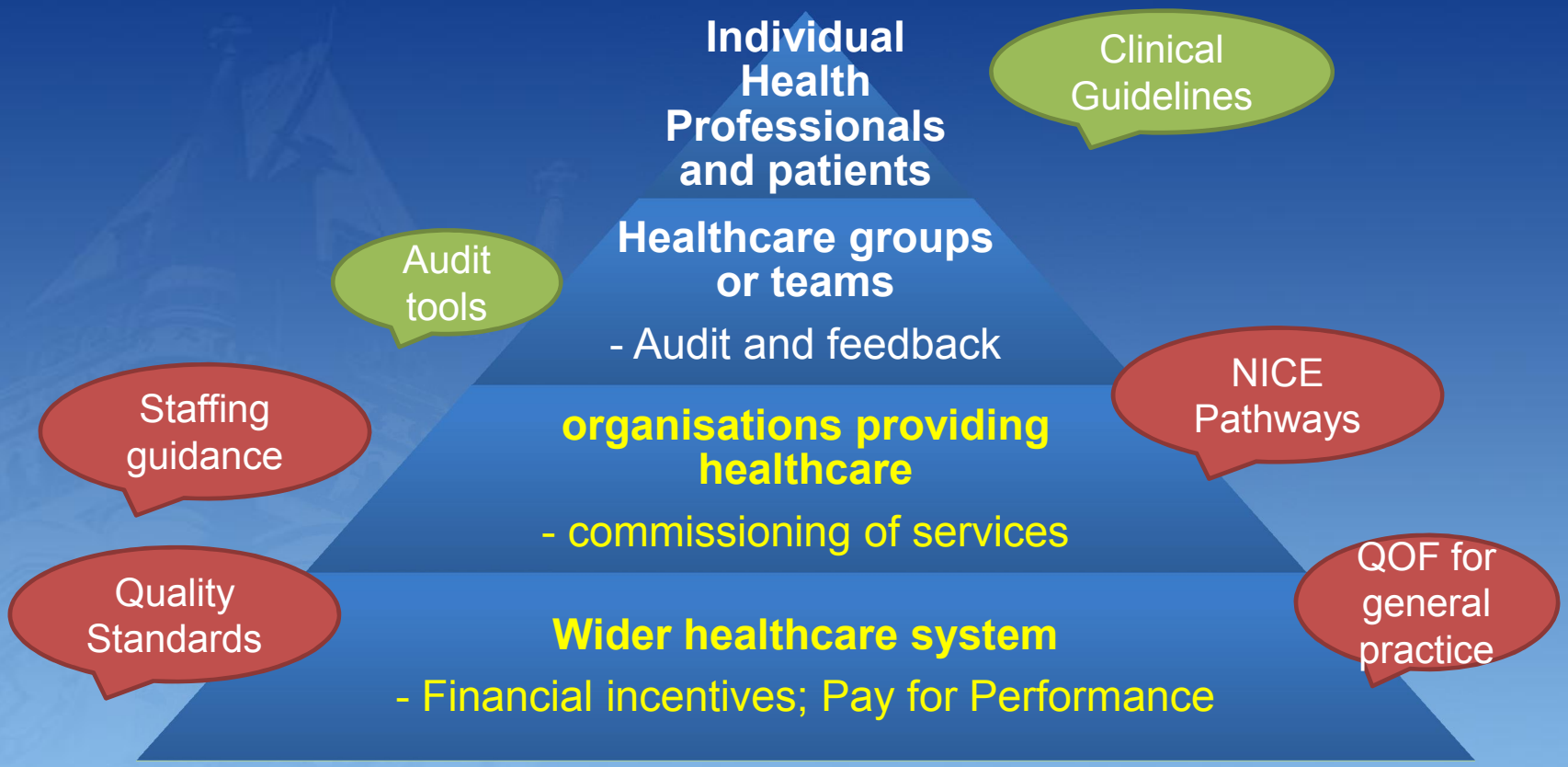
In Health News

Levels of implementation



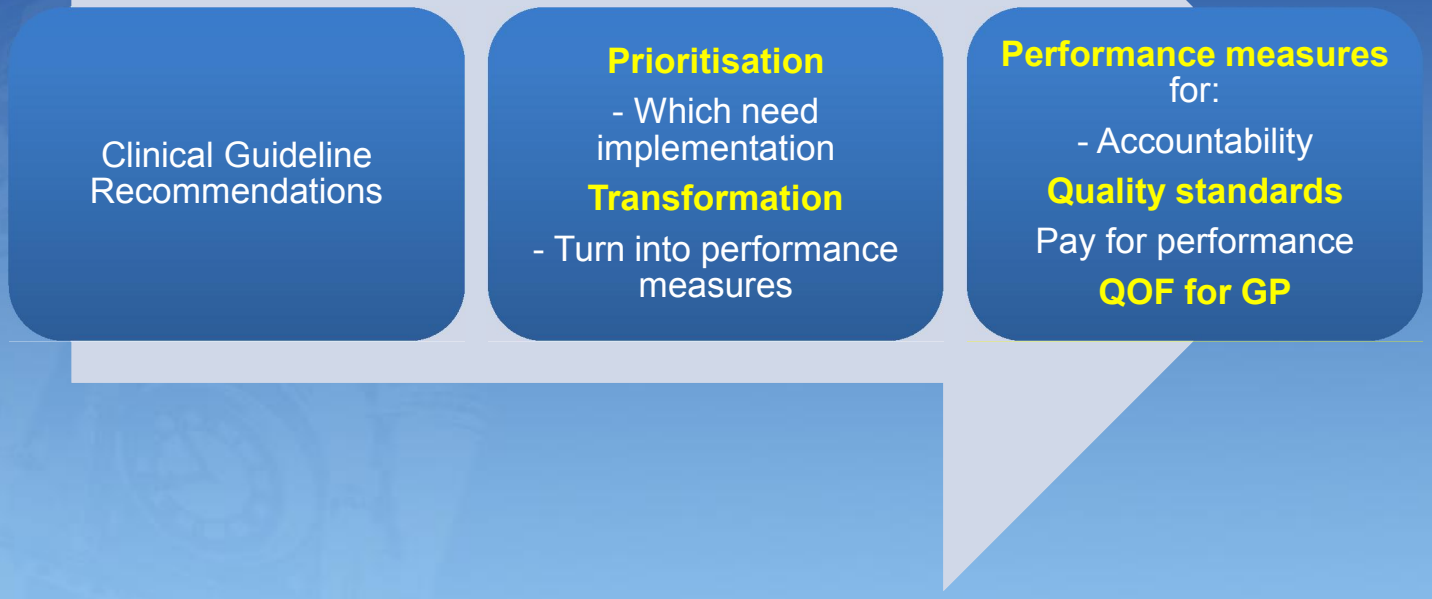
Ferlie EB, Shortell SM. Improving the quality of health care in the United Kingdom and the United States: a framework for change. Milbank Q. 2001;79(2):281-315

The rise of metrics

- “we can only be sure to improve what we can actually measure” (Ara Darzi)
  - Measurement for judgement / accountability
  - Measurement for quality improvement

Department of Health (2008). *High Quality Care for All*

The NICE approach: guideline derived performance measures



The third age of implementation

- Evaluation of Quality improvement initiatives should:
  - Consider effects at all levels in the system (Ferlie and Shortell)
  - Use a variety of methods and approaches
    - Not just quantitative paradigms
  - Do rapid reviews of “what works”
    - Formal evaluations of UK Health Foundation’s QI programmes

Dixon-Woods M, McNicol S, Martin G. healthcare: Ten challenges in improving quality in healthcare: lessons from the Health Foundation's programme evaluations and relevant literature *BMJ Qual Saf*doi: 10.1136/bmjqs-2011-000760

What are the challenges?

DESIGN AND PLANNING OF IMPROVEMENT INTERVENTIONS	Challenge 6: Tribalism and lack of staff engagement
Challenge 1: Convince people that there's a problem	Challenge 7: Leadership
Challenge 2: If you do it, will it work? Convince people of the solution.	Challenge 8: Incentivising participation and 'hard edges'
Challenge 3: Data collection and monitoring systems	**BEYOND THE INTERVENTION: SUSTAINABILITY, SPREAD AND UNINTENDED CONSEQUENCES**
Challenge 4: 'Projectness' and ambitions	Challenge 9: Securing sustainability
ORGANISATIONAL AND INSTITUTIONAL CONTEXTS, PROFESSIONS AND LEADERSHIP	Challenge 10: Side effects of change
Challenge 5: Organisational context, culture and capacities	*Dixon-Woods, McNicol, Martin, 2012*

Concluding thoughts

- Clinical guidelines are here to stay
  - Clinical guideline recommendations remain an important component of knowledge translation
    - Getting evidence into practice
- They need embedding at all levels of the health system
- Quality initiatives need evaluation
  - Need to know what works
  - AND why

Guidelines vs Pathways

Contextualizing the NICE respiratory tract infection pathway for New Zealand

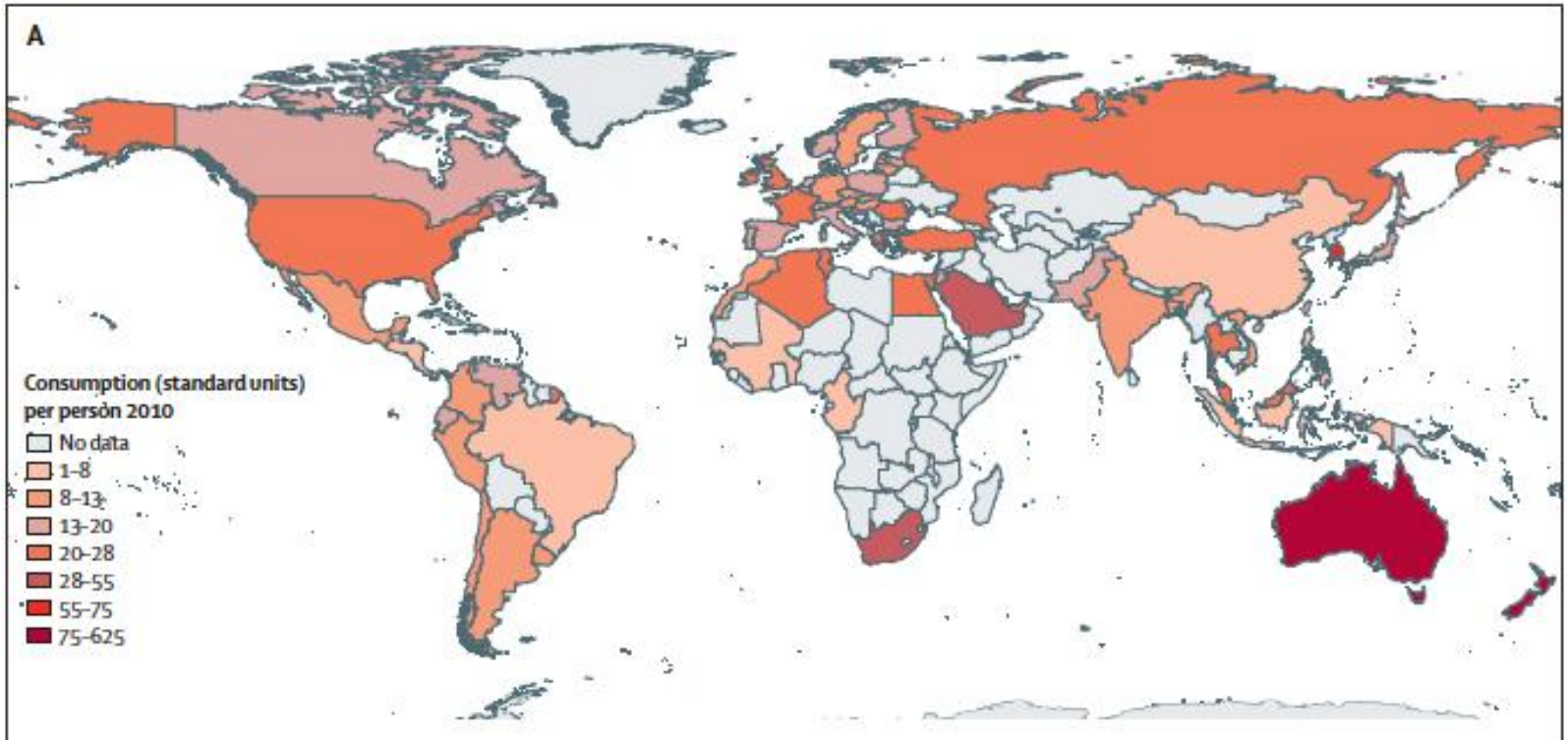
Associate Professor Mark Thomas
Dept Molecular Medicine and Pathology
University of Auckland

