

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Implementation Policy for NICE Guidelines

Effective: October 2010

Review: October 2012

1. Introduction

This policy is intended for all Trust staff involved with the implementation of NICE guidance. It should be read in conjunction with the [Clinical Audit Policy](#) and [Clinical Practice Guidelines & Protocols policy](#).

2. Definitions

- 2.1 The policy covers all guidelines issued by NICE: Technology Appraisals (TAGs), Interventional Procedures (IPGs), Clinical Guidelines (CGs), Public Health Interventional guidelines (PHIs), and Guidance for Cancer Services: Improvement Outcomes Guidance (IOGs).
- 2.2 TAGs are recommendations on the use of new and existing health technologies. As stated in the NICE publication "*How to put NICE guidance into practice – a guide to implementation for organisations*" (NICE 2005), the Secretary of State has directed that the NHS provides funding and resources for medicines and treatments that have been recommended by TAGs normally within three months from the date of publication.
- 2.3 IPGs cover the safety and efficacy of surgical and diagnostic procedures with the core standard stating that healthcare organisations should protect patients by following NICE IPGs.
- 2.4 CGs provide guidance on the appropriate treatment and care of people with specific diseases and conditions. Implementation of Clinical Guidelines forms part of the Care Quality Commission developmental standards.
- 2.5 PHIs provide guidance on the promotion of good health and the prevention of ill health.

3. Principles of Implementation

3.1 Roles and Responsibilities

3.1.1 The Trust approach will follow the principles set out in the NICE publication "*How to put NICE guidance into practice – a guide to implementation for organisations*" (NICE, 2005) with particular reference to the following key components:

- board support and clear leadership
- support from Clinical Governance and Risk Department to coordinate the process

- multidisciplinary committee structure to consider all new guidance
- systematic approach to financial planning
- systematic approach to implementing guidance
- evaluation and audit.

3.1.2 Board support and clear leadership

Ultimately, responsibility for the implementation of NICE guidance rests with the Medical Director who will maintain an overview of the implementation of NICE guidance and provide advice and guidance in relation to NICE guidance in which the Trust is non-compliant.

3.1.3 Support from Clinical Governance and Risk Department

The Department will coordinate the implementation of NICE guidance by:

- disseminating guidance to key groups
- reviewing and informing stakeholders of prospective guidance being issued from NICE
- ensuring effective processes for monitoring
- producing regular board reports.

3.1.4 Multidisciplinary committee structure

The Clinical Effectiveness Audit and NICE Guidelines Committee (CEAGC) will consider all new guidance issued by NICE to ensure:

- effective forward planning occurs and financial implications have been considered
- process for implementation are followed
- where a baseline assessment (gap analysis) has identified difficulties with compliance that the relevant issues are monitored.

3.1.5 Systematic approach to financial planning

- The Trust recognises the importance of clear financial planning in implementation NICE guidance. This is in accordance with the Audit Commission report “Managing of the financial implications of NICE guidance”. In particular, the implications of Payment by Results on funding of NICE recommendations must be clearly understood.
- The CEAGC will seek clarification and assurances that appropriate assessments have been made by Directorates.

3.2 Systematic approach to implementing guidance

NICE issues new guidance on the fourth Wednesday of each month and upon receipt of these guidelines into the Trust the following approaches are undertaken:

Technology Appraisal Guidelines (TAGs) see Appendix 1

- TAG received in CGARD and posted on Clinical Guidelines Database for dissemination to staff and Quarterly Clinical Guidelines Newsletter on Intranet Newsletter.
- CGARD send TAG to respective Directorate Manager / lead clinician to determine if Guideline is relevant for use within the Trust. If the Guideline is not relevant then no further action is required and is identified For Reference on the Clinical Guidelines Database.
- If Guideline is relevant to the Trust (Endorsed), then if guideline is a drug related TAG then TAG goes to North of Tyne Area Prescribing Committee / North East and Cumbria Drugs Approval Group for ratification / interpretation see Appendix 2.
- If Guideline is a non-related TAG then lead clinician is asked to undertake a baseline assessment (gap analysis).
- The lead clinician attends the CEAGC to discuss implementation and baseline assessment (gap analysis) to determine if the Trust is compliant.
- If the Trust is compliant, then the baseline assessment (gap analysis) is filed For Reference.
- If the Trust is not compliant, then recommendations / actions are identified for achieving compliance. Risks of non-compliance rated as Moderate or above are entered onto the risk register and monitored by CEAGC on a quarterly basis. Risks rated as less than Moderate are recorded on the risk register and monitored locally by the directorate.

