Barnsley Hospital NHS
NHS Foundation Trust

POLICY CONTROL SHEET

Policy Title And ID number	**LfE 5.8 Best Practice - NICE**			
Sponsoring Director:	**Medical Director**			
Implementation Lead:	NICE Lead			
Impact:	*(a) To patients*	Yes		
	(b) To Staff	Yes		
	(c) Financial			
	(d) Equality Impact Assessment (EIA)	Completed: **Yes**		
	(e) Counter Fraud assessment	Completed: **Not required**		
	(e) Other			
Additional Costs:			*Budget Code*	*Revenue or Non Revenue*
	(a) Training:	*£*		
	(b) Implementation:	*£*		
	(c) Capital:	*£*		
	(d) Other	*£*		
Training implications:	*To be incorporated into induction:* **No**		*Other:*	
Date of consultation at:	*Board of Directors*		October 2007	
	Executive Team		*25 Feb 2010*	
	Divisional Medical Directors/Clinical Directors			
	Assistant Divisional Directors/Heads of Department			
	Board Committee		*3 March 2011*	
	Joint Partnership Forum			
	Local Negotiating Committee			
	Infection Control Committee:			
	Health & Safety Committee			
	Clinical Guideline & Policy Group		*4 Feb 2010, March 2011*	
Alignment	*HR:*			
	Strategic Direction:			
	Board Assurance:			
	Clinical Governance Committee:		2 March 2011	
Date of Final Draft:	*25 February 2011*		Issue Number:	2
Date of Final Approval:	*3 March 2011*		Approved by:	CGC
Implementation Date:				
Date of last review:	November 2010	Date of next review:	January 2013	
Circulation Date:				

Circulation:		Yes	Comment
	Directors	✓	
	Non Executive Directors	✓	
	Divisional Medical Directors/Clinical Directors	✓	
	Medical Staff Committee/SMSF	✓	
	Assistant Divisional Directors	✓	
	Assistant Nursing Directors	✓	
	Heads of Department	✓	
	H&S Committee Members		
	Policy database/warehouse	✓	
	Others (to be listed):		

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NHS Foundation Trust

BEST PRACTICE - NICE POLICY

DOCUMENT ID: LfE 5.8
ISSUE NO 2

OCTOBER 2007
(AMENDED JANUARY, SEPTEMBER 2010 AND FEBRUARY 2011)

SPONSORING DIRECTOR: MEDICAL DIRECTOR

BEST PRACTICE - NICE POLICY
(POLICY ID: LfE 5.8)

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BEST PRACTICE - NICE POLICY
(POLICY ID: LfE 5.8)

1. STATEMENT OF INTENT

The Trust is committed to ensuring that there is a systematic process for introducing, implementing, monitoring and evaluating National Institute for Health and Clinical Excellence (NICE) guidance and Quality Standards within the Trust. This implementation of NICE guidance will be overseen by the Clinical Guidelines and Policies Group (CGPG). NICE Quality Standards will be overseen by the Medical Director.

2. INTRODUCTION

NICE guidance

The Trust has an obligation to implement guidance issued by NICE. The role of NICE is to provide patients, health professionals and the public with robust and reliable guidance on current 'Best Practice'. NICE guidance covers:

- **Technology Appraisals (TA) –** guidance on the use of new and existing health technologies (including drugs, medical devices and procedures)
- **Clinical Guidelines (CG) –** guidance on the appropriate treatment and care of patients with specific diseases and conditions
- **Interventional Procedures (IPG) –** guidance on the efficacy and safety of interventional procedures
- **Public Health Guidance** – guidance on the promotion of good health and the prevention of ill health

In 2001 the government placed a statutory obligation on NHS organisations to implement NICE Technology Appraisal guidance.

The Care Quality Commission (CQC) in their guidance, Essential Standards of Quality and Safety, state in Outcome 16: Assessing and monitoring the quality of service provision, that relevant guidance must be taken into account including that from the CQC Schedule of Applicable Publications that includes NICE guidance.

Guidance will be implemented in a co-ordinated way across the local health community, however the Trust will support working in a co-ordinated way with other partners in the local health and social care community. Any shared care protocols should reflect NICE Guidance.

