Trust-wide Document

NHS
Great Western Hospitals
NHS Foundation Trust

Dissemination, Monitoring and Reporting of National Institute of Clinical Excellence (NICE) Guidance Policy

Document No	Corp - 00057	**Version No**	1.0
Approved by	Policy Governance Group	**Date Approved**	03/10/2019
Ratified by	Patient Quality Committee	**Date Ratified**	01/09/2020
Date implemented (made live for use)	09/09/2020	**Next Review Date**	01/09/2023
Status	LIVE		
Target Audience- who does the document apply to and <u>who should be using it</u>. - The target audience has the responsibility to ensure their compliance with this document by: • Ensuring any training required is attended and kept up to date. • Ensuring any competencies required are maintained. • Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.	All employees directly employed by the Trust whether permanent, part-time or temporary (including fixed-term contract). It applies equally to all others working for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees. For simplicity, they are referred to as 'employees' throughout this policy		
Special Cases	None		
Accountable Director	Medical Director		
Author/originator – Any Comments on this document should be addressed to the author	Clinical Audit and Effectiveness Manager		
Division and Department	Corporate – Clinical Audit & Effectiveness Department		
Implementation Lead	Divisional Quality Governance Facilitators and Divisional Associate Medical Directors		
If developed in partnership with another agency ratification details of the relevant agency			
Regulatory Position	NICE Guidance (Ref 1). NHS Improvement (Ref 7). Care Quality Commission (CQC) (Ref 8).		
Review period. This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.			

Contents

1 Introduction & Purpose

1.1 Introduction & Purpose

The National Institute for Health & Care Excellence (NICE) (Ref 1) is an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE guidance aims to ensure that promotion of good health and patient care in the National Health Service (NHS) are in line with the best available evidence of clinical effectiveness and cost effectiveness, this includes:

- The care and services that are suitable for patients with a specific condition or need.
- The care and services suitable for particular populations, groups or people in particular circumstances or settings (for example, when being discharged from hospital).
- Ways to promote and protect good health or prevent ill health.
- The configuration and provision of health and social care services, and/or,
- How national and local public sector organisations and partnerships can improve the quality of care and services (for example, how the NHS and social services work together).

Implementing NICE guidance helps to ensure consistent improvements in people's health and equal access to healthcare. For the purpose of this policy implementation is defined as a specified set of activities designed to put NICE guidance into practice (Ref 1).

Although implementing NICE guidelines is not a legal requirement, there is an expectation from external regulatory bodies and the public, for healthcare organisations to adopt and implement NICE guidance that are relevant to their services; compliance with NICE guidelines provides an assurance of the services being delivered to the patients, the Board, and local commissioning groups.

The Trust's level of compliance is submitted annually to the CQC who monitor our services against their five key lines of enquiry; changes in performance are benchmarked against national standards and with other providers.

This policy outlines the process for assuring a consistent approach towards the dissemination, implementation and monitoring of NICE guidance at Great Western Hospitals NHS Foundation Trust (the Trust).

1.2 Glossary/Definitions

The following terms and acronyms are used within the document:

CA&E	Clinical Audit and Effectiveness
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CQGF	Clinical Quality Governance Facilitators
EIA	Equality Impact Assessment
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PQC	Patient Quality Committee
TA's	Technology Appraisals

2 Main Document Requirements

2.1 NICE Publications

A schedule of forthcoming NICE guidelines to be published can be found on the NICE website (Ref 1). The schedule outlines the proposed scope of the guideline and expected publication month to help organisations plan.

NICE guidance is usually published on their website on or around the 4th Wednesday every month and the number of publications can vary; some NICE guidelines may become withdrawn due to inadequate supporting evidence during the development process.

2.2 Dissemination of NICE Guidance

A list of newly published guidance is downloaded from the NICE website on the day it is published by the Clinical Audit & Effectiveness Department; this is usually on or around the fourth Wednesday of each month.

With the exception of Technology Appraisals, the list of guidelines are disseminated to the Divisional Governance Facilitators who identify the relevant clinical lead/s to assess the relevance and where practice meets recommendations.

The assessment and implementation of ALL new medical **Technology Appraisals (TA's)** is incorporated in a separate process led by the Pharmacy Department and Medicine Assurance Committee via the Formulary Working Group. For queries relating to TA's please contact the deputy director or director of Pharmacy.

2.3 Assessment of NICE Guidance

If the guidance is not relevant to the service, for example, it may be that some patients are referred to another hospital for a particular test or treatment, in this case this would indicate 'not applicable'

Where an assessment confirms 'unintentional non-compliance', the Clinical Lead together with the Clinical Quality Governance Facilitator (CQGF) , Divisional Director and Associate Medical Director will need to decide what actions are required to be implemented to become 'Compliant' and these are recorded in the action plan section of the assessment proforma (Appendix B).