Interventional Procedures (IPGs) see Appendix 3

- IPG received in CGARD and posted on Clinical Guidelines Database for dissemination to staff and Quarterly Clinical Guidelines Newsletter on Intranet Newsletter.
- CGARD send IPG to respective Directorate Manager / lead clinician to determine if Guideline is relevant for use within the Trust. If the procedure is not undertaken within the Trust then no further action is required and is identified For Reference on the Clinical Guidelines Database.
- If the Trust is already undertaking the procedure, then it is Endorsed and no further action is required and is identified For Reference on the Clinical Guidelines Database.
- If the Trust does not currently undertake the procedure but a clinician wishes to do so then they must apply to the Clinical Governance and Quality Committee to undertake the procedure.
- The lead clinician is informed of the of the Committee's decision and, if successful, CGARD record Endorsed on the Clinical Guidelines Database.

Clinical Guidelines (CGs) see Appendix 4

- Clinical Guideline received in CGARD and posted on Clinical Guidelines Database for dissemination to staff and Quarterly Clinical Guidelines Newsletter on Intranet Newsletter.
- CGARD send guideline to respective Directorate Manager / lead clinician to determine if Guideline is relevant for use within the Trust. If the Guideline is not relevant then no further action is required and is identified For Reference on the Clinical Guidelines Database.
- If Guideline is relevant to the Trust (Endorsed), then lead clinician is asked to undertake a baseline assessment (gap analysis).
- The lead clinician attends the CEAGC to discuss implementation and baseline assessment (gap analysis) to determine if the Trust is compliant.
- If the Trust is compliant, then the baseline assessment (gap analysis) is filed For Reference.
- If the Trust is not compliant, then recommendations / actions are identified for achieving compliance. Risks of non-compliance rated as Moderate or above are entered onto the risk register and monitored by CEAGC on a quarterly basis. Risks rated as less than Moderate are recorded on the risk register and monitored locally by the directorate.

Public Health Interventional Guidelines (PHIs) see Appendix 5

- PHI is received in CGARD and posted on Clinical Guidelines Database for dissemination to staff and Quarterly Clinical Guidelines Newsletter on Intranet Newsletter.
- CGARD send the PHI to the respective lead clinician to determine if Guideline is relevant for use within the Trust. If the Guideline is not relevant then no further action is required and is identified For Reference on the Clinical Guidelines Database.
- If Guideline is relevant to the Trust (Endorsed), then lead clinician is asked to undertake a baseline assessment (gap analysis).
- The lead clinician attends the CEAGC to discuss implementation and baseline assessment (gap analysis) to determine if the Trust is compliant.
- If the Trust is compliant, then the baseline assessment (gap analysis) is filed For Reference.
- If the Trust is not compliant, then the PHI is referred to the Trust Public Health Group.

Improvement Outcomes Guidance (IOGs)

- The Implementation of IOGs is coordinated by cancer networks working in collaboration with partner organisations.
- Each organisation undertakes a gap analysis, for the Trust this is lead by the Cancer team. Key stakeholders meet with the network to devise a plan which goes to the Department of health with appropriate timescales for implementation.
- It is important that representatives of the Trust at Network level communicate with the relevant Clinical Director / Directorate Managers and with the Trust's Cancer team with regards to the implementation of any action plan before that plan is passed to the Network for approval.

3.3 Dissemination of Guidance

In order to ensure that staff are aware, and have access to all appropriate NICE guidelines, all guidelines will be disseminated via the monthly Newsletter issued to staff by CGARD, and posted on the Clinical Governance website. Each guideline will be located within the appropriate directorate's catalogue of NICE guidelines.

3.4 Deviance from NICE Guidance

Where the lead clinician(s) for a specific guideline considers it to be inappropriate to follow the recommendations of NICE, e.g. the evidence base from which the recommendations are derived is considered to be insufficiently robust, it is essential that appropriate discussions are held within the Clinical Effectiveness, Audit and Guidelines Committee.

The Committee will appraise the arguments before confirming or declining its support for the deviance from the guideline. Any deviances will be notified to the Chair, Clinical Governance and Quality Committee by the Chair of the Clinical Effectiveness, Audit and Guidelines Committee. Deviances will be notified to the appropriate Directorate Management team by the Lead Clinician responsible for the particular guideline and this will be entered on to the Risk Register by the team and monitor accordingly.

On the occasions where there are certain aspects of a guideline where the Trust is non compliant, the areas of non compliance will be notified to their respective management team by the lead clinician for inclusion on their risk register and monitored accordingly.