The following guidance was taken into account in writing this Policy:

National Institute for Health and Clinical Excellence December 2005, '*How to put NICE guidance into practice. A guide to implementation for organisations.*'

3. IMPLEMENTATION OF NICE GUIDANCE

3.1 Identification, dissemination and implementation of relevant documents

The CGPG will be responsible for the identification, dissemination and overseeing the implementation of NICE guidelines. The CGPG will be chaired by the Medical Director and report to the Clinical Governance Committee. The duties for the CGPG members are outlined in 'Section 4. Management Arrangements' and in the Terms of Reference (Appendix I).

3.2 Process for identification, dissemination and implementation of NICE guidance

The process for identification, dissemination and implementation of NICE guidance is outlined in Appendix IV.

3.3 Designated Leads

The designated lead will normally be a clinician, health professional or manager whose service would be affected by the guidance they are designated to review and implement.

Designated leads are responsible for co-coordinating a baseline assessment including developing an action plan in conjunction with their Governance Team; and identifying any cost implications. They will have responsibility for quarterly reporting on progress of implementation and identifying any barriers to implementation to the CGPG.

If guidance cannot be implemented fully, partially or within the agreed timescales, a risk assessment must be carried out and documented within the relevant Risk Register as per Trust policy.

4. MANAGEMENT ARRANGEMENTS

Overall responsibility for the management of risk lies with the Chief Executive as Accountable Officer for the Trust.

All Trust directors are responsible, collectively, for the Trust's systems of internal control and management. The Board of Directors needs to be satisfied that appropriate policies and procedures are in place and that systems are functioning effectively.

The Board of Directors has delegated its accountability arrangements for the Policy for implementation of NICE guidance to the Medical Director.

The responsibility for the effective implementation of the NICE policy and supporting procedures necessarily involves the whole management chain of command, and all members of staff have a responsibility to ensure the effective implementation of the policy and procedures.

Within that system there are certain key officers who's specific functions are outlined below.

Medical Director
The Medical Director has delegated authority and responsibility for the dissemination, review, implementation and monitoring of all NICE guidance.

The Medical Director will Chair the CGPG and ensure gaps in assurance are reported to the Clinical Governance Committee.

Divisional Directors
The Divisional Directors will ensure the process for review, implementation and monitoring of NICE is followed within their areas of responsibility.

They will ensure any identified gaps in the implementation process are communicated to the CGPG, action planned and monitored through local governance arrangements.

Chief Pharmacist
Will ensure that all NICE Guidance relating to the use of medicine is reviewed by the Medicines Management Committee, ensuring compliance or gaps in assurance are documented.

Ensure any identified gaps in assurance have an action plan in place and progress is reported to the CGPG through close liaison with Trust NICE Lead.

Director of Quality and Standards
The Director of Quality and Standards is responsible for consistently implementing the organisational arrangements for Governance throughout the Trust with operational responsibility for ensuring NICE recommendations are reviewed, implemented and monitored as necessary.

Clinical Guidelines and Policies Group
The CGPG, chaired by the Medical Director, will be responsible for:

- Forwarding, on a quarterly basis, the NICE Forward Planner to the Director of Strategy and Assistant Divisional Directors.

- Dissemination and monitoring the implementation in respect of NICE Guidance. This group will report into the Clinical Governance Committee.

5 MONITORING

See monitoring matrix at appendix I.

6 QUALITY STANDARDS

The implementation and evidencing of NICE Quality standards will be overseen by the NICE/NHSLA Lead using Performance Accelerator as a monitoring tool.

7. REVIEW DATE

This policy will be reviewed every 2 years or as required by new legislation.