NICE/bpac^{nz} symposium
Te Papa, Wellington
4 March 2015

Key messages

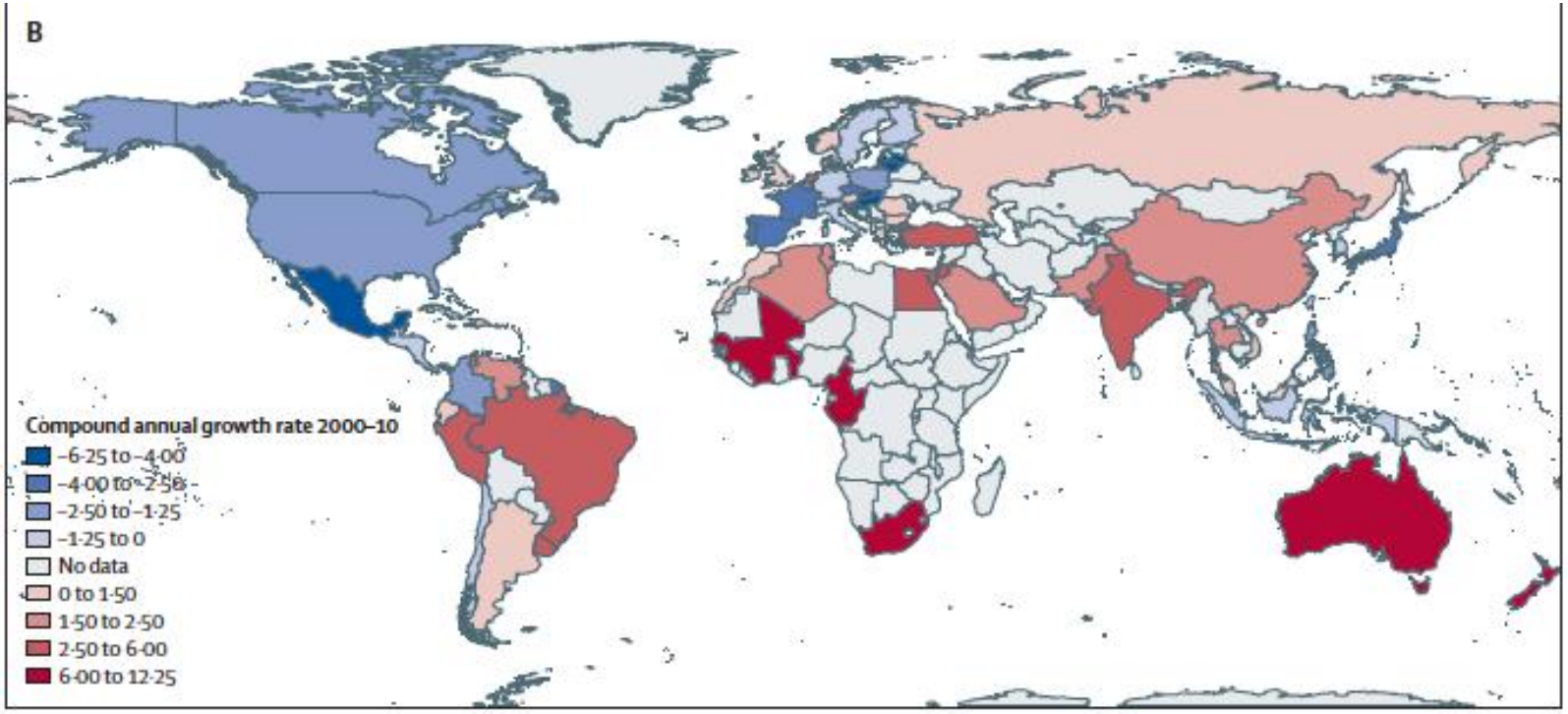
1. Antibiotic prescribing in NZ is excessive
2. Much of this excessive prescribing is for patients with respiratory tract infections
3. There is an absence of evidence of a sustained improvement in prescribing for respiratory tract infections in NZ in recent years
4. The NICE guidelines are in most respects applicable for the NZ context
5. Guidelines/pathways are not enough

National per capita consumption of antibiotic “units”
(IMS data 2010)



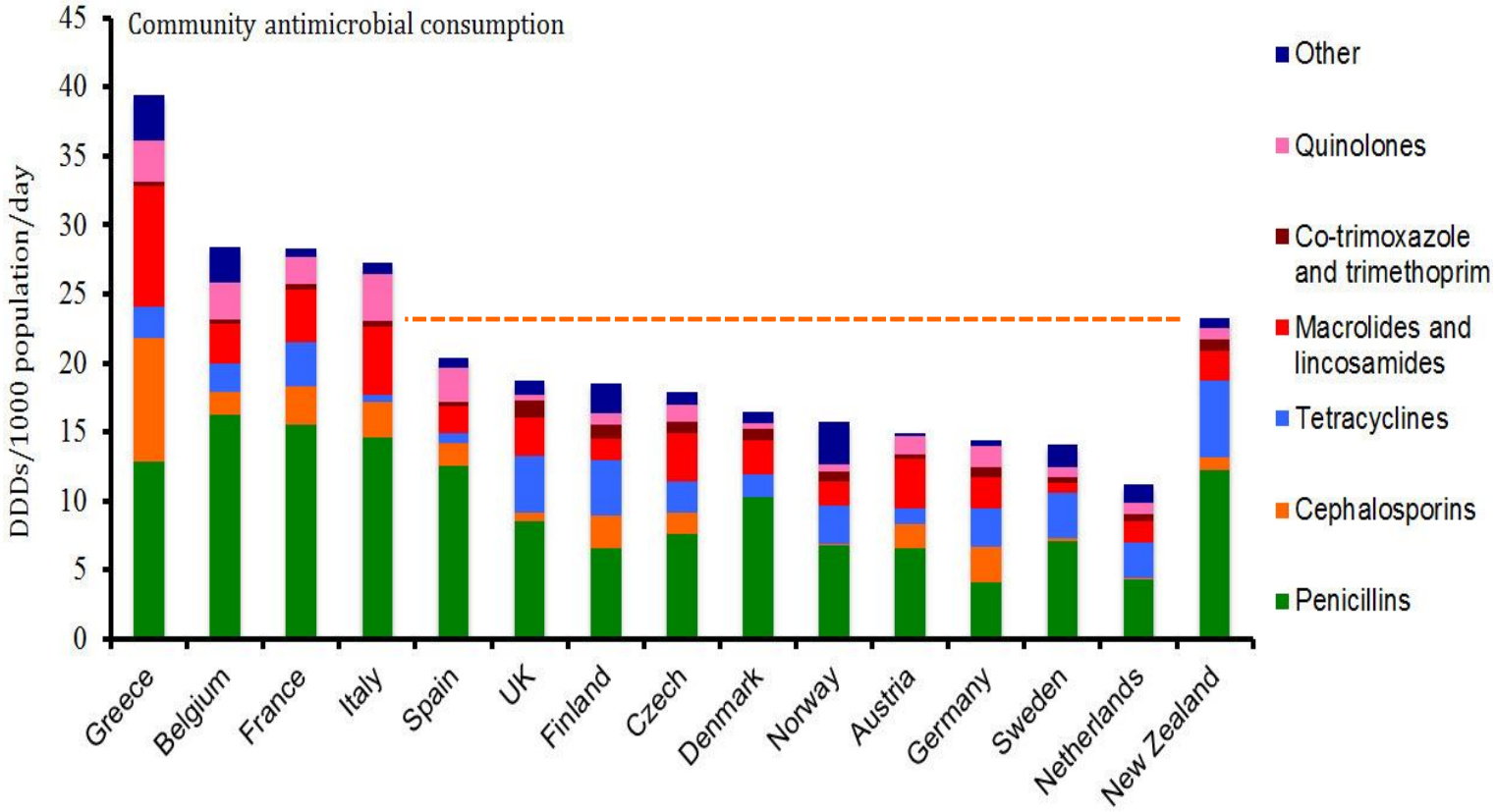
Van Boeckel et al. Lancet Infectious Diseases 2014;