4. Monitoring

Compliance with this policy will be monitored by the Clinical Effectiveness Manager who will request that each NICE Guideline Lead clinician provides an initial organisational gap analysis on implementation of the respective guideline within the Trust to determine the level of compliance with any areas of non-compliance identified.

The Clinical Effectiveness Manager will present a quarterly status report to the Clinical Effectiveness, Audit and Guidelines Committee (CEAGC) who will monitor progress against any identified deficiencies in gap analysis. If this identifies any risks to the Trust rated as Moderate or above these are entered onto the Risk Register and monitored by CEAGC on a quarterly basis. Risks rated as less than Moderate are recorded on the Risk Register and monitored locally by the Directorate. The report will also include a monitoring matrix of Clinical Guidelines and Interventional Procedures.

Where there are specific issues requiring higher level further guidance or issues about implementation these will be reported by the Chair of the Clinical Effectiveness, Audit and Guidelines Committee to the Chair of the Clinical Governance and Quality Committee, who will take further action as required.

In addition, a six-monthly overview report will be presented to the Trust Board by the Clinical Effectiveness Manager, detailing progress on the implementation of NICE TAGs, IPGs, CGs and PHIs.

5. References

Audit Commission. (September 2005) *Managing the financial implications of NICE guidance*. London: Audit Commission

Department of Health (September 1997a) *The NHS Plan*. London: Department of Health.

Department of Health (December 1997b) *The New NHS: modern, dependable*. London: Department of Health

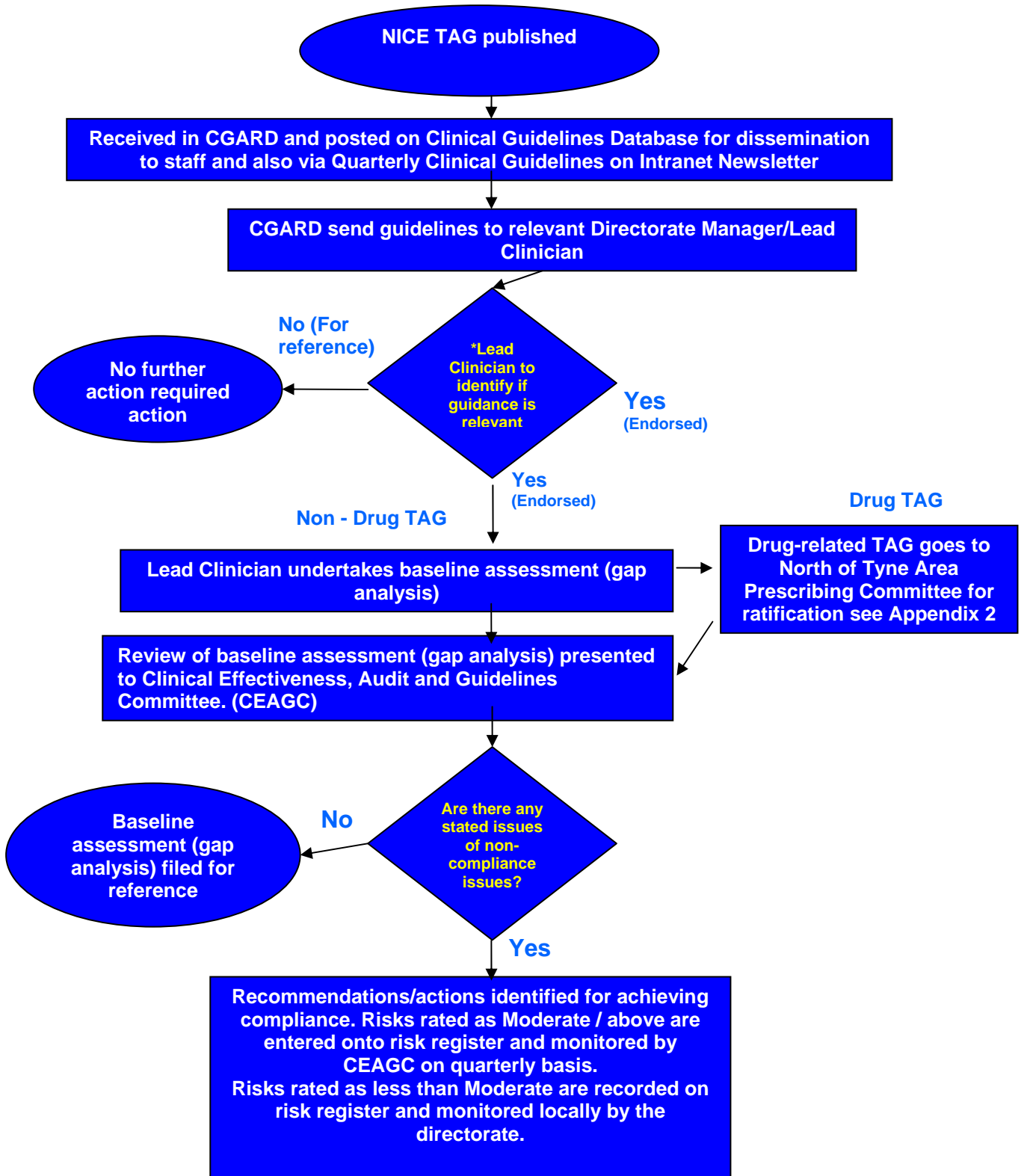
Department of Health (July 1998) *A First Class service: Quality in the new NHS*. London: Department of Health

