Clinical effectiveness and evidence-based practice


Summary

An essential component of clinical governance is clinical effectiveness, which is achieved through evidence-based practice. This has enormous implications for the way nurses work, and the qualitative approach often taken by nurse researchers can be difficult to incorporate into the new systems. Clinical governance should have benefits for patients and NHS staff alike. If the goals are to be achieved, a multidisciplinary approach will be needed, with greater encouragement being given to creative research methods. In addition, nurses will have to become more powerful inside healthcare organisations.

The AIM of this article is to identify and discuss issues involved in clinical governance, focusing particularly on the aspects of clinical effectiveness and evidence-based practice. Critical considerations of relevant literature will be provided, concluding with debates and suggestions for future professional and academic development. Clinical governance is a topical issue as a result of the current government initiative of improving health care for all. The White Paper The New NHS: Modern, Dependable set out the government’s proposals for a reform of the health service (DoH 1997). The aim was to establish a new way of managing the NHS by ending the divisive internal market, but without returning to the type of ‘central command and control system’ that characterised the NHS for the first 40 years of its existence (Crinson 1999).

Clinical governance

The Royal College of Nursing identifies that: ‘Clinical governance is an umbrella term for everything that helps to maintain and improve high standards of patient care’ (RCN 2000). Clinical governance encompasses a range of quality improvement activities that many clinicians are already involved in, such as risk management, clinical audit and staff development (Fig. 1). It provides a framework to draw these together in a more co-ordinated way. The framework ensures that high quality services are delivered at a local level (RCN 2000). The government expects the principles of clinical governance to apply to all those who provide or manage patient care services in the NHS. All healthcare organisations will be required to develop local systems for ensuring quality of care, setting standards and collecting information to demonstrate the quality of their work (DoH 1998).

The government has put in place sets of standards and milestones known as National Service Frameworks (NSFs), while the National Institute for Clinical Excellence (NICE) develops information about improving standards of access and treatment across the country (Pickersgill 1998). Hospitals, community services and general practices will implement the standards, and progress will be monitored by the NHS trusts and regional offices. Trust chief executives are responsible for clinical governance and report regularly to publicly held board meetings (Anon 1999).

The aim of clinical governance is to make sure that healthcare organisations develop systems of culture and ways of working that ensure quality of care is at the heart of the business of all organisations at every level. Chief executives are now ultimately accountable for the quality of care delivered in their organisations (RCN 2000). As the introduction of clinical governance has made chief executives accountable for the care of patients in their trusts, the previous balance of accountability and power has been unsettled — traditionally, healthcare managers had left almost all clinical decision making to the clinicians.

This new emphasis on accountability has led to the need for highly visible, well-researched guidelines for practitioners to follow (Bloomfield and Hardy 2000). The responsibility of the trust managers will now be to ensure that standards are set and maintained by healthcare professionals; the responsibility of the healthcare professionals will be to provide high quality care.

There are several key components of clinical governance (Box 1, Fig. 1). These include (Crinson 1999):

- Clinical audit.
- Clinical effectiveness.
- Clinical risk management.
- Quality assurance.
- Staff development.

The NHS Executive described clinical effectiveness as: ‘The extent to which specific clinical interventions when deployed in the field for a particular patient or population do what they are intended to do,'...
that is maintain and improve health, and secure the greatest possible health gain from the available resources’ (NHSE 1996).

Clinical effectiveness and evidence-based practice

The goal of clinical effectiveness is that nurses will acquire professional skills and knowledge to practise evidence-based care. Nurses will be reliant on the information marshalled by the Institute for Clinical Excellence (McClarey and Duff 1997). Evidence-based practice is a critical part of clinical governance for achieving clinical effectiveness and quality services to patients (McSherry and Haddock 1999). Clinical effectiveness has three distinctive parts:

- Obtaining evidence.
- Implementing the evidence.
- Evaluating the impact of the changed practice.

All practitioners who are using research-based evidence in practice and can show that they have improved patient outcomes can claim to be practising clinical effectiveness (McClarey and Duff 1997). The limitations of the evidence-based practice approach raise the question of what counts as ‘sufficient evidence’ to amend practice.