Rate of change in national per capita antibiotic “unit” consumption 2000 - 2010



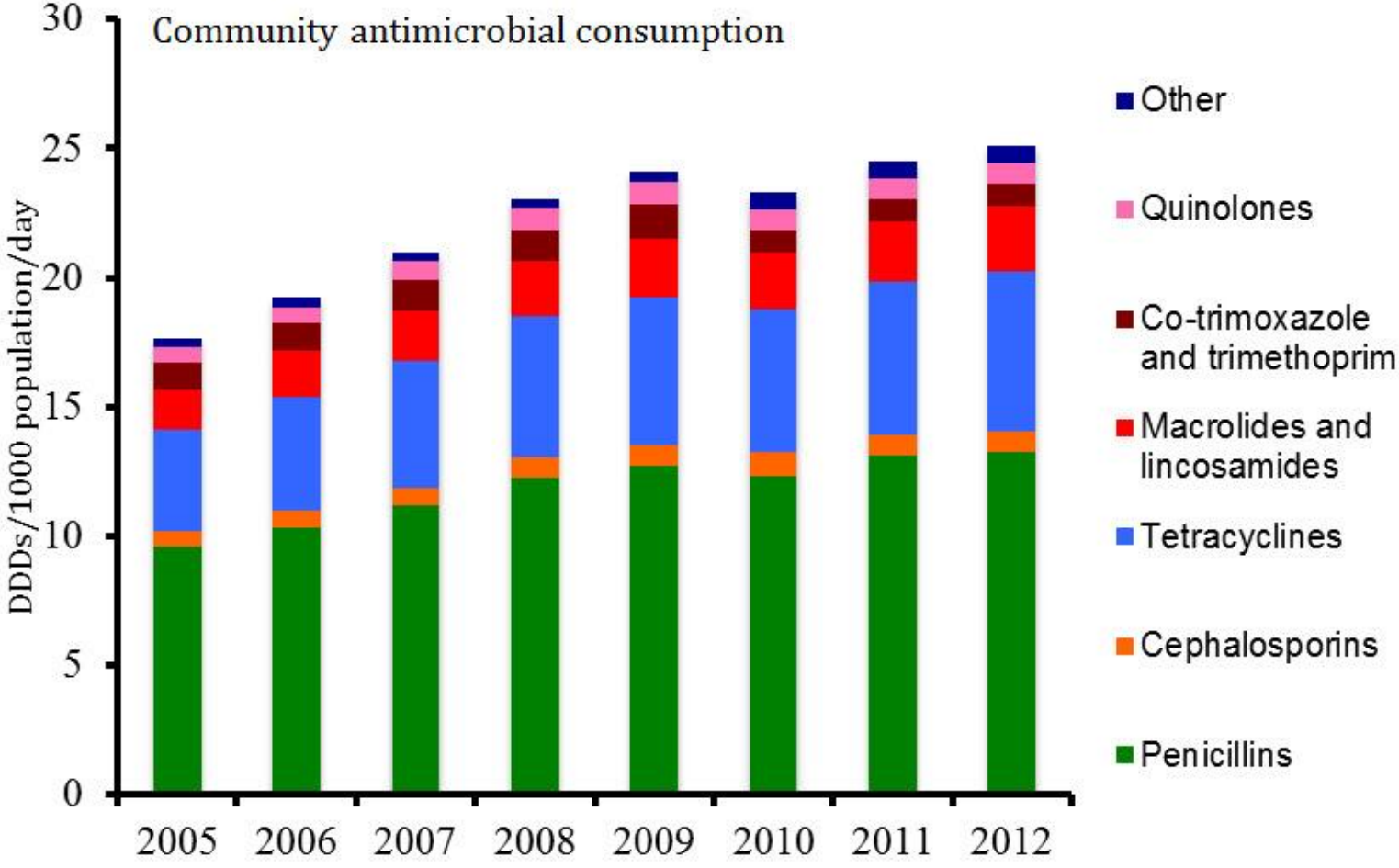
Van Boeckel et al. Lancet Infectious Diseases 2014;

Community antibiotic consumption in NZ 2010 (DDDs/1000 population/day)



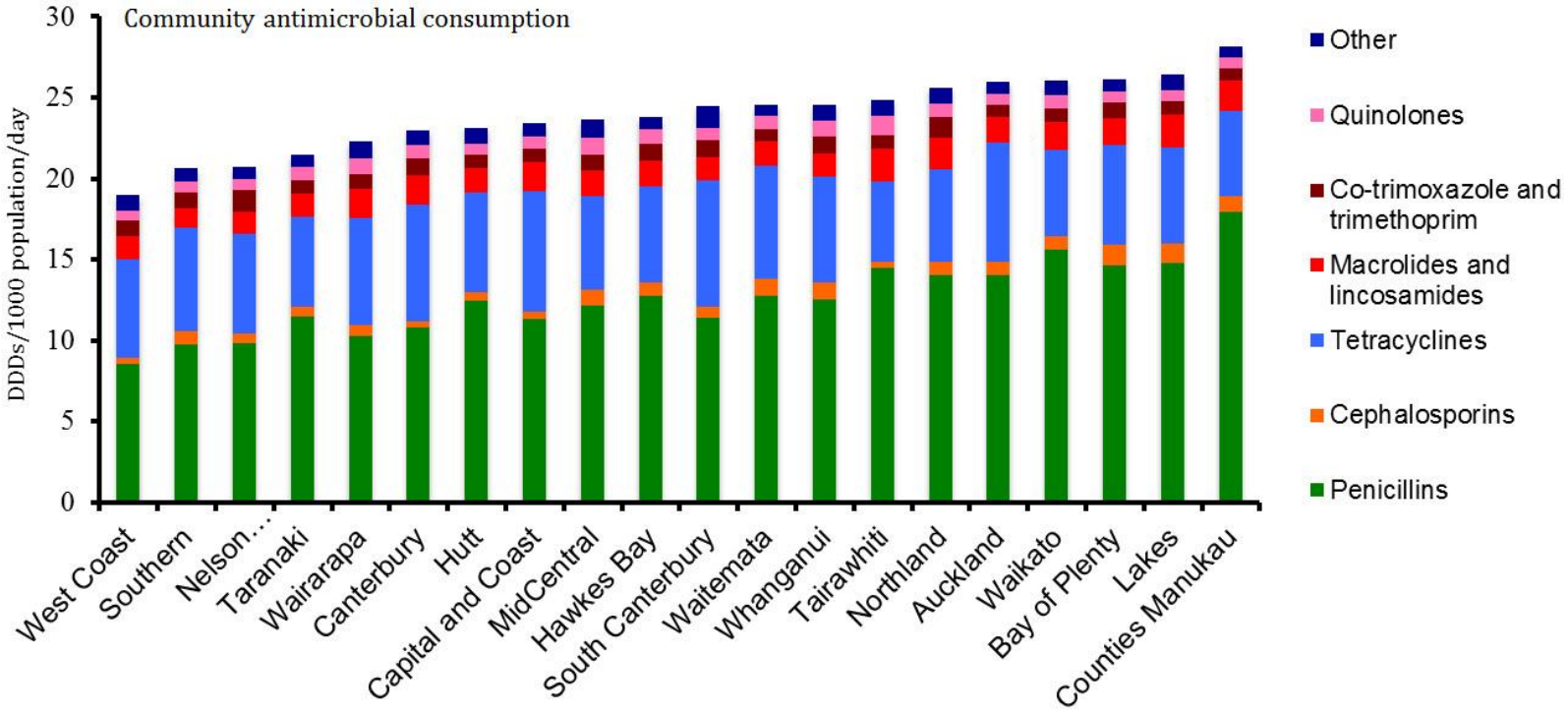
Thomas, Smith, Tilyard. NZMJ 2014;127:1394:1-13.

Community antibiotic consumption in NZ increased by approx 6% per year 2005-2012



Thomas, Smith, Tilyard. NZMJ 2014;127:1394:1-13.

Modest variation between DHBs in community AB consumption (2012)



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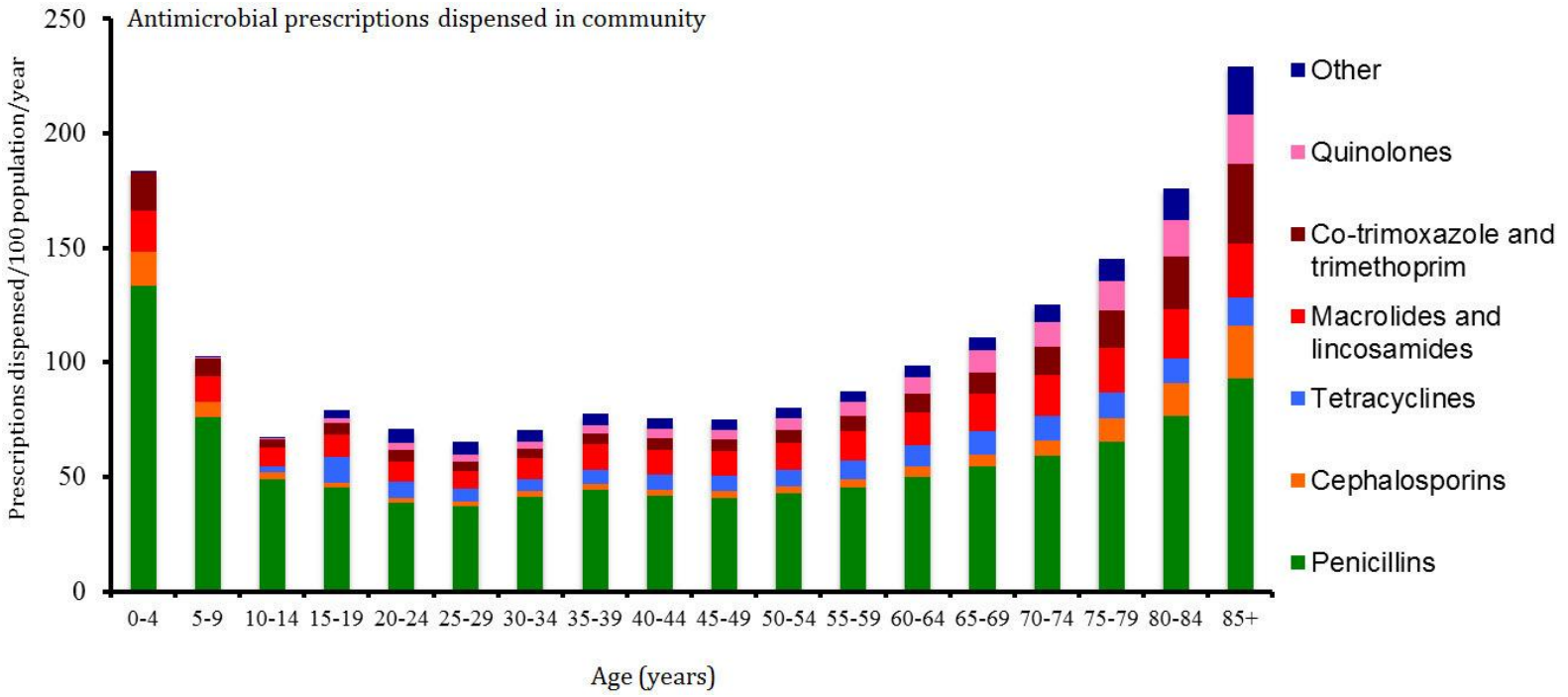
High rates of dispensing across age groups (2012)