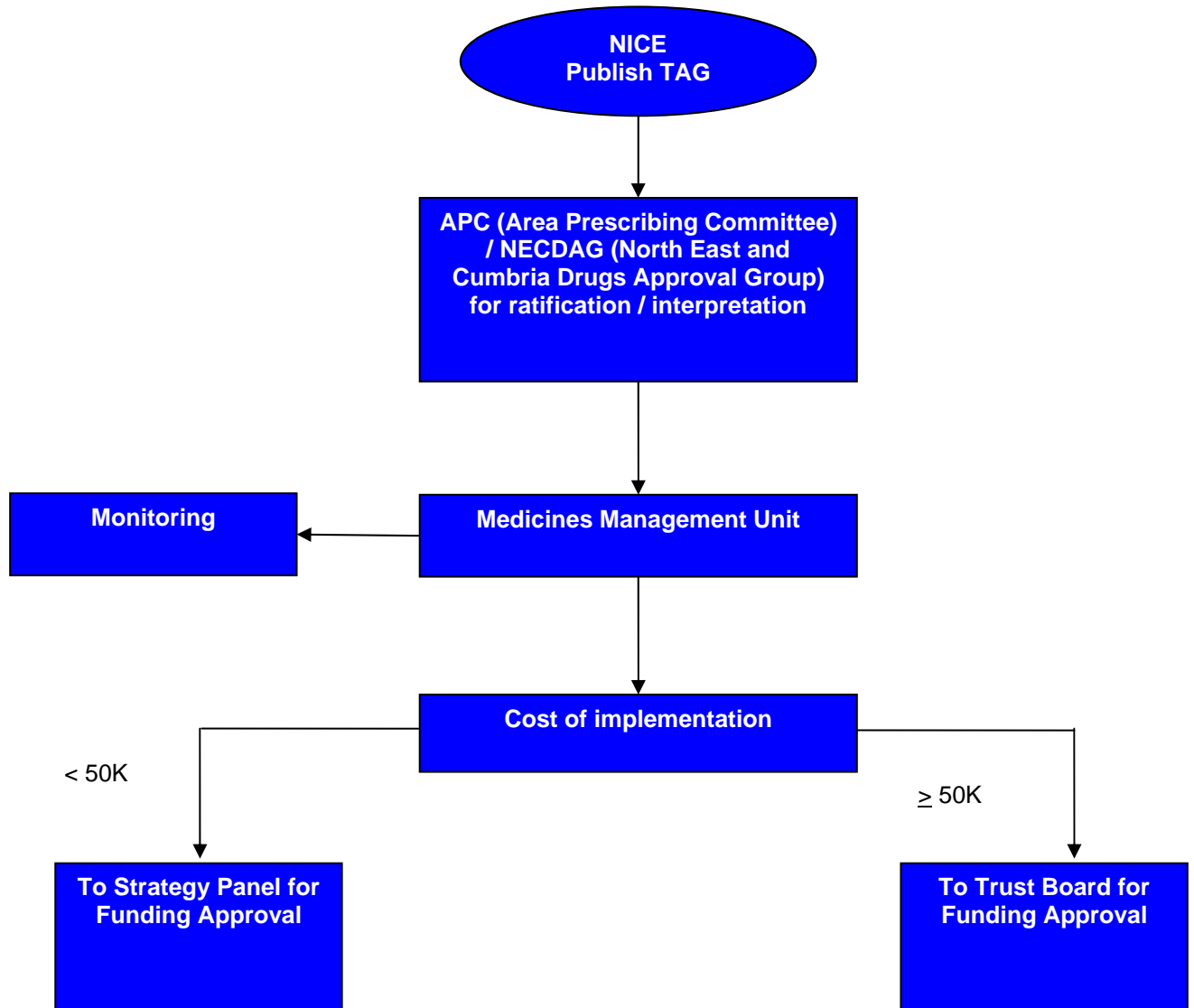
National Institute for Health and Clinical Excellence (December 2005) *How to put NICE guidance into practice: A guide to implementation for organisations* London: National Institute for Health and Clinical Excellence

