Consultation Submission Form
Prioritisation of National Clinical Guidelines

You are invited to provide feedback on the proposed National Clinical Effectiveness Committee (NCEC) prioritisation process for National Clinical Guidelines. Your feedback is very important to us. We welcome responses to all questions as well as any additional comments you would like to make.

When commenting on a specific section of the document, it would help if you can identify which element you are commenting on and the relevant page number.

The closing date for consultation is 5pm on 20th February 2015.

You may email or post a completed form to us.

Email: ncec@health.gov.ie

Post: Prioritisation Consultation, Clinical Effectiveness Unit, Room 7.51, Department of Health, Hawkins House, Dublin 2.

Queries: Contact Paula Monks: *Tel:* 01 6354513 *Email:* Paula_Monks@health.gov.ie

Name	Irish Medical Organisation
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Are you replying in a personal capacity or on behalf of an institution or organisation?	The Irish Medical Organisation is the professional representative body for all doctors in Ireland.
Date	20th February 2015

Freedom of Information: Please note submissions received may be made available under the Freedom of Information Acts and as such may be published on the Department of Health website.

Further detail on NCEC is available at: http://health.gov.ie/patient-safety/ncec/

Question 1

Do you have any feedback in relation to the proposed prioritisation streams as outlined in Section 2 and Figure 2?

The document identifies three streams of sources for proposals for clinical guidelines:

- Stream 1 Significant Patient Safety or Policy Issue
- Stream 2 Clinical/National Programmes
- Stream 3 Wider Health System

Any individual or entity proposing a clinical guideline for prioritisation by the NCEC should be required to declare any potential conflict of interest.

Question 2

Do you have any feedback in relation to the proposed prioritisation criteria and weighting as outlined in Section 3?

Section 3 outlines the weighting process and the subsequent Likert scoring of each guidelines or topic, however the section does not indicate what weighting is to be used to select clinical guidelines. Arguably criteria of patient safety and potential for improved health should be prioritised before other criteria and weighted accordingly. Similarly the Likert Scoring system does not indicate what score is desired for a guideline to be prioritised by the NCEC nor if failure on a particular criteria will lead to exclusion. If two or more guidelines are scored equally then priority should be given to the guideline that scores highest on patient safety and potential for improved health.

Criteria 1 Patient Safety Issue

As mentioned above criteria 1- patient safety and 6 - potential for improved health should be prioritised before other criteria and should be weighted accordingly.

Criteria 2 Burden of Clinical Topic

Topics for Clinical Guidelines are often selected because they are important to large numbers of people with substantial morbidity or mortality and where evidence of variation in care exists, however clinical guidelines may often address a significant patient safety issue or substantially improve outcomes for patients where the burden of disease is small.

Criteria 3 Evidence Analysis

When carrying out a systematic review of clinical trials and studies, reviewers should be aware of potential bias towards positive results in the publication of clinical trials. The IMO supports the registration and reporting of all clinical trials, however up to half of clinical trials and studies registered are not published in medical journals and positive results are more likely to be published than negative results. (See Alltrials.net)

Criteria 4 Economic Impact

The implementation of clinical guidelines will have resource implications both in terms of initial set-up costs and ongoing implementation. The resource implications of a Guideline in both Primary and Secondary Care must be fully exhaustive and assess the cost of implementation both in terms of financial cost and the opportunity cost of investing resources into other areas of healthcare provision. No guideline should be included within the National Suite of Clinical Guidelines unless it is accompanied by the appropriate allocation of resources. Nor should a guideline reduce resources from healthcare provision elsewhere within the system. No doctor should be required to implement a guideline that is inadequately funded or that may impact negatively on other areas of patient care.

There may be potential long-term savings to the health budget from the implementation of a clinical guideline which should be welcomed, however long-term savings should not be weighted above criteria of patient safety or improvement to health outcomes in the endorsement of a clinical guideline.

A guideline may be adopted because it fits a budget allocation and not because it provides the most cost effective care. Medical Practitioners have a paramount responsibility to act in the best interest of a patient and to advise patients on the different options of care available to them including the most effective care. It is not appropriate for a clinical guideline that is constrained by resources to conflict with this requirement.

Criteria 5 Variability in Practice

Topics for Clinical Guidelines are often selected because they are important to large numbers of people with substantial morbidity or mortality and where evidence of variation in care exists. Classical quality assurance seeks to remove variation in care both below and above the standard chosen. Clinicians providing excellent care should not be required to deliver a lower standard of care.

Criteria 6 Potential for Improved Health

As mentioned above criteria 1- patient safety and 6 - potential for improved health should be prioritised before other criteria and weighted accordingly.

Criteria 7 Clinical Guideline Implementation

Clinicians must be engaged in the development and implementation of clinical guidelines. Frontline clinicians who have knowledge of effectiveness should be explicitly represented in the development of clinical guidelines. They should have appropriate clinical experience and should enjoy the confidence of their peer colleagues. Similarly patient representative organisations involved in guideline development should be appropriate to the topic and bring practical experience to the table.

Medical Practitioners have a duty to act in the best interest of their patients and to help patients make an informed decision about their own care. Clinical Protocols that are defined as a precise sequence of activities with little scope for variation may in certain circumstances be incompatible with the professional and ethical requirements of the Medical Council.

Guidelines are useful where what they are seeking to guide is a uniform linear process however patients are far from linear and their needs and preferences can differ vastly.

Modern scientific developments are increasingly identifying individual factors that underlie disease and strengthen the evidence for the need to personalise care. Clinicians are expected to be wise in their application of data, information and knowledge. Clinicians judge the effectiveness and appropriateness of care by monitoring individual patient response and need to be able to react to this clinical feedback on the effects of any guidance they may be following. Guidelines are to be adhered to only if they result in an optimal clinical outcome.

Medical practice is also a dynamic process and guidelines are quickly dated. Practitioners will be up to date in their field of practice through CPD/CME. Given the time lag involved in gathering the evidence for systemic reviews and the additional time for its incorporation into formally quality assured clinical guidelines, many guidelines will not be as up to date as the practitioners who may be requested to apply them. Furthermore strict adherence to clinical guidelines may stifle innovation and the advance of medical science. Provision should be made for clinicians to modify guidelines accordingly.

Failure to adhere to a clinical guideline, when acting in the best interests of a patient should not be grounds for a complaint to the Medical Council or litigation against a healthcare professional.

Question 3

Do you have any general or specific feedback on the document? In your response, where applicable, please specify the section and page number to which you are referring.