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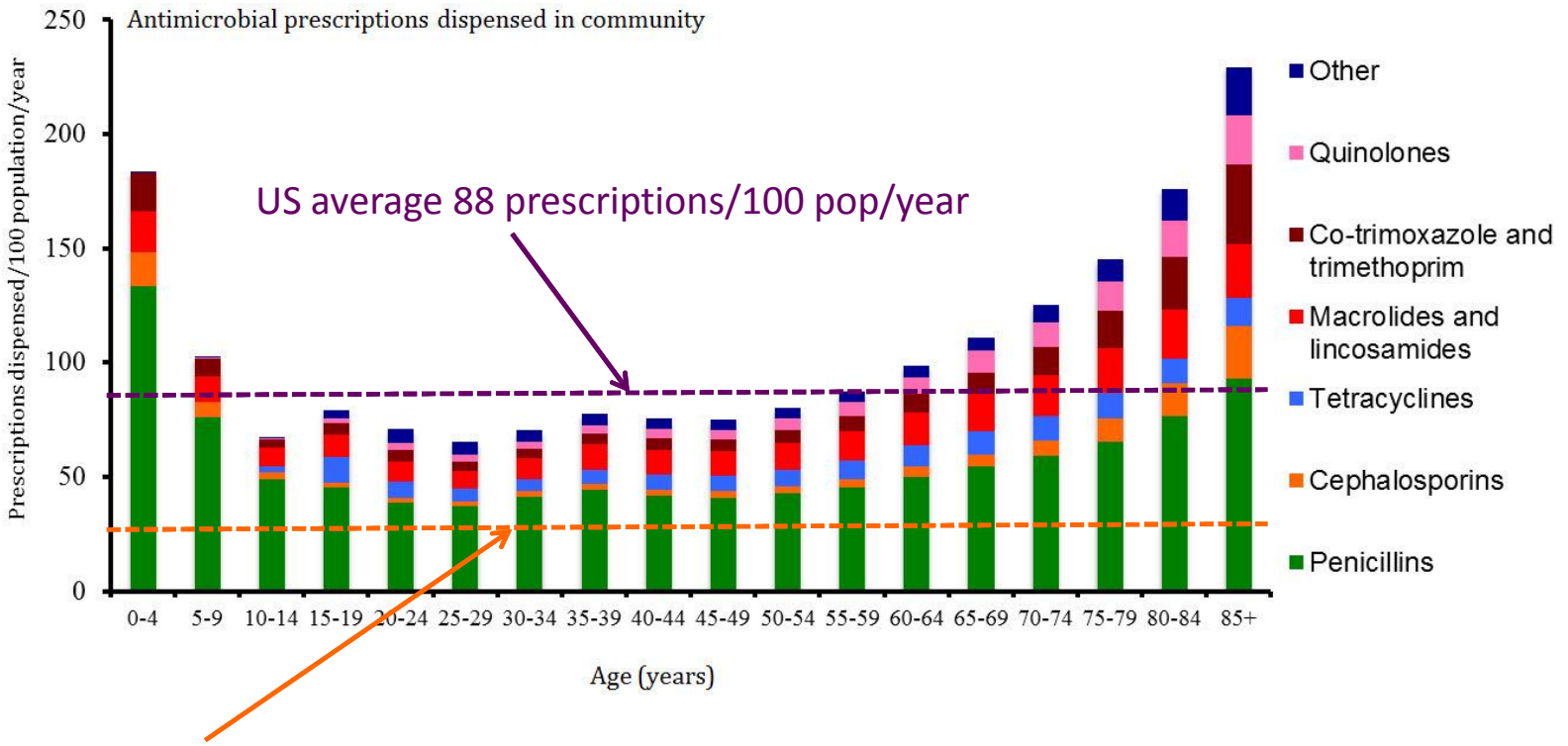


Thomas, Smith, Tilyard. NZMJ 2014;127:1394:1-13.

How much of this **excessive prescribing** is for patients with **respiratory tract infections**?

Sparse NZ data

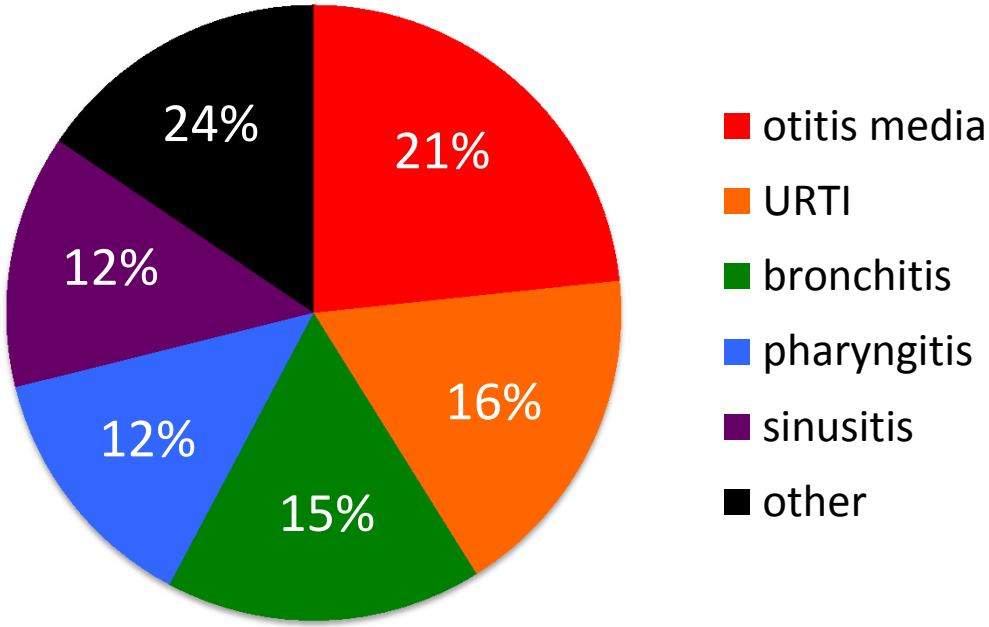
But probably a large proportion.

What conditions are treated with an antibiotic?

34,606 consultations with 3,000 community-based US physicians

during 1992 (similar results during '80,'85,'89).

percentage of total AB prescribing



McCaig & Hughes. JAMA 1995;273:214-9.

Antibiotic prescribing for URTI is common in NZ

Computerised records for 100,222 patients in 17 general practices in NZ (12mths 1991-1992).

28,286 consultations (8.9%) for URTI.

Treatment	Proportion
No antibiotic	22.5%
Amoxycillin	21.7%
Amox/clav	18.7%
Cotrimox	9.7%
Cefaclor	9.1%

Rates of prescribing per general practice = 61 – 89% **(mean = 76%)**

McGregor, Dovey, Tilyard. Antibiotic use in upper respiratory tract infections in New Zealand. Family Practice1995;12:166-70.

What features would encourage you to prescribe antibiotics?

(Telephone interviews of 65 Auckland GPs)

	1998	2002-3	p
Symptoms of sinusitis	68%	98%	0.00001
Purulent nasal discharge	52%	71%	0.029
Green coloured sputum	63%	75%	0.86
Patient requests antibiotics	38%	62%	0.1

Sung et al. NZMJ 2006;119: 1233: 1-7.

NICE Guidelines (July 2008)

1.1 At the first face-to-face contact in primary care, including walk-in centres and emergency departments, adults and children (3 months and older) presenting with a history suggestive of the following conditions should be offered a clinical assessment:

- acute otitis media
- acute sore throat/acute pharyngitis/acute tonsillitis
- common cold
- acute rhinosinusitis
- acute cough/acute bronchitis.

The clinical assessment should include a history (presenting symptoms, use of over-the-counter or self medication, previous medical history, relevant risk factors, relevant comorbidities) and, if indicated, an examination to identify relevant clinical signs.

1.3 A no antibiotic prescribing strategy or a delayed antibiotic prescribing strategy should be agreed for patients with the following conditions:

- acute otitis media
- acute sore throat/acute pharyngitis/acute tonsillitis
- common cold
- acute rhinosinusitis
- acute cough/acute bronchitis.

condition	NICE *	bpac
Acute otitis media	Antibiotic Rx if: 1. bilat OM in child <2 yrs 2. acute OM + otorrhoea	Antibiotic Rx is usually unnecessary
Acute sore throat	Antibiotic Rx if: ≥ 3 Centor criteria present	Recommended for those at increased risk of rheumatic fever
Common cold		No advice
Acute rhinosinusitis		Consider antibiotics for those with severe symptoms
Acute cough/bronchitis	Antibiotic Rx if: age > 65 yrs plus 2 criteria age >80yrs plus 1 criterion (a) Hospitalisation in last year (b) Diabetes (c) CHF (d) Steroid Rx	Acute COPD – Antibiotic treatment is most helpful in patients with severe symptoms and those with more severe airflow obstruction at baseline
	* Not applicable if: (a) Patient very unwell (b) Patient at high risk of serious complications	

Centor criteria

Temperature >38	1
Absence of cough	1
Swollen, tender anterior cervical lymph nodes	1
Tonsillar exudate	1
Age: 3 – 14	1
15 - 44	0
≥ 45	-1

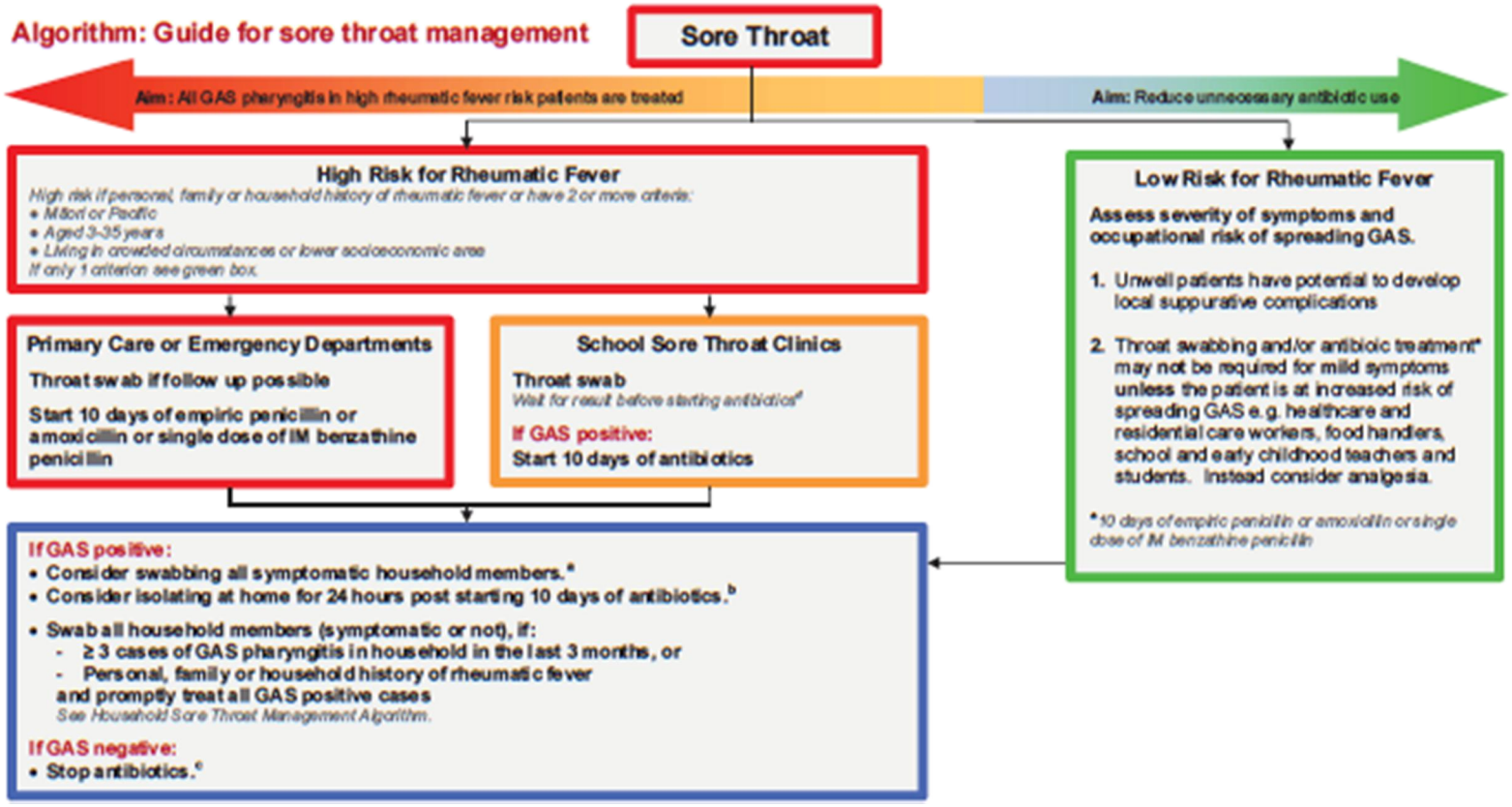
Centor score : Probability of *S. pyogenes* infection