Where an assessment confirms 'intentional non-compliance' justification must be recorded in the appropriate section of the assessment proforma (Appendix B) accordingly.

In all cases, areas of non-compliance (intentionally or unintentionally) need to be risk assessed to ensure no harm occurs to patients or employees. The risk assessment section in the assessment proforma must be completed and the identified risks must be registered accordingly by a senior lead within the Division.

2.4 Monitoring of NICE Guidance

The Trust is required to report its levels of compliance to external regulatory bodies; therefore, current NICE status and progress with NICE action plans are required to be monitored to ensure NICE recommendations are on schedule to be met.

Divisions are required to monitor the implementation of their NICE guidelines and levels of compliance, including any associated risk assessments and action plans. Any changes to compliance or updates should be reported to the Clinical Audit and Effectiveness Department for logging onto the central NICE database.

2.5 Reporting NICE Guidance

The NICE database is stored, managed and updated by the Clinical Audit & Effectiveness Department.

Individual NICE guidance is logged onto the database at the time of publication; records are updated based on the information received from the completed assessment proforma and further updates as advised by the Clinical Lead/s and or Divisions.

Progress reports are prepared on a monthly basis by the Clinical Audit & Effectiveness Department for each Division to review. Quarterly updates are provided at the Patient Quality Committee (PQC), and bi-annually for the Clinical Commissioning Group (CCG) and CQC.

Additional ad hoc reports are prepared upon request.

The NICE database is also accessible by the Divisional CQGF who are also able to prepare specific reports for their respective Divisions.

3 Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

Measurable policy objectives	Monitoring or audit method	Monitoring responsibility (individual, group or committee)	Frequency of monitoring	Reporting arrangements (committee or group the monitoring results is presented to)	What action will be taken if gaps are identified
An Action Plan is completed for **ALL** NICE guidelines relevant/not relevant to the Trust or if a decision is not to implement.	NICE database	CQGF's/Clinical Audit & Effectiveness Department	Continuously reviewed and updated		Persistent offenders that do not complete an Action Plan within the time frame stipulated with the policy even after the first chase from the CQGF's the NICE guidance will be reported as outstanding. The outstanding NICE guidance is reported with the NICE monitoring report to PQC, where it is added to the PQC action tracker to be monitored monthly. The relevant Division will follow up,
	NICE monitoring report Clinical Audit & Effectiveness Monthly Report (NICE Monitoring section).	Clinical Audit & Effectiveness Manager	Quarterly six Monthly	PQC Commissioners	
	Divisional Report	CQGF's	Monthly	Divisional Governance Meeting	
Action Plans are completed by all leads for NICE guidelines to identify and address any shortfalls including decisions not to implement.	NICE database updated every month	CQGF's	Monthly	PQC (NICE monitoring section)	
Dissemination, monitoring and implementation of NICE guidance	Nice database with record of compliance and exceptions. Internal audits to ensure adherence to implementation. Compliance reporting to all Divisional	CQGF's	Continuous monitoring. Monthly reporting.	PQC Divisional Governance Meeting. Clinical Audit & Effectiveness Monthly meeting	

	Governance meetings. Compliance and exception reporting to PQC				action and report to PQC.

4 Duties and Responsibilities of Individuals and Groups

4.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

4.2 Ward Managers, Matrons and Managers for Non Clinical Services

All Ward Managers, Matrons and Managers for Non Clinical Services must ensure that employees within their area are aware of this document; able to implement the document and that any superseded documents are destroyed.

4.3 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

4.4 The Clinical Audit and Effectiveness Department

Responsibilities include:

- Ensuring all new published guidance from the NICE website is registered to the Trust's NICE database upon publication.
- Disseminate new NICE guidance and an Assessment Proforma (Appendix B) on the day of publication to the CQGF's.
- Provide a quarterly Trust status update and report areas of non-compliance with details of supporting action plans and /or any associated risk identified to the Patient Quality Committee meeting.
- Ensure all NICE records are accurately maintained using the Trust's NICE database as advised by Clinical Leads and/or Divisions.

4.5 Clinical Quality Governance Facilitators

Responsibilities include:

- Assess all new published guidance received from the Clinical Audit and Effectiveness Department; identify the relevant clinical lead/s.
- Disseminate published guidance and assessment proforma to the relevant clinical lead/s to complete.
- Monitor completion of assessment proformas in line with local governance arrangements.
- Work with/liaise with clinical leads to ensure timely completion.
- Ensure any completed assessments and additional upates are provided to the Clinical Audit Department for logging onto the Trust's NICE database.