Crinson (1999) asks: ‘Is a single study sufficient, or is a meta-analysis required, where the data from a number of individual studies are pooled and reanalysed?’

Evidence-based practice and validity

The quality of evidence is often referred to as the level of evidence. First-level evidence is based on a systematic review, which has been packaged and collated, forming recommendations for practice, as in clinical guidelines (McClarey and Duff 1997). Second-level evidence comprises overviews of appraised research and systematic reviews. Third-level evidence is sound research, which has been identified by the individuals searching the source themselves. Fourth-level evidence is that which has been implemented as a result of quality improvement programmes, or evidence that is based on expert opinion (McClarey and Duff 1997).

The main databases containing information on research projects relevant to health care are Medline, CINAHL, Embase and PsycLIT. These are available at most teaching hospitals’ libraries, and on the internet. There are limitations with information retrieval when using these databases, and they might not contain all the relevant research information, even if they are updated regularly.

The process of critical appraisal is also a fundamental problem for many healthcare professionals. Swage (1998) identifies that: ‘Many nurses (indeed all healthcare professionals) stumble at the first hurdle, because they are not confident about understanding research and reviews.’ The Cochrane Library might provide an analysis of the results of more than one piece of research on the same topic, and the RCN has an audit information service, which can also provide details about research-based projects and other links to information and guidelines. The level of evidence on which practice is based and how it has been applied in practice are key considerations when assessing clinical effectiveness. It might be that help is needed in putting existing evidence into practice.

Qualitative versus quantitative approaches

Nurses need guidelines to assist them in finding ‘best practice’. Walsh and Ford (1989a) state that: ‘To participate fully in the clinical effectiveness movement, there is a requirement on practitioners not only to understand and implement research, but also to provide the evidence upon which practice is based.’

Nursing is slowly moving away from a reliance on
procedures, towards interventions based on rigorous appraisal of evidence (Crinson 1999). The qualitative versus quantitative debate has gone on for many years. The aim of both methods is to contribute to our knowledge about a particular subject or area (Begley 1996). The qualitative methodologists are trying to document and interpret as fully as possible the totality of whatever is being studied, and they are generally regarded as being less scientific (Gavin 1997).

The quantitative approach is favoured by those who support the view that information, usually in numerical form, should be obtained in a systematic, objective and measurable way, and then be subjected to rigorous analysis by means of which a definite conclusion might be reached (Begley 1996). This is often difficult for nurses to achieve in their daily work, and they might find a qualitative approach more appropriate.

Gavin (1997) states that: ‘The dilemma for nurses is that a phenomenological approach is often more appropriate to the study of many issues of central concern to nurses, but least fits with the values of those whom they are trying to persuade’. These people are those in power in the healthcare system, such as general managers, politicians and the medical profession. As a result of this support, funding and resources for qualitative research might not be easy to acquire, and the results might not have the influence they merit.

As the debate continues, most writers agree on the compromise position in which both sorts of research and both world views are accepted as valid pursuits by nurses. Gavin (1997) concludes: ‘The final choice of research methodology should depend on the research question to be answered. However, the constraints of time, resources and the researcher’s particular skills might also influence the decision’.

Professional regulation

The evidence-based medicine movement has always had a major influence on healthcare systems worldwide. Accessing and appraising evidence is quickly becoming a core clinical competency. Clinical decisions and health policy can no longer be based on opinion alone (Scally and Donaldson 1998).

With clinical governance, all clinicians must continuously improve quality and safeguard standards of care, with the help of the framework. The national standards will be enforced by systems of local responsibility, and the whole system will be backed by lifelong learning and professional self-regulation.

The government says that professional self-regulation has failed patients in the past, taking insufficient account of their expectations and demands. It is acknowledged that the United Kingdom Central Council (UKCC), along with other professional bodies, has already strengthened its code of professional conduct (RCN 2000).