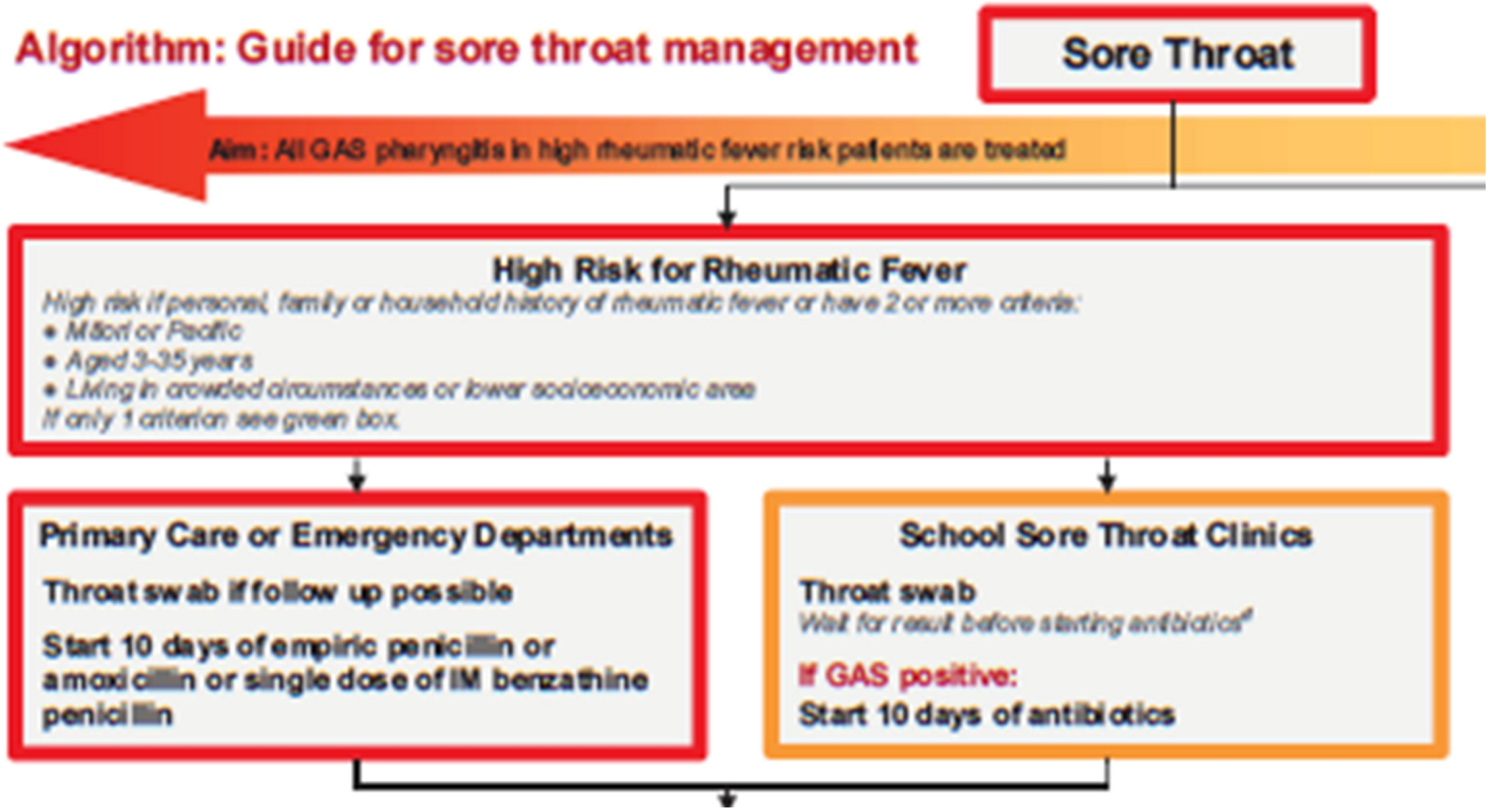
0 : 2.5% 1: 6.5% 2: 15% 3: 32% 4: 56%

McIsaac et al. JAMA 2004;291:1587-95.


"MY BROTHER ALMOST DIED."
IT STARTED WITH A SORE THROAT
SORE THROATS
RHEUMATIC FEVER
HEART DAMAGE
A sore throat can lead to Rheumatic Fever and heart damage. If your child has a sore throat take them to a free Sore Throat Clinic or see a doctor or nurse.
STOP

NZ Heart Foundation Group A streptococcal sore throat management guideline 2014




Algorithm: Guide for sore throat management
Sore Throat
Aim: All GAS pharyngitis in high rheumatic fever risk patients are treated
High Risk for Rheumatic Fever
High risk if personal, family or household history of rheumatic fever or have 2 or more criteria:
• Māori or Pacific
• Aged 3-35 years
• Living in crowded circumstances or lower socioeconomic area
If only 1 criterion see green box.
Primary Care or Emergency Departments
Throat swab if follow up possible
Start 10 days of empiric penicillin or amoxicillin or single dose of IM benzathine penicillin
School Sore Throat Clinics
Throat swab
Wait for result before starting antibiotics*
If GAS positive:
Start 10 days of antibiotics

NZHF Sore Throat Guidelines

In people at “High Risk for Rheumatic Fever”

1. No use of clinical criteria to diagnose bacterial illness
2. Throat swab “if follow-up possible”
3. Start 10 days of antibiotics
   Amoxycillin, Penicillin V, Benzathine penicillin

4. “Recurrent GAS or chronic GAS”
   Cephalexin, Augmentin, Benzathine penicillin

Conclusions

1. NICE guidelines for acute OM, common cold, acute rhinosinusitis, acute cough/bronchitis are very similar to bpac guidelines

1. Important differences between NICE guidelines and NZ guidelines for sore throat

2. NICE guidelines are even more concise than the bpac guidelines

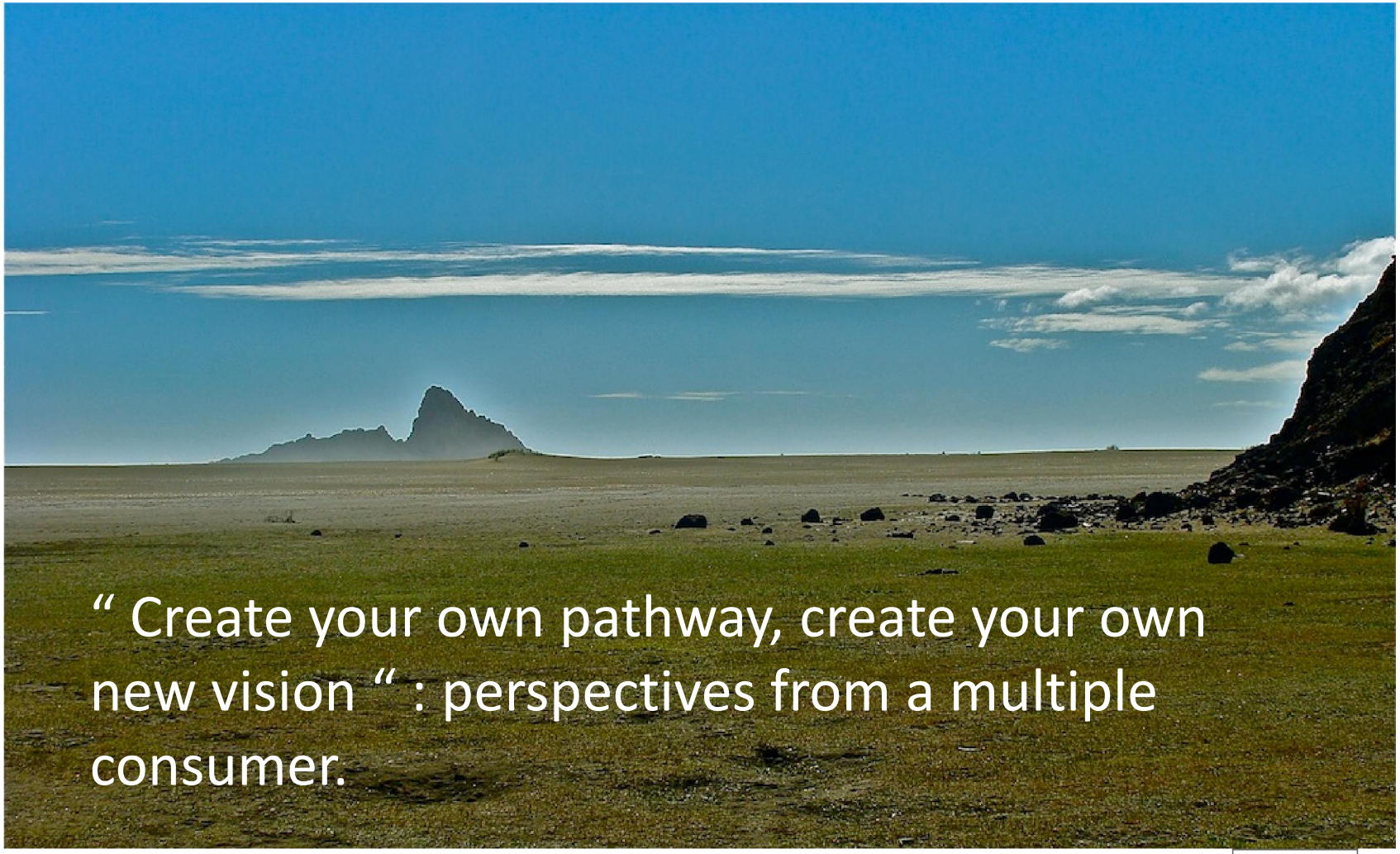
Problems

1. Introduction of guidelines/pathways has relatively small effect on prescriber behaviour (approx 5-10%)

   (Butler et al. BMJ 2012;344:d8173)

2. Effects of other interventions are less well studied. but auditing prescriber behaviour has been effective with other problems. (vaccine uptake, smoking cessation advice, etc.)

3. Sore throat management guidelines in NZ are not consistent with NICE (or Australian or US) guidelines.



“ Create your own pathway, create your own new vision “ : perspectives from a multiple consumer.

Department of Primary Health Care and General Practice
University of Otago – Wellington – New Zealand
Tony Dowell

This afternoon

- Consumer perceptions of guidelines
- Guidelines and pathways – the most exciting thing since the last exciting thing
  - An 8 point plan
  - Complexity
  - Hard to reach topics

A multiple consumer ?

