

9 Implementation

9.1 GETTING GUIDELINES INTO PRACTICE

To achieve the objective identified in section 1.1 “to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances”¹ it is important not only to develop valid guidelines by a sound methodology, but also to ensure the implementation of the evidence based recommendations. As one of a range of tools to help health care professionals and organisations to improve clinical effectiveness and patient outcomes (see section 1.3), guidelines provide an opportunity for practitioners to improve shared clinical decision-making, increase team working, expand their evidence-based knowledge, and reduce variation in practice. They can also enable professionals to keep up to date and to assess their own clinical performance against the recommendations for best practice.

However, there is often a gap between the development of guidelines, as set out in the previous sections of this handbook, and their implementation into practice. Just as guidelines themselves help provide a bridge between research and practice, this section outlines the strategies that can assist practitioners, and health services to bridge the gap between guideline development and implementation.

9.2 IDENTIFYING BARRIERS TO IMPLEMENTATION

There are two types of barriers to the implementation of guidelines: those internal to the guideline itself, and the external barriers relating to the clinical environment and particular local circumstances. Potential external barriers to guideline implementation include:

- Structural factors (e.g. financial disincentives)
- Organisational factors (e.g. inappropriate skill mix, lack of facilities or equipment)
- Peer group (e.g. local standards of care not in line with desired practice)
- Individual factors (e.g. knowledge attitudes, skills)
- Professional-patient interaction (e.g. problems with information processing).

SIGN addresses the internal barriers by developing guidelines according to a highly respected methodology, described in detail in the earlier sections. For successful implementation, the external barriers also need to be assessed and implementation strategies developed to address them.

9.3 IMPLEMENTATION INITIATIVES

Implementation of guidelines is a local responsibility and many local initiatives have already been successful in overcoming these barriers to implementation. Most clinical governance support teams in NHS Boards now have audit and clinical effectiveness facilitators with some resources to help local implementation. This is an opportunity to encourage team working and co-operation within primary and secondary care and at the interface between them.

Although its remit is limited to guideline development, SIGN seeks to facilitate guideline implementation with a number of approaches. These include wide dissemination of the guidelines at no cost to the practitioner, awareness raising initiatives and using electronic publishing to improve the availability of guidelines.

SIGN's guideline distribution policy (see section 8.5) encourages Boards to take responsibility for local dissemination, which further promotes local awareness and opportunities for local implementation. SIGN uses the media to promote the publication of guidelines when appropriate. Members of SIGN Council are also actively involved in promoting guidelines and developing projects.

Initiatives both nationally and locally have taken into account evidence on the effectiveness of different strategies to implementation: "evidence based medicine requires evidence based implementation".² Implementing guidelines is not simple or straightforward. Difficulties often centre on the need for personal, organisational or cultural change.³ However, such change is being carried through in many areas of clinical practice and information to support a local evidence-based strategy is available from a variety of sources.

The Cochrane Effective Practice and Organisation of Care (EPOC) group has published a summary of 44 systematic reviews of implementation interventions, giving an indication of the most effective approaches⁴ as summarised in Figure 9.1. The authors were quick to point out that there are "no magic bullets". Each implementation strategy is effective under certain circumstances, and a multifaceted approach is most likely to achieve change. The approach should be tailored to suit local circumstances taking into account any particular potential barriers. It is important to build in support and incentives and to consider the resources needed for successful implementation.

Figure 9.1

EFFECTIVENESS OF INTERVENTIONS TO PROMOTE IMPLEMENTATION

<i>Variable effectiveness</i>	<i>Largely Effective</i>
Audit and feedback	Reminders
Local consensus conferences	Educational outreach (for prescribing)
Opinion leader	Interactive educational workshops
Patient mediated interventions	Multi-faceted interventions

Figure 9.2, adapted from Palmer and Fenner⁵ and the Effective Health Care Bulletin,⁴ illustrates how each strategy can be used to form part of a local implementation strategy.

9.4 PRACTICAL STEPS

The first step in this process is to prioritise the topic for the team. This may be decided by the NHS Board through their Local Health Plan, or a local service or practice may identify a priority clinical area in which they wish to examine care and identify areas for improvement. It is important to recognise that clinical teams can only tackle one guideline at a time for an active implementation strategy. Indeed it may be that only certain key recommendations within the guideline are prioritised for implementation. However the clinical team should identify the strengths and weaknesses of present provision and not merely choose those areas that are most easily implementable. It is encouraging to identify what you are doing well but also important to identify where services could be improved ensuring that any changes that are planned are achievable.