Another source states that: ‘Clinical governance was introduced to tackle the wide differences in quality of care throughout the country, and to help address public concern about well-publicised cases of poor professional performance’ (Anon 1999).

The General Medical Council has a system for investigating complaints about doctors who are suspected of poor performance. Although the number of cases of seriously poor performance by doctors is probably small in proportion to the total volume of care given, they can have serious repercussions for individual patients, and they attract media attention and damage public confidence.

Some situations have drifted on, and poor practice has continued and been tolerated over a long period, not being formally acknowledged until a crisis arises. At this point, the doctor’s practice has been debated publicly, and there has been a lengthy suspension while the employers have considered what action to take and the level of legal involvement needed. This is also an issue for nurses, as they might also have difficulty in whistle-blowing and reporting other healthcare professionals in incidences of poor practice.

Early action when there are problems, and greater openness with the public, are to characterise the new relationships (as yet unclear) between the professional bodies and local systems of governance. It is likely that local accountability will raise questions about the number of statutory bodies, their administration and their capacity to deal with local quality issues (RCN 2000). There are several ways in which healthcare professionals will become responsible for quality of care (Box 2).

There are contradictions involved in operating a hierarchical power structure and attempting to develop an open and democratic framework of clinical governance. These can result in a ‘blame and shame’ culture, rather than a supportive environment.
in which healthcare professionals can critically appraise practice (Crimson 1999). Many healthcare organisations failed to recognise the role of professional nursing in their clinical governance strategies, and highlighted the importance of medicine and general management (Castledine 1999). However, the government now supports a shared approach whereby the profession and the organisation are accommodated.

McSherry and Haddock (1999) identify that: ‘Effective channels of communication between healthcare professionals must be established in order to promote an organisational culture that practically develops infrastructure (for example, training, education and research) and nurtures professional and practice development in the pursuit of clinical excellence.’

Evidence-based practice occurs through the integration of clinical expertise with the best available external evidence from systematic research. It gives healthcare professionals confidence that their interventions (clinical, educational and managerial) are informed by a current and appropriate knowledge base. Practitioners and guidelines can then be audited and measured against agreed standards at a national or local level (McSherry and Haddock 1999).

Certain key components are required for evidence-based practice to work effectively (Fig. 2). Healthcare professionals require organisational leadership, service support and sufficient resources to equip themselves with the appraisal skills needed to rationalise the risks and benefits of care, and to critique research evidence.

To instigate evidence-based practice at a clinical level, organisations and healthcare professionals need to become familiar with the barriers (Box 3), and overcome them by developing realistic strategies (McSherry and Haddock 1999). If healthcare professionals are to have the knowledge and skills to deliver evidence-based practice, employing organisations must encourage and support this approach. In some healthcare organisations, quality, standards and clinical risk have taken second place, as financial issues have been a priority over the past 15 years (McSherry and Haddock 1999). This point is also identified by Castledine (1999), who states that: ‘The last government was particularly keen for trust managers to meet financial targets which was often at the expense of quality care’.

**The nursing profession** Another important challenge for nurses is to achieve strong representation with the National Institute for Clinical Excellence (NICE). It has been suggested that NICE will produce some 50 guidelines each year during the ten-year strategy for improvement and modernisation of the NHS. This will help to define the currency of accountability in the NHS; to do this, nursing will have to move beyond its traditional role (Bloomfield and Hardy 2000).

As a result of recent changes, nursing needs to develop an identity based on a solid understanding of its position in a health service that is ‘modern and dependable’. The profession of nursing has been characterised by difficulties in defining and asserting a distinctive professional identity. There has been a long-standing disagreement between those who emphasise the technical and scientific aspects of nursing, and those who highlight its caring aspects (Bloomfield and Hardy 2000). Both of these aspects are of the utmost importance to clinical effectiveness.

In the 1970s, the Briggs report (1972) called for nursing to be a research-based profession. The report prompted the most radical shake-up of nurse education, whereby education was taken from the hospital setting and merged with higher education and the formation of Project 2000. What emerged from this was a rapid expansion and uptake within nursing of all aspects of research culture (Bloomfield and Hardy 2000).