Guideline Producer

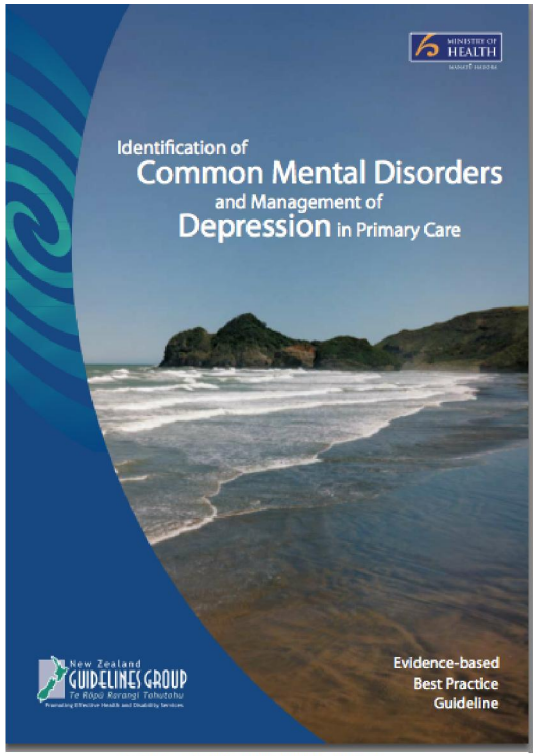
- 1992 Leeds Dyspepsia Guideline
- 2008 Common mental disorder

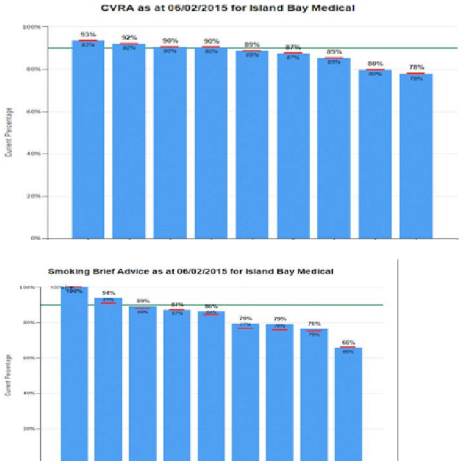
Guideline Evaluator

- Review of NZGG
- Evaluation of mental health guidelines

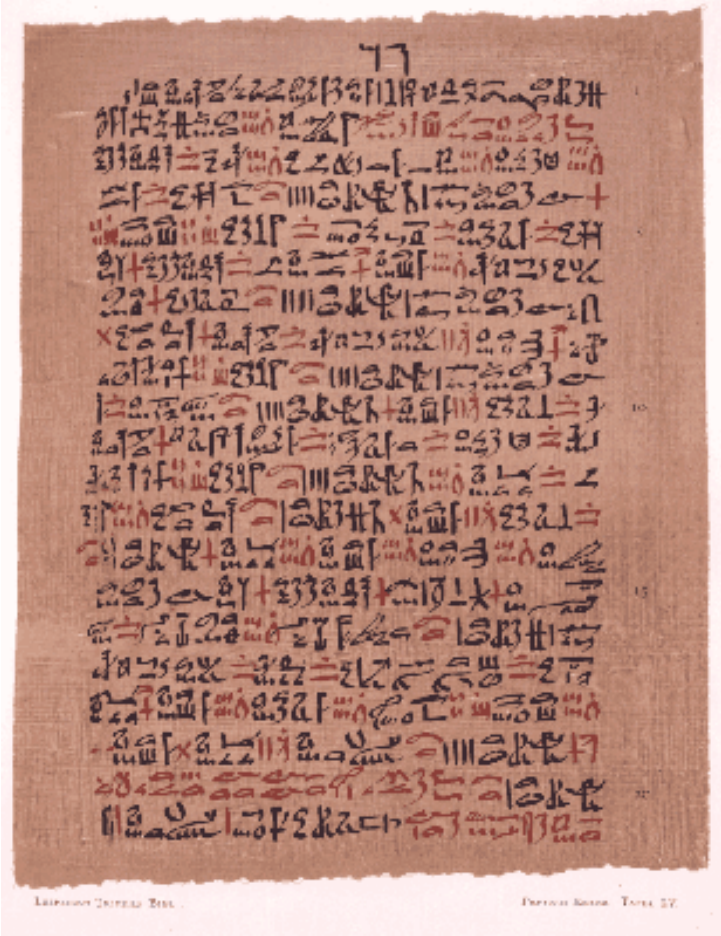
And

- Recidivist enthusiast practitioner
- Pathway novice and advisor
- Patient





History of Guidelines and Pathways



- The Ebers papyrus – Egypt 1500 BCE
- 1850's – public health programmes – 'Do the same thing'
- 1950's – growth of medical research and RCTs
- EBM – 1980's
- 1998 – AGREE Collaboration, NICE, NZGG
- 2012 onwards – Guidelines to Pathways

Pathways


TE ARA TAURIMA
3D HealthPathways
Wairarapa, Hutt Valley and Capital & Coast District Health Boards
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Allied Health
Child Health
Investigations
Lifestyle & Preventive Care
Medical
Mental Health
Older Person's Health
Pharmacology
Public Health
Surgical
Women's Health
Our Health System
What is HealthPathways?
HealthPathways provides a manual for general practice teams to manage and refer their patients to secondary, tertiary, and community services. The pathways have been designed for use during consultation and are jointly developed by consensus and collaboration between hospital clinicians and general practice teams.
The 3D HealthPathways has been developed by clinicians from the Wairarapa, Hutt Valley and Capital & Coast DHB areas. The 3D HealthPathways team are currently working on publishing additional new pathways developed across the subregion in recent years. As time allows, they will also work through the existing Canterbury pathways to reflect our local service arrangements.
Special Notices
Public Health Alert: Measles (1st October)
Latest Localised Pathways
Increased Haemoglobin
Thrombocytosis
Chronic Hepatitis B
Chronic Hepatitis C
Ebola
Cognitive Impairment and Dementia
Elder Abuse and Neglect
Carer Stress
Carpal Tunnel Syndrome
Intermenstrual and/or Post Coital Bleeding
Heavy or Irregular Menses
Hernia in Adults
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View a video and FAQ on using the formulary.
HealthInfo
Open HealthInfo
What is HealthInfo?
Add link to MedTech
Most Frequently Viewed Pathways
1. Cellulitis
2. Cognitive Impairment and Dementia
3. Deep Vein Thrombosis (DVT)
4. Tonsillitis and Sore Throat
5. Colonoscopy
6. Heavy or Irregular Menses
7. Rheumatic Fever
8. Carpal Tunnel Syndrome
9. Smoking Cessation Advice

Pathways: Are we sure what they are?

- **Web-based** information portal **supporting primary care clinicians** to plan patient care through primary, community and secondary health care systems
- A 'care map', so that **all members of a health care team** can be on the **same page** when it comes to looking after a **particular person**.
- Primarily for **General Practitioners** but is also **available to Hospital Specialists**, Nurses, Allied Health and other Health Professionals

What do consumers think of them

- Question (to GP colleagues) – What do you think of clinical pathways ?

"Are they the ones on 'healthpoint' ? - GP (Feb 2015)

"Well – they're a bit.....well they're a bit , well actually they're a bit boring - GP (March 2015)

Are pathways different to guidelines

With guidelines, it was a bunch of people, usually hospital specialists sitting round a table, eating rubbery chicken sandwiches deciding what was good for us …

With clinical pathways you have people from both the hospital and general practice, all eating the same chicken sandwiches

Why don’t clinicians follow guidelines

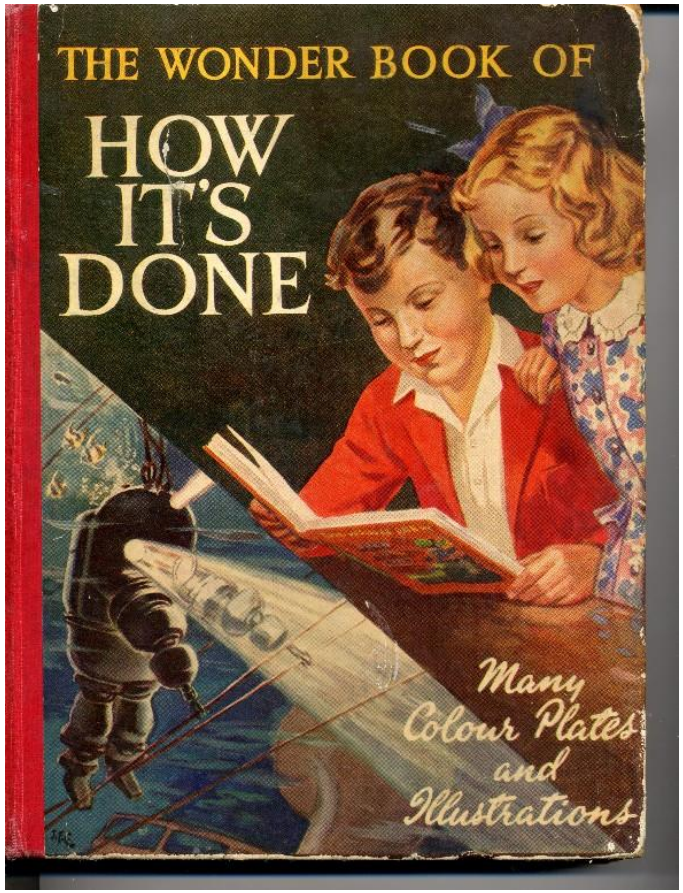
- Focus groups, interviews , surveys
- 1999 onwards (Cabana)

e.g. Lutenberg 2009 – Dutch.

- Lack of agreement with the recommendations
  - lack of applicability
  - lack of evidence
- Environmental factors
  - Organisational constraints
  - Time , resources
- Lack of knowledge about guideline recommendations
- Unclear or ambiguous guideline recommendations

Ways forward

1. Clarity of purpose
2. Acknowledging complexity
3. Mismatch with clinical reality?
4. Style and substance
5. Celebrate success
6. The look of the thing
7. Teamwork and behaviour
8. Humanity in activity



The future is already here - it's just unevenly distributed." - William Gibson.

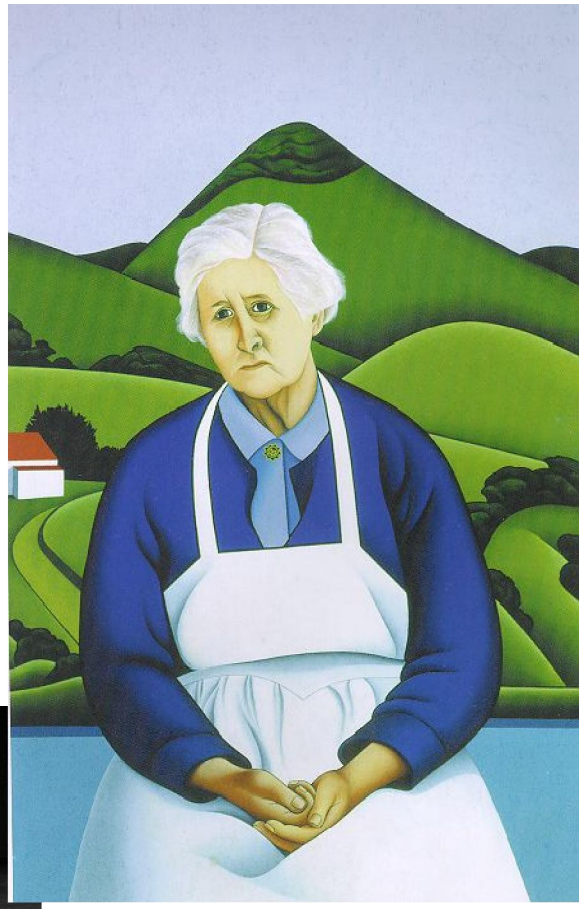
1. Clarity of purpose and meaning

- What is it for?
- Who is it for?
- What are the priorities?
- How to signpost them ?