Appendix 1

Monitoring matrix

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible person/group/ committee	Frequency of monitoring	Responsible person/group/ Committee for review of results	Responsible person/group/ Committee for development of action plan	Responsible person/group/ Committee for monitoring of action plan
a. Duties	Attendance at CGPG meetings	CGPG	Quarterly	Medical Director	CGPG	Medical Director
b. process for identifying relevant documents	CGPG minutes	NICE Lead	Monthly	CGPG	CGPG	Medical Director
c. process for disseminating relevant documents	BaNGdb reports	CGPG	Monthly	CGPG	CGPG	Medical Director
d. process for conducting an organisational gap analysis	Baseline assessment	Division/Specialty	Monthly	CGPG	Division/Specialty	Medical Director
e. process for ensuring that recommendations are acted upon throughout the organisation	Quarterly review of action plans at CGPG	CGPG	Quarterly	CGPG	Medical Director	Medical Director
f. process for documenting any decision not to implement NICE recommendations	Exception reports from BaNGdb, CGPG Minutes, Trust Risk Register	CGPG	Monthly	CGPG	Medical Director	Medical Director

Appendix II

TERMS OF REFERENCE
CLINICAL GUIDELINES AND POLICIES GROUP

1. Constitution

The Clinical Governance Committee resolves to establish a group to be known as the Clinical Guidelines and Policies Group (CGPG).

2. Membership

2.1 The Clinical Guidelines and Policies Group will consist of:

Medical Director (Chair)
NICE Lead, Deputy Clinical Effectiveness Manager
Divisional Medical Director Emergency and Integrated Medicine or deputy
Divisional Medical Director Surgery and Critical Care or deputy
Divisional Medical Director Women's, Children's and diagnostics or deputy
Clinical Director Anaesthetics or deputy
Clinical Director Pathology or deputy
Clinical Director Medical Imaging or deputy
Director of Post Graduate Medical Education or deputy
Deputy Chief Nurse or deputy
Pharmacy Adviser or deputy
Finance Representative or deputy
Risk Manager or deputy

2.2 Members will be required to attend at least 75% of meetings each year.

2.3 The presence of at least five members, including at least two clinical representatives shall constitute the required quorum to enable the Group to operate.

2.4 Deputies will be expected to attend in place of the Group members as necessary.

2.5 The Group will be chaired by the Medical Director, and in their absence by a Senior Clinician.

3. Attendance at Meetings

3.1 Other clinical professionals will be co-opted to provide advice as required.

3.2 Other members of staff may attend the meetings as necessary to discuss particular issues.

3.3 The Secretary to the meeting will be determined.

4. Frequency of Meetings

The CGPG will meet monthly within two weeks of the release of NICE specific publications. Meetings to alternate between virtual and actual meetings. The Group will meet more frequently if required.

5. Purpose

To oversee the:

- process for introducing NICE Guidance within the Trust and to monitor and evaluate progress made in implementation.
- monitoring and approval of NHS Litigation authority (NHSLA) polices
- approval of clinical policies and guidelines.

6. Duties

The duties of the Group will be:

NICE

a) To determine, agree and review (with Board approval) the initiation, implementation and monitoring of NICE guidance within its' Services
b) To review guidance issued by NICE for assessment and action by the Trust and initiate its introduction into the Trust services where applicable
c) To determine which operational service and designated lead who will be responsible for assessing the implications of a particular piece of guidance and producing an implementation action plan, costed where appropriate
d) To issue summary recommendation proformas and Baseline Compliance Review Questionnaires to the designated lead
e) To receive and monitor implementation action plans from the designated lead/division
f) To ensure that the audit requirements related to specific NICE guidance have been included in operational service's Clinical Audit schedules and registered on the Clinical Audit database (CLAUDe)
g) Receive action plans from appropriate Division(s) to monitor progress made in implementation
h) To provide feedback to the Commissioner (this should be through the Director of Quality and Standards) on the progress of implementing NICE guidance within the Trust through contract monitoring meetings.
i) To send the NICE Forward Planner, on a quarterly basis, to the Director of Strategy and Assistant Divisional Directors.

NHSLA

j) Monitor and approve NHSLA (clinical only) policies for onward transmission to the Executive Team (ET) and/or Board.

CLINICAL POLICIES AND OTHER GUIDELINES

k) To monitor and approve Clinical Policies and other best practice guidelines for onward transmission to ET and/or Board

l) To determine which operational service and lead person will be responsible for assessing the implications of a particular piece of guidance and producing an implementation action plan.

7. Reporting Arrangements

The Clinical Guidelines and Policies Group will report to the Clinical Governance Committee via monthly exception reports.