4.6 Clinical Leads

Upon receipt of new NICE Assessment Proforma, it is the responsibility of the Clinical Lead to:

- Ascertain if they are the most appropriate person to respond.
- Identify if the guidance is relevant to the Trust.
- Consider the guidance and complete the assessment proforma.
- To carry out a Risk Assessment on areas of non-compliance.
- Submit completed assessment proforma to the Clinical Audit Department within four weeks.

4.7 All Employees

All employees are responsible to ensure their compliance with this document by:

- Ensuring any training required is attended and kept up to date.
- Ensuring any competencies required are maintained.
- Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.

4.8 The Patient Quality Committee

The Committee is responsible for overseeing all Clinical Governance activity in the Trust, including divisional responsibility for NICE guidance and standards. The Committee oversees the Trust Clinical Audit and Effectiveness activity.

The Committee will ensure that adherence to this policy provides assurance to the Trust Board on implementation of guidance from NICE. The Clinical Audit & Effectiveness Department will continue to ensure the NICE database is updated to provide evidence of a robust process for future Care Quality Commission (CQC) assessments and inspections.

The PQC includes key representatives from each Clinical Division, Allied Health Professionals, Medical, Nursing, Management, Clinical Audit, Infection Prevention & Control, Health & Safety, and Clinical Risk Management.

Responsibilities include:

- Providing assurance to the Trust Board about Divisional NICE Compliance.
- Reviewing and approving the Trust's annual audit programme and annual report.
- Co-ordinating the implementation and monitoring of cross Division Clinical Governance and quality management and providing support to the Integrated Governance Committee.
- Supporting the implementation of the Trust wide Audit Plan to ensure quality of patient care is in line with the best available evidence of clinical and cost effectiveness.

They also make the decisions about participation in any Clinical Audit and Effectiveness audits, based on their quality and relevance to the organisation.

5 Further Reading, Consultation and Glossary

5.1 References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	How to put NICE Guidance into Practice	https://www.nice.org.uk
2	Standards for Better Health	http://webarchive.nationalarchives.gov.uk
3	New NHS, Modern, Dependable	http://webarchive.nationalarchives.gov.uk
4	A First Class Service	http://webarchive.nationalarchives.gov.uk
5	Clinical Audit and Effectiveness Policy	T:\Trust-wide Documents
6	Risk Management Strategy	T:\Trust-wide Documents
7	NHS Improvement	https://improvement.nhs.uk/
8	CQC	http://www.cqc.org.uk/

5.2 Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department	Date Consultee Agreed Document Contents
Divisional Clinical Quality Governance Facilitator Lead	19/08/2019
Clinical Risk & Patient Safety Advisor - Clinical Risk Department	09/08/2019
Regulator & Compliance Manager	29/08/2019

6 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been completed for this document and can be found at Appendix A.

Appendix A - STAGE 1: Initial Screening For Equality Impact Assessment

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project? Dissemination, Monitoring & Reporting of NICE Guidance Policy		
2.	Briefly describe the aim of the policy, strategy, and project. What needs or duty is it designed to meet? This policy outlines the process for assuring a consistent approach towards the dissemination, implementation and monitoring of NICE guidance at Great Western Hospitals NHS Foundation Trust (the Trust).		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?		**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?		**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?		**No**

Signed by the manager undertaking the assessment	Sharon Edwards
Date completed	11/09/19
Job Title	Clinical Audit and Effectiveness Manager

On completion of Stage 1 required if you have answered YES to one or more of questions 3, 4 and 5 above you need to complete a STAGE 2 - Full Equality Impact Assessment

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

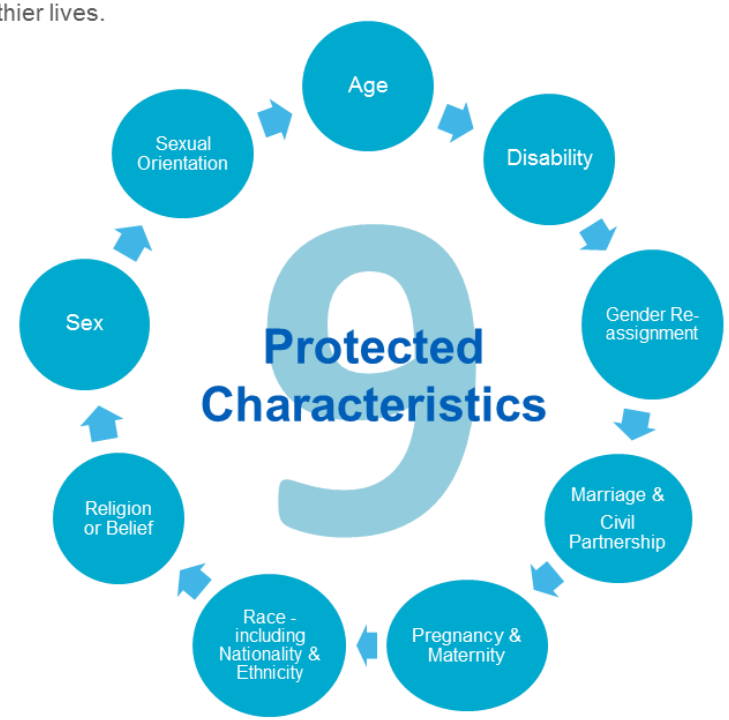
If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.