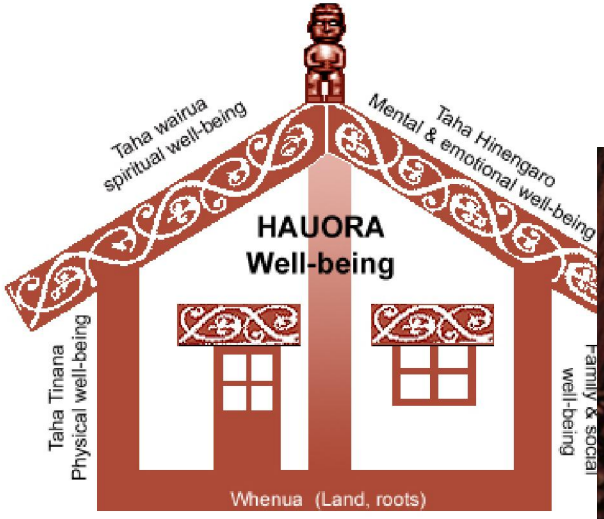
Doing the right thing and doing it right

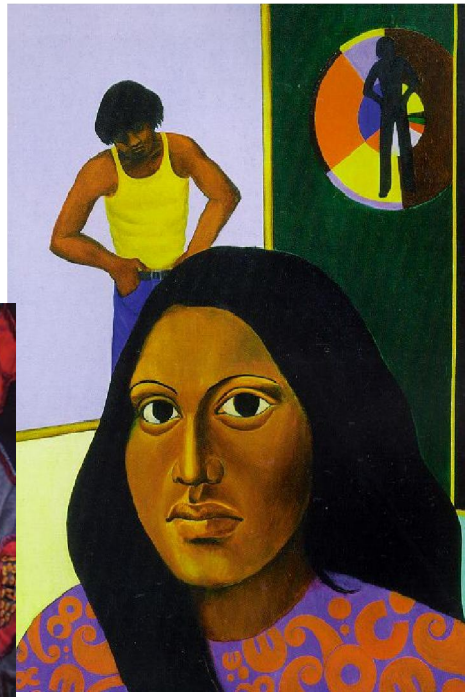
- Doing it right is *relatively* straightforward
  - We can get clinicians to do the same things
  - Doing " wrong things " very well
- Doing the right thing – much more complicated
  - What is the *right* thing?
  - What is the *best* thing?
- Guidelines and pathways should be about doing the right thing.

Pathways across the life course



Cultural responsiveness





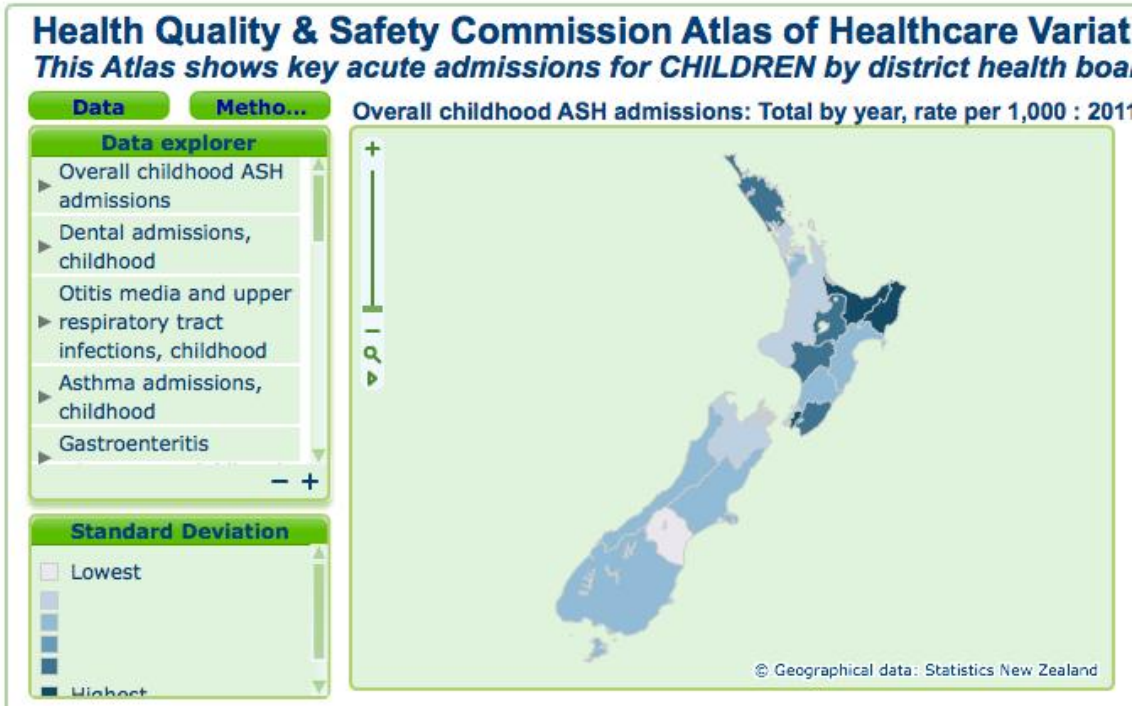
2. Acknowedging Complexity

Simple or not ?

Should Bethany go to hospital ?

- 14 months old - Onset of difficulty breathing and wheeze
- Smoking household . Damp house, poor nutrition
- Anxious solo mum
- Seen at GP – " Wheezy infant " , Feeding less than usual
- Apyrexial , Resp rate 35, HR 120, Wheezing.
- Intercostal indrawing

A bit of complexity ?

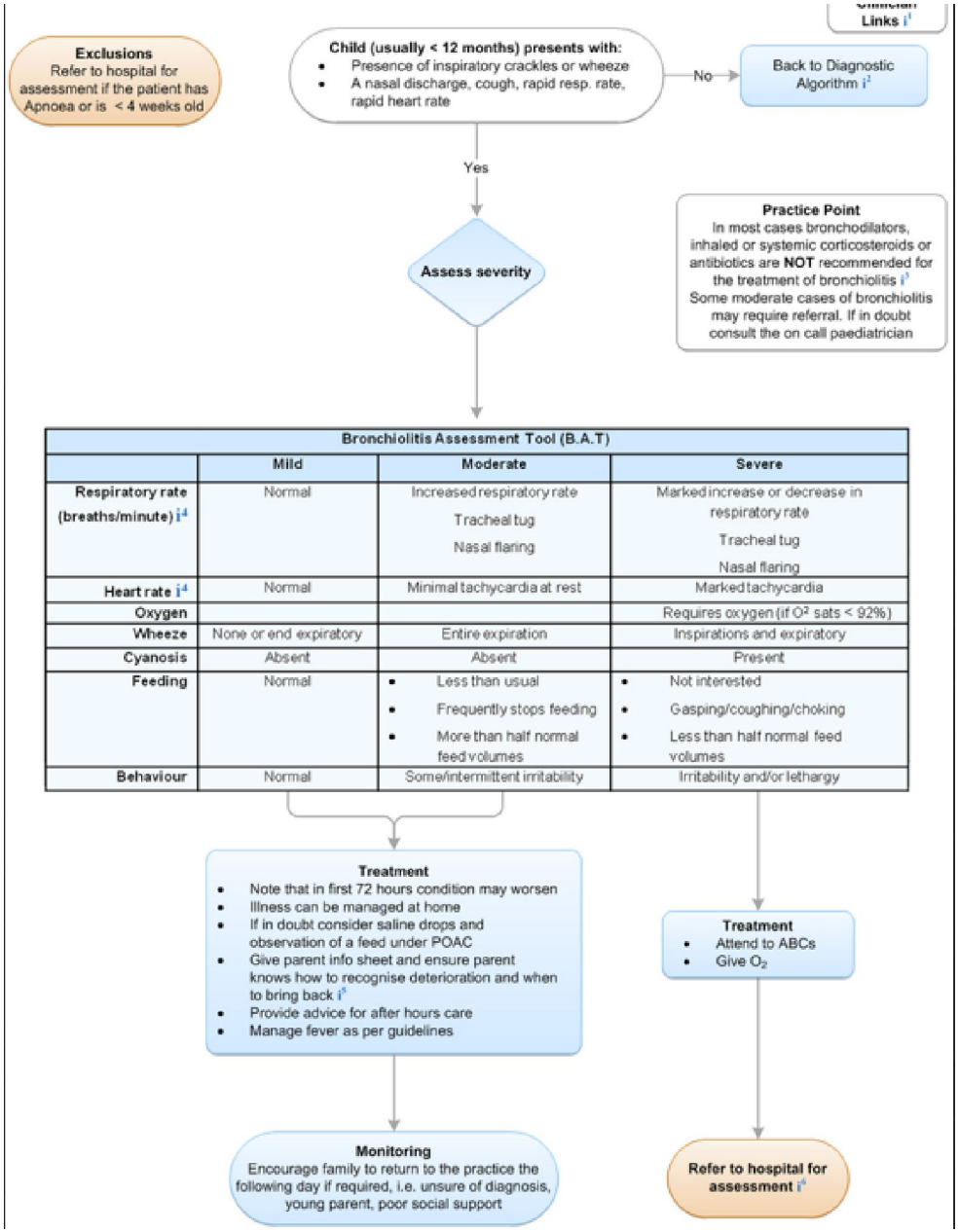


- 2 – 3 fold variation

Clinical Pathway

Mild / Moderate

- At home
- Parent information sheet
- Advice for after hours



Should Bethany go to hospital

- Discussed with Paediatric Reg. “ I think she can probably stay at home , there’s a four hour wait in ED”
- Observe / stay at Aunties
- “ Wheezing worse “
- Unable to afford After Hours => ED – admitted
- Discharge code – “Bronchiolitis “

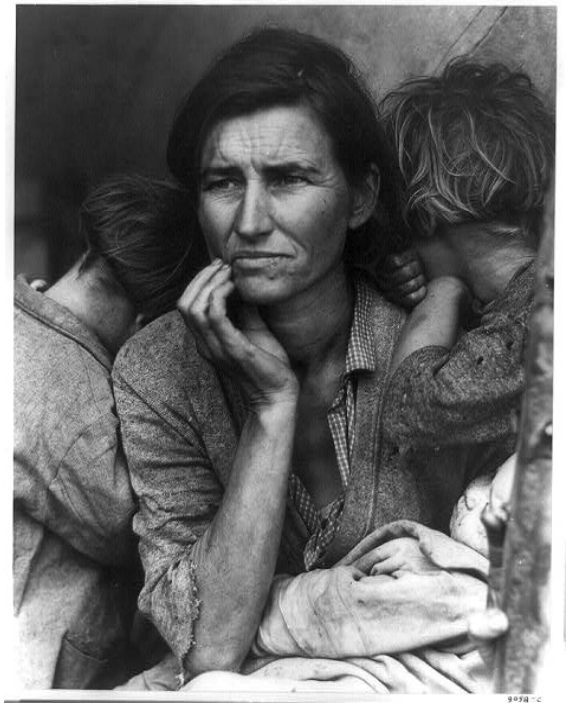
Challenges to a clinical pathway

- No clear agreement of an end point e.g. admission rate
- Complexity around the ‘grey ‘ areas

How effective can clinical pathways be ?