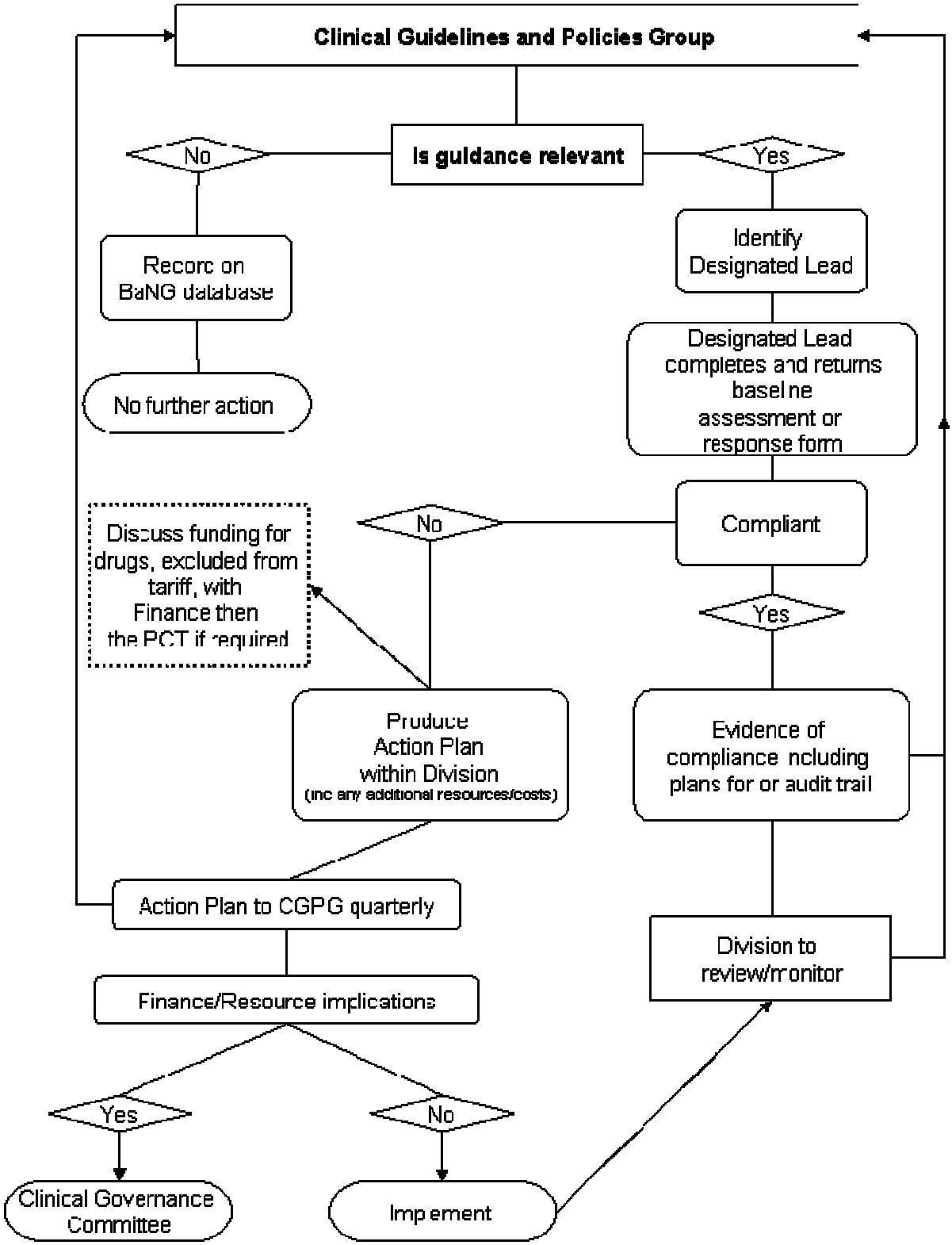
8. Review

The Terms of Reference and membership of the Clinical Guidelines and Policies Group will be reviewed annually.