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Figure 9.2: IMPLEMENTATION STRATEGIES

<i>Method</i>	<i>Effectiveness</i>	<i>Local considerations</i>
Written materials	Variable findings; at best, small effect	Whilst impact is small, could be used to raise awareness of the guideline through materials or through medical journals or local publications. Useful in combination with other strategies.
Audit and feedback	Sometime effective; small to moderate effect but potentially important	This could be a valuable starting point to provide baseline information from which to develop an implementation strategy.
Education (group)	Variable effects which improve when the influence of peers is included	Identify a local multiprofessional group who can be supported with education from experts or by attending workshops or conferences. Facilitation at practice/unit level is helpful.
Education (individual)	More effective than other educational initiatives	Targeting stakeholders through individual education centred on the topic, or more general implementation issues. Consideration needs to be given to cost.
Opinion leaders	Mixed effects	Identify local and national opinion leaders and consider how they might be involved.
Product champions	No conclusive evidence	Identifying product champions might highlight innovative methods for implementation.
Academic detailing / educational outreach	Effects are small to moderate but of potential importance	Could be incorporated with individual education approach and written materials.
Mass media	May have a positive influence on how health services are used	Take advantage of mass media coverage and additionally local media sources.
Patient-mediated interventions	No conclusive research evidence	Consider local patients, consumer and pressure groups so that involvement is part of strategy at the outset
Continuous quality improvement	No conclusive research evidence	Include local audit/clinical governance/ effectiveness departments in developing the implementation strategy.
Financial incentives	Some appear to influence practice, but not all	This may only be available for some professional groups and would depend on the nature of the guideline, e.g. financial support for audit, prescribing incentives.
Policy / regulation	No conclusive research evidence	National standards drawn up by bodies such as the CSBS are supported by clinical guidelines are influential in supporting local implementation.
Reminder systems	Computerised records have supported the implementation of guidelines. Manual reminder systems were effective in many, but not all studies.	Implementation may prompt a review of the record keeping system and may initiate developments such as multiprofessional integrated care pathways. Computerised decision support is being developed.
Internet / on-line databases	No conclusive research evidence	If local services are networked this could form a useful medium for communication and information sources
Combinations of methods	Appear to be more effective than any one intervention on its own	Importantly, a local strategy needs to consider which of the above and in what combination such strategies may be helpful

Figure 9.3 outlines the likely steps that a local implementation group might take, adapted from the Royal College of Nursing Guidelines⁶ and the SPICEpc (Scottish Programme for Improving Clinical Effectiveness in Primary Care) project (www.ceppc.org/spice/index.shtml).

Figure 9.3

PRACTICAL STEPS TOWARDS GUIDELINE IMPLEMENTATION

Step 1

Decide who will lead and co-ordinate the team and identify stakeholder representatives for the implementation group. It is often helpful to have a key facilitator for this process. The team should be multiprofessional in composition.

Step 2

Determine where you are now. First, you have to know how you are doing and identify where changes need to be made. It is helpful to audit current clinical practice. It is also important to review the local environment considering people, systems, structures and internal and external influences. Through this process it is possible to identify potential barriers and facilitators to implementation.

Step 3

Prepare the people and the environment for guideline implementation. It is important to ensure that the professionals are receptive with a positive attitude to the initiative and have the skills and knowledge to carry out the procedures. This requires time, enthusiasm and commitment with good communication and offers of tangible help. It is important also to involve patient groups in planning the initiative so they are involved from the outset and can influence the way that the guideline is implemented into local services. It is important to take into account patient preferences and views e.g. Scottish Consumer Council publications, local surveys. In preparing the environment it may be necessary to acquire new equipment or change forms or access services in a different way. It may be possible to consider the inclusion of reminder notes or computer assisted reminders.

Step 4

Decide which implementation techniques to use to promote the use of the clinical guidelines in practice. This should take into account the potential barriers already identified and use the research evidence on effective strategies.

Step 5

Pulling it all together. This requires an action plan for the improvement process. It requires everyone to agree the aims with a named person responsible for the action plan; a time scale identified with contingency plans to deal with any problems along the way.

Step 6

Evaluate progress through regular audit and review with feedback to the team. Rewarding achievements is important. Plans may be required to be modified in the light of difficulties or surprises found during the implementation process. It is always important though to celebrate successes and aim for small achievable steps along the way to improve the quality of patient care.

9.5 MONITORING IMPLEMENTATION

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Monitoring of guideline implementation is part of the responsibilities of NHS Quality Improvement Scotland (NHSQIS). NHSQIS clinical standards focus on clinical issues and are evidence based, although levels and types of evidence vary. Where possible they are based on standards drawn from SIGN and other evidence based guidelines as well as good practice statements.

References to section 9

1. Institute of Medicine. Committee to Advise the Public Health Service on Clinical Practice Guidelines. Clinical practice guidelines : directions for a new program. Washington (DC): National Academy Press; 1990.
2. Grol R, Grimshaw J. Evidence-based implementation of evidence-based medicine. *Jt Comm J Qual Improv* 1999;25(10):503-13.
3. Grol R, Grimshaw J. From best evidence to best practice: effective implementation of change in patients' care. *Lancet* 2003;362(939):1170.
4. Getting evidence into practice. *Effective Health Care* 1995;5.
5. Palmer C, Fenner J. Getting the message across : a review of research and theory about disseminating information in the NHS. London: Gaskell; 1999.
6. Pressure ulcer risk assessment and prevention: implementation guide and audit protocol 2003. London: Royal College of Nursing; 2003.