- Personal pre-primary care attribution
  - Health literacy, health promotion
  - Patient and family behaviour
  - Social determinants – poverty
- Access to and activity by Primary Care
  - After Hours Activity and management by Primary Care
- Access to Emergency Departments et al
  - Waiting time rules
- Hospital Policy

3. Do pathways align to clinical reality ?



Mental health

- Depression
- Anxiety
- Grief and Loss
- FSUCLS
  - Feeling screwed up ‘cos life sucks
- Bodily stress

Depression or what

There is no such thing as Depression

- OMG !!
- Or Anxiety

BUT

- There is a spectrum of Anxious Depression

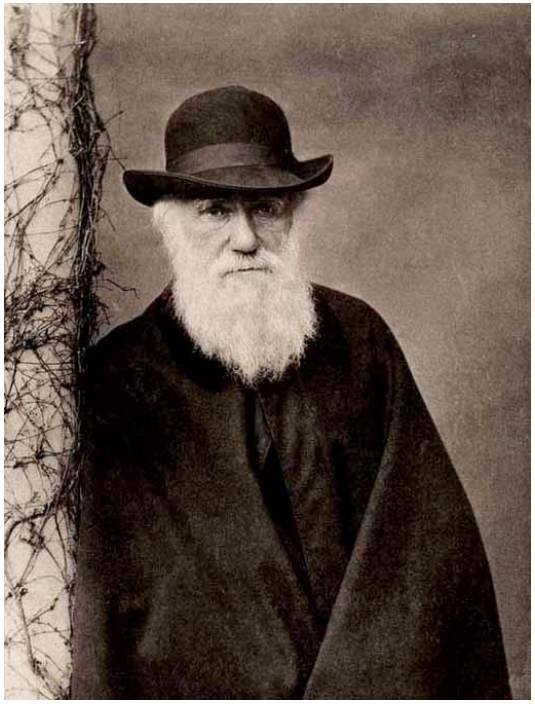
Is this important ?

- Most common mental disorder in primary care
- Not currently addressed well in guidelines and pathways
- Hegarty K, Gunn J, Blashki G, Griffiths F, Dowell A C, Kendrick T. How could depression guidelines be made more relevant and applicable to primary care? A quantitative and qualitative review of national guidelines. *Br J Gen Pract* 2009; DOI: 10.3399/bjgp09X42058/
- Anxiety symptoms currently under diagnosed and receive less 'sympathy'

*I've had depression and I've anxiety ; depression is easy , anxiety is f***ing awful*

- Patients missing out on treatment options

A typical patient
- Bodily Stress



- Malaise , vertigo, dizziness, muscle spasms, vomiting, cramps, bloating and nocturnal intestinal gas, headaches, alterations of vision, severe tiredness, nervous exhaustion, breathless, eczema, tachycardia, tinnitus.
- “ Severely debilitated for long periods of time, incapable of normal life and intellectual production. Constant attacks…. stops all work.”

Bodily Stress Syndromes – Medically Unexplained Symptoms

- Gastroenterology – IBS, Non ulcer dyspepsia
- Rheumatology – Fibromyalgia
- Cardiology – Non cardiac chest pain
- Respiratory – hyperventilation
- Dental - TMJ syndrome
- Neurology – ‘ headache’
- Gynaecology – chronic pelvic pain
- Psychiatry – somatiform disorders
- Chronic fatigue Syndrome

- Often the ‘non diagnosis’ exclusion of a clinical pathway

Aligning with clinical reality

- Guidelines and Pathways need to address hard to reach topics
  - Mental health
  - Child and Youth
- Some topics don't fit standard boxes
  - Or classifications
- May push us into excluding a more 'holistic ' approach to patient problems

Top 5 pathways viewed in November 2014:

1. Diabetes – Type 2 Management
2. Acute Respiratory Illness in Children
3. DVT
4. Renal Colic
5. Adult Cellulitus

Where should we put red flags ?

The curious case of back pain

Acute Spinal Pain in Adults

This pathway covers pain originating from the spine at any anatomical level for the first 6 weeks.

Red Flags

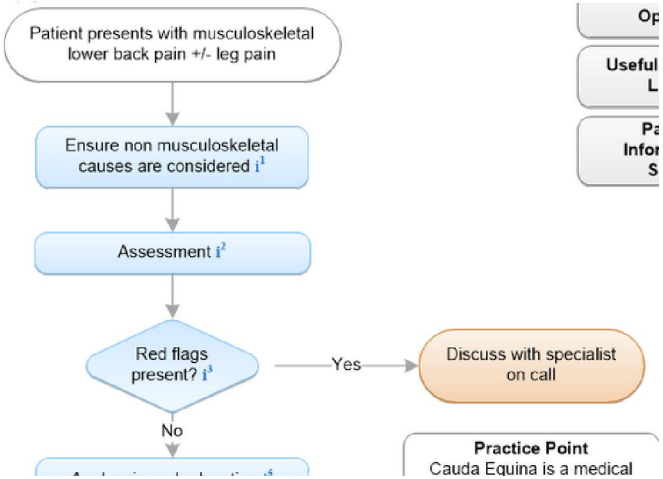
- Recent significant trauma, or milder trauma age > 50
- Suspected cancer
- Suspected infection e.g., osteomyelitis of vertebra, discitis, extradural abscess, meningitis
- Spinal pain with severe upper or lower limb neurologic deficit, or saddle anaesthesia

Assessment

1. Exclude red flags by assessing:
   - Risk – past history of cancer, recent infections, trauma,
   - Pain history – looking at the severity, features, and r
   - Limb pain associated with a major change in bowel or b
   - Distinguish between radicular and somatic symptom
2. Examination should include a screening neurological exam.
3. Investigations:
   - Avoid investigations for low-risk patients with spinal
   - Consider spine X-rays:
     - If recent significant trauma, or milder trauma in t
     - If suspected osteoporotic vertebral collapse.
   - If spinal pain with upper or lower limb neurologic deficit including CT or MRI.
   - If red flags or inflammatory arthritis are suspected, arra
4. Determine the most likely diagnoses:

Exclusions
Investigate and consider specialist referral

- Known malignancy
- Suspicion of fracture or infection
- Ankylosing spondylitis
- Inflammatory disorders



Practice Point
Investigations in first 4-6

Practice Point
Cauda Equina is a medical

Sequencing and priorities ?

4. Determine the most likely diagnoses:
   - Cervical disc prolapse
   - Lumbar disc prolapse
   - Thoracic disc prolapse
   - Osteoporotic vertebral collapse
   - Inflammatory arthritic conditions
   - Lumbar spinal stenosis
   - Polymyalgia rheumatica (PMR) or giant cell arteritis
   - Mechanical or non-specific spinal pain

Management

Practice Point!

Reserve injected opioid analgesia for severe spinal pain with red flags otherwise patients will expect this with each exacerbation.

But - Prevalence of pathology

Henschke et al 2009

1172 consecutive patients receiving primary care for acute LBP in Sydney

- 11 cases serious pathology (0.09%)
  - 8 cases of fracture; 2 inflammatory arthritides; 1 cauda equina
  - 5 diagnosed at initial consult
  - Conclusion – previously undiagnosed serious pathology rarely presents as acute low back pain

Side effects of red flags

- Anxiety

  I now (long pause) try to see that in perspective of the harm that you cause by trying to exclude serious pathology all the time
  GP01 (28 years experience)

  , it becomes difficult to reassure the patient .. where you're saying 'now if any of these things happen, you must come back,' and they of course pick up on your anxiety about the whole situation as well.
  GP06 (2 years experience)

- Increased perception of vulnerability
- Incidental findings
- Radiation exposure
- Unnecessary subsequent investigation

5. Celebrate success

- Amazing hard work commitment
- Lots and lots of pathways and guidelines
- Local adaptation
- Relationship building

Log into Canterbury HealthPathways

Username

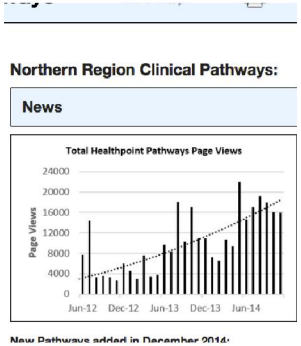
Password

Login

How to access Canterbury HealthPathways

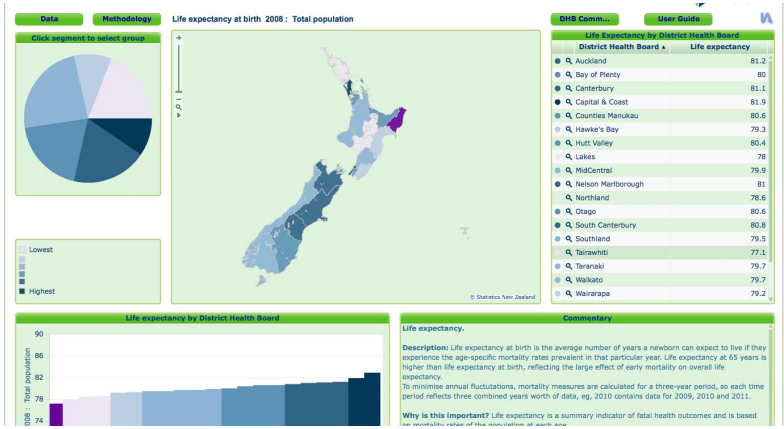
6. The look of the thing

- Format , Layout
- Avoid perverse messaging
- Accessibility
- 3 clicks



Tools and formats

- Using data to support guidelines
- Local information
- Directories and contacts



Number of types vs local adaptation ?
How many websites ?
How much updating ?

Lord Ronald said nothing; he flung himself from the room, flung himself upon his horse and rode madly off in all directions.

Consistent advice

Dave Shaw: The big fat debate bungle

2:15 PM Thursday Apr 24, 2014 39 comments

Dave Shaw | Health | Health & Wellbeing | ... 844 36 23 1

There are so many mixed health messages out there, it's confusing for Kiwis, health experts say. Photo / Thinkstock

Did you see the *Big Fat Debate* last night on Third Degree? It was a showcase of where some academic minds are at in deducing the effects of saturated fat on our

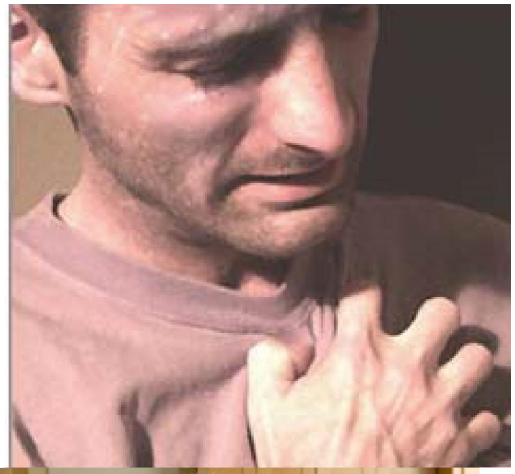
7.Time and teamwork

- Communication
- Time

8. Humanity in activity

Getting the patient voice into a pathway ?

- Appreciation of narrative and patient stories
- Recognition of the social context
  - The difficulties in adhering to guidelines and pathways
- Consumer participation in pathway development



The patient experience

Following a pathway and guideline. –

PT: um me I've got an older sister to look after that's had a stroke
GP: so you take her for a walk twice a week?
PT: so you know
PT: I work with preschoolers I'm walking around all day

GP: it's not good enough
PT: it's not good enough? oh cripes
GP: you need to be working up a sweat
PT: oh oh
GP: every day
PT: oh crikeys

Acknowledgement of the patient's life

I was in hospital for three days. I was asked whether I smoked six times, once at half past one in the morning. In all that time not one person asked me how I was feeling