The College of Emergency Medicine

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CLINICAL EFFECTIVENESS COMMITTEE

Implementation Framework

To ensure the highest quality of clinical care for patients attending Emergency Departments in the UK, the Clinical Effectiveness Committee (CEC) of the College of Emergency Medicine (CEM) needs to adopt an implementation framework that not only reflects the CEC's role in promoting clinical effectiveness, but also the CEM's role as an effective partner in the collaborative leadership of academic medical royal colleges to support and promote integrated evidence-based care with its stakeholders and partner organisations.

For the purposes of ensuring clinical effectiveness at every level, ranging from national policy-making to local implementation, the following framework is proposed. This draws upon relevant national policies and the international literature regarding knowledge translation and clinical effectiveness. The aim is to develop and establish an emergency care system that benefits from active participation of the CEC. Crucial to this is the development of social and collaborative networks to facilitate the formulation and uptake of policies and strategies. Many of these activities are already underway.

Active engagements at the national level:

- National participation with the Department of Health and all its agencies
- The Academy of Medical Royal Colleges (especially the clinical effectiveness units of the Royal College of General Practitioners, the Royal College of Physicians and the Royal College of Paediatrics and Child Health), and the Royal College of Nursing
- The Care Quality Commission and the National Institute for Health and Clinical Excellence – by involvement as stakeholders and through networks
- Voluntary agencies – inviting representation
- Key personnel such as the National Clinical Directors to help align strategic working especially urgent and emergency care, primary care, older people and trauma
- National research and audit funding organisations to input into decisions on national priorities for emergency research and audit. This may help secure funding at national and local levels for research and development relevant to primary and secondary research in emergency medicine
- Develop a collaborative network of personnel engaging in emergency research, including knowledge translation and implementation
- Clinical leadership organisations including the Collaborative Leadership and Applied Health Research Centres and the Chief Executive Officers Forum
- Higher education organisations to promote the teaching and uptake of evidence based emergency medicine and clinical effectiveness

- Organisations that have an impact on national policy making and public health such as the Health Protection Agency
- Establish a professional network of "Quality Care Champions" at a regional level consisting of motivated, enthusiastic, self-selected people who are ambassadors for clinical effectiveness and who will help to disseminate the CEC's goals and aspirations supported by similar individuals within individual emergency departments

The following is an adaptation from the taxonomy of interventions for effective implementation highlighted in the Tooke (2007) report that could be used at a local level:

Professional Interventions:

- Distribution of educational materials
- Educational meetings within the Emergency Department (ED), themed around topic
- Educational visits to the ED by specialists
- Identification and involvement of local opinion leaders and champions
- Feedback of audit findings at departmental meetings
- Reminders in daily clinical management, in the ED and as an integral part of case based discussions
- Media, including the use of educational DVDs and virtual learning environments

Organisational Interventions:

- Formal integration of services across Healthcare Trusts to ensure seamlessness and effective commissioning of care pathways
- Participation in Trust and Regional Strategy Groups, and clinical governance networks
- Skill mix changes to address care need
- Satisfaction of providers with the conditions of work and the material and psychic rewards
- Continuity of care and communication between healthcare professionals
- Efficient handling of relevant patient complaints, including sharing across care providers via morbidity/mortality meetings
- Patient representation and participation
- Changes in medical records systems to aid effective communication

These collaborations could be maintained by people in various roles including appointments and liaison.

A concerted effort should be made to seek out such pre-existing appointments and liaisons to expedite the development of a network. The framework that this should be based upon is described below, and is the Toyota model for implementation.

1. **Philosophy:** there is a constant need to promote long-term strategic changes to develop a highly effective emergency care system. These efforts need to be sympathetic and sensitive to the socio-political and cultural dimensions and repercussions of such effort. The need to implement short term objectives is crucial to maintain the participation and interest of partners and stakeholders, but these have to be aligned to the long term goals so that change management is seen to be a proactive rather than a reactive process.

2. **Problem-solving:** developing effective emergency care systems is a complex process, and there are bottlenecks at several levels to thwart and challenge such ventures.

The CEC needs an active process of learning that should include developing risk logs for implementation of all its activities through every subcommittee including patient safety, best practice, guidelines network, standards & audit and informatics. Collaborative research bids should be actively developed to foster a better understanding of the barriers and facilitators to implementation including methodological, organisational and clinical issues.

3. **Process management:** "pull systems" to be promoted rather than "push systems". The practice of Emergency Medicine is based on powerful principles of collaboration with other disciplines across primary and secondary care, and team-working. The CEC should encourage the establishment of emergency care networks including input from clinicians from all relevant acute care disciplines, management, social care, informatics and education to help facilitate the delivery of clinically effective care.

4. **Partners:** there is a need to respect and challenge CEM's partners and grow with them to ensure continuing collaboration, seamlessness of care, natural evolutional changes in systems and to encourage the uptake and diffusion of strategies, innovations and ideas. It also strengthens solicitations for political will to influence change.

Further reading:

1. COCHRANE, L.J., OLSON, C.A., MURRAY, S., DUPUIS, M., TOOMAN, T. & HAYES, S. (2007). Gaps between knowing and doing: Understanding and assessing the barriers to optimal health care. Journal of Continuing Education in the Health Professions. 27(2):94-102.
2. SHAW, B., CHEATER, F., BAKER, R., GILLIES, C., HEARNSHAW, H., FLOTTORP, S & ROBERTSON, N. (2005).Tailored interventions to overcome identified barriers to change: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews. Issue 3. Art. No.: CD005470. DOI: 10.1002/14651858.CD005470.
3. TOOKE, J. (2007). A Report of the high level group on clinical effectiveness. Department of Health.

Jay Banerjee, on behalf of the **Clinical Effectiveness Committee**
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