There is now a focus on providing nursing students with more practical skills and ‘on the job’ training. There are also postgraduate nurse training courses that take two years to complete, as opposed to the standard three-year registered nurse training. Various pilot schemes of cadet nursing exist around the country, and many other efforts to get more people to join nursing in the NHS, as a result of staff shortages and the increasing demand for more nurses.

Bloomfield and Hardy (2000) suggest that: ‘As a response to the shortage of new recruits and the suboptimal retention of existing staff nurses in practice, the government also insisted that nurses

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**Fig. 2. Key components and structure of evidence-based practice**

- Developing the culture: managerial, organisational support
- Developing skills
- Application of skills
- Evaluation of skills in practice
training should place less emphasis on academic education, and more on practical training’. Registration The registration of nurses remains an unresolved issue. The UKCC introduced PREP, which is a post-registration and practice requirement and was an attempt to encourage nurses to be lifelong learners. With the implementation of the new Nursing and Midwifery Council, there will still be a continual need for updating, monitoring and registration of practice. The new register will be streamlined into three parts. For people to be admitted to the register, they will have to have an approved qualification that is less than five years old and be of good character and health (Caulfield 2000). Criteria will be set for those who want to be re-admitted to the register, and might include the need for the person to undertake additional training. Renewal will be dependent on evidence of continuing professional development. The most important change to the register is that it will include a ‘duty to protect the public’, which will be enforced by setting and monitoring standards of training, conduct and performance. At present, the UKCC does not have that duty written into its legislation (Caulfield 2000).

Professional development and nursing research Some tensions and uncertainties in the professional development of nursing are played out in the profession’s relationship with research. Over the past two decades, there has been a large increase in the number of nurse researchers, academic nurses and nursing journals. The impact of nursing research has been hindered by two problems. First, nursing is a relative newcomer to the world of research and has been practised from a traditional ‘we’ve always done it like this’ approach rather than based on any research findings. Despite attempts to implement research evidence to support practice, many healthcare professionals continue to experience difficulty in ensuring that the treatment they provide is evaluated effectively (McSherry and Haddock 1999).

Box 3. Barriers to the introduction of evidence-based practice
- Attitudes towards research
- Lack of confidence, understanding and the skills to appraise critically
- Insufficient time within work commitments
- Lack of support from peers, managers and other health professionals
- Lack of resources
- Resistance to change

It might be concluded that the implementation of clinical governance will have many benefits for all involved, especially that patients can be sure that the care they receive will be audited, checked and regulated against set standards in a continuing attempt to improve health care; and that staff who are identified as lacking in certain skill areas will be given training and development. However, there are several problems associated with the introduction of clinical governance – the integration of qualitative or interpretative research into the evidence-based framework will not be straightforward.

The procedures developed for evidence-based practice have been designed for quantitative research, especially randomised controlled trials. Incorporating qualitative research might require considerable adaptation to the evidence-based practice model (Bloomfield and Hardy 2000). If the goals of evidence-based practice are to be realised, a multidisciplinary approach to change management is required, and if the goals of evidence-based practice are to be fully recognised by the nursing profession, the process must give more encouragement to use interpretative and creative research methods.

If nursing is to benefit from a greater involvement in the organisation or trust, then nurses will have to be allowed to become more powerful within the structure of the organisation. This might prove very difficult in some healthcare trusts, as nursing has always been seen as subordinate to general management and medicine (Castledine 1999).

It could be argued that the knowledge base of nursing is insufficient to support control of practice as professionals, and it might be that nurses do not want more professional accountability and authority. Clinical governance does, however, provide a direct link between the organisation and the nurse at any level.

Nurses might demonstrate concern for their own individual accountability and autonomy, and the quality and standard that is expected of them within the organisation, and raise the question of whether the standard will be tailored to suit the individual needs of the patients. For the new quality-of-care framework to be a lasting success that will benefit all concerned, clinical governance requires further clarity and to be allowed time to develop, especially considering the current changes in the NHS structure.

REFERENCES