Appendix B – NICE Assessment Proforma

National Institute for Health and Care Excellence (NICE) Assessment Proforma

Guidance Number: **Guidance Title:** **Date:** *Click here to enter a date.*

Division: *Choose an Item.* **Lead/s:** **Division:** *Choose an Item.* **Lead/s:**
Division: *Choose an Item.* **Lead/s:** **Division:** *Choose an Item.* **Lead/s:**

SECTION ONE – INITIAL ASSESSMENT

1. **Is this guideline relevant to your service?** ☐ Yes ☐ No - **Please clarify**:
This reason may be used to justify why the Trust should not change practice to comply with this guideline. i.e. service is not commissioned.

If the guideline is relevant –

2. **Does current practice meet the guideline?** ☐ Yes ☐ No - **Please clarify**:
3. **Is an audit required?** ☐ Yes ☐ No - **Audit is required if deemed a priority by the Division or is a NICE TA**
4. **Will this guidance have Financial Implications?** ☐ Yes ☐ Cost of Drugs/Equipment ☐ Delivery of Service ☐ No financial implications

   a. **If yes, are you able to give an immediate estimate of the total financial cost?**

SECTION TWO – NON/PARTIALLY COMPLIANT NICE GUIDELINES

All NICE guidelines that are confirmed with areas of non-compliance are required to be risk assessed and an action plan developed in order to become compliant.
Action Status – (1) Recommendation agreed but not yet actioned, (2) Action in progress, (3) Recommendation fully implemented, (4) Recommendation never actioned (please state reasons) and (5) Other (please provide supporting information)

NICE ACTION PLAN

NICE Recommendation / Area of Non Compliance	Actions required to become compliant	Deadline Date	Person Responsible	Division	Comments / Action status

RISK ASSESSMENT (see matrix below for further support)

What are the hazards?	Who might be harmed and how?	What are you doing already?	Consequence (S) (1-5)	Likelihood (L) (1-5)	Risk Rating (SXL)	What further action is necessary?	Action by whom?	Action by when?	Completion date	Reviewed Date and new Risk Rating

Significant risks must be added to the Trust's Risk Register

When the above NICE action plan has been implemented the risk assessment should be reviewed to show the new risk rating

Risk Registered Number:

Risk Scoring Matrix

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1-3 Low Risk 4-6 Moderate Risk 8-12 High Risk 15-25 Extreme Risk

Risk = Consequence x likelihood (S x L)

			Likelihood		
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Appendix C – NICE Process

NICE Publish guidelines on or around the 4th Wednesday of each month

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Clinical Audit & Effectiveness Department disseminate list of published guidelines to Divisional Quality Governance Facilitators

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Divisional Quality Governance Facilitators disseminate relevant NICE guidelines to Clinical Leads for assessment and completion of NICE assessment proforma.
Completed assessment proforma to be submitted to the Clinical Audit & Effectiveness Department via the Divisional Governance Facilitator.

→ If the guideline has been assessed as "Compliant", the Trust NICE records are updated. The Divisional Governance Facilitator will keep track of compliant guidelines and ensure these are audited where

→ If the guideline has been assessed as "Not Compliant", the action plan along with the Risk Assessment must be completed on the Assessment Proforma. This must be added to the Divisional Risk Register if appropriate.

If the guideline has been assessed as intentionally 'Not Compliant' the NICE data base will be updated accordingly.

Once the action plan has been received the Trust status will change to "Implementing" until confirmed as "Compliant"

When the action plan date has expired the status will change to "Out of Time Frame" until confirmed as completed and becomes "Compliant"

→ If the guideline has been assessed as "Not Applicable" the Trust records are updated and no further action is required

→ All completed NICE assessment proformas are logged onto the central NICE database for reporting.

Any exceptions and outstanding responses will be reported at the Divisional Patient Safety and Quality Meetings across the Trust and also Trust Patient Quality Committee on a quarterly basis