Last reviewed: September 2010
Next review: September 2012

Appendix III

NICE Implementation Flowchart



Appendix IV

Process for Identification, Dissemination and Monitoring of NICE guidance

1. Receipt and Recording

All NICE guidance will be downloaded on a monthly basis by the NICE/NHSLA Lead and recorded on the Barnsley NICE Guidance Database (BaNGdb) and disseminated to the members of the Clinical Guidelines and Policies Group (CGPG) prior to the next meeting.

The CGPG will determine the relevance of the guidance to the Trust and will identify the most appropriate Designated Lead to review and implement the guidance. This information will be recorded on BaNGdb and in the minutes of the relevant meeting.

2. Dissemination to Designated Leads

Following the meeting the NICE/NHSLA Lead will ensure that the guidance is disseminated to relevant Designated Leads either by email or face-to-face meeting as required.

The email/meeting will inform the Designated Lead of their role and will include a copy of the summary guidance and a request to reply, using the baseline assessment or designated form, outlining:

- The current level of compliance and how this has been assessed and can be evidenced.
- The actions required to achieve compliance including a comprehensive action plan which must include any resource implications and timescales for review and implementation. (The NICE costing template will be forwarded as appropriate).
- Requirements for Clinical Audit.

Guidance relevant to Surgery will be taken to the Divisional Governance Meetings by the Non Clinical Risk Adviser where it will be discussed, and the reply forms completed. The Non Clinical Risk Adviser will return the forms to the NICE/NHLA Lead following the meeting.

The reply should be returned to the NICE/NHSLA Lead, using the guidance specific form, in line with the following timescales:

- Technology Appraisals – within 2 months of receipt
- Clinical guidelines – within 3 months of receipt
- Interventional procedure guidelines – within 3 months of receipt
- Public Health guidance – within 3 months of receipt

If a Technology Appraisal relates to the use of medicines the Divisional Director for Diagnostics will ensure that the guidance is reviewed by the Medicines Management

Group and returned to the CGPG with the outcome of the review and action plan if appropriate.

If the guidance is relevant to more than one specialty, the Medical Director will nominate a member of staff to lead implementation across the Trust.

Responses will be recorded on the BaNGdb by the NICE/NHSLA Lead.

Responses will be either:
discussed at the following CGPG meeting
or
forwarded to CGPG members for comments at virtual meetings

A reminder will be sent to Designated Leads if replies are not received within the above timescale and will be reported at the CGPG meeting. Consistent non replies will be reported to the Clinical Governance Committee.

BASELINE ASSESSMENTS - NICE Clinical Guidelines only
Baseline assessments, showing compliance and evidence of compliance will be completed by the appropriate Division. Initially the Key Priorities for Implementation (KPIs) will be completed, followed by the remaining recommendations when compliance with KPIs achieved.

The Baseline Assessment will form the action plan for the guideline.

ACTION PLANS – NICE guidance other than Clinical guidelines
Action plans will be produced by each division where the Trust is non-compliant.

3. Monitoring of Implementation

3.1 Action plans for non compliant specialties will be submitted by divisions and monitored by the CGPG on a quarterly basis.
3.2 Decisions not to implement NICE guidance will be recorded on the BaNGdb, in the CGPG minutes and discussed at the Clinical Governance Committee and added to the relevant Division and Trust risk register.
3.3 The NICE/NHSLA lead will produce bi-monthly response, exception and non-compliance reports to be reviewed at the CGPG meeting.
3.4 If guidance cannot be implemented fully, partially or within the agreed timescales, a risk assessment must be carried out and documented within the relevant Risk Register as per Trust policy.

4. Clinical Audit

The NICE/NHSLA Lead will produce a quarterly report of guidance appropriate to the Trust for use by the Clinical Effectiveness Officer within the Clinical Audit Department. This guidance will be added to the Divisional Clinical Audit Programmes.

5. Definitions for Reporting Purposes

Under Review: In the process of being reviewed by the designated lead to determine the Trust's compliance and development of an action plan if required.

Compliant: the Trust is fully compliant with the guidance.

Partially Compliant: the trust is working toward full compliance and an action plan has been developed to address areas of non-compliance.

Non Compliant: the Trust is not working toward full compliance. The reasons for this will be recorded on the BaNGdb, in the CGPG minutes and discussed at the Clinical Governance Committee and added to the relevant Division and Trust Risk Register.