The Newcastle Upon Tyne Hospitals NHS Foundation Trust (September 2005) *Safety Alert Broadcast System Policy*

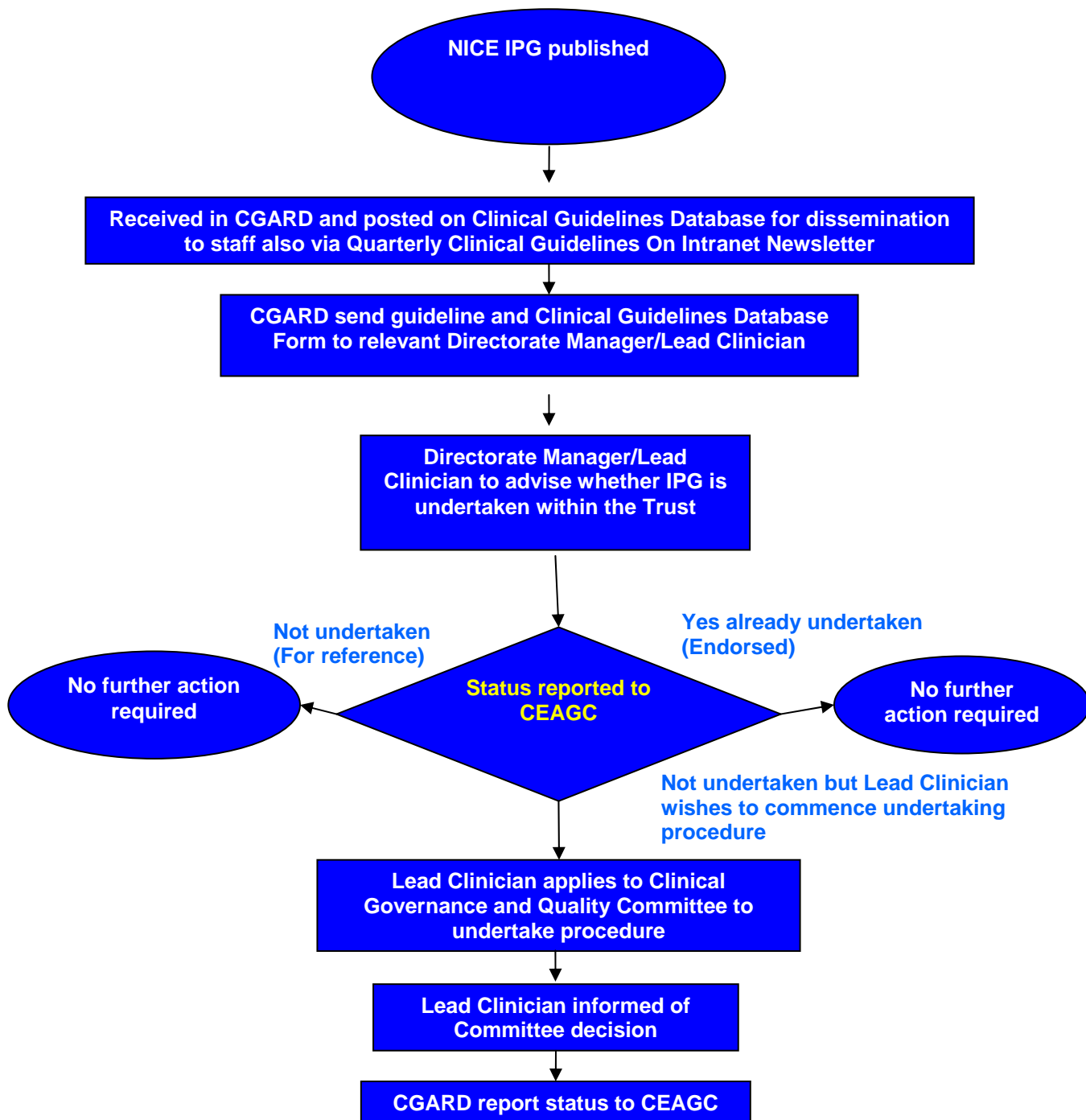
The Newcastle Upon Tyne Hospitals NHS Foundation Trust (October 2007) *Clinical Practice Guidelines & Protocols policy*

Policy Author: Clinical Effectiveness Manager, Clinical Governance and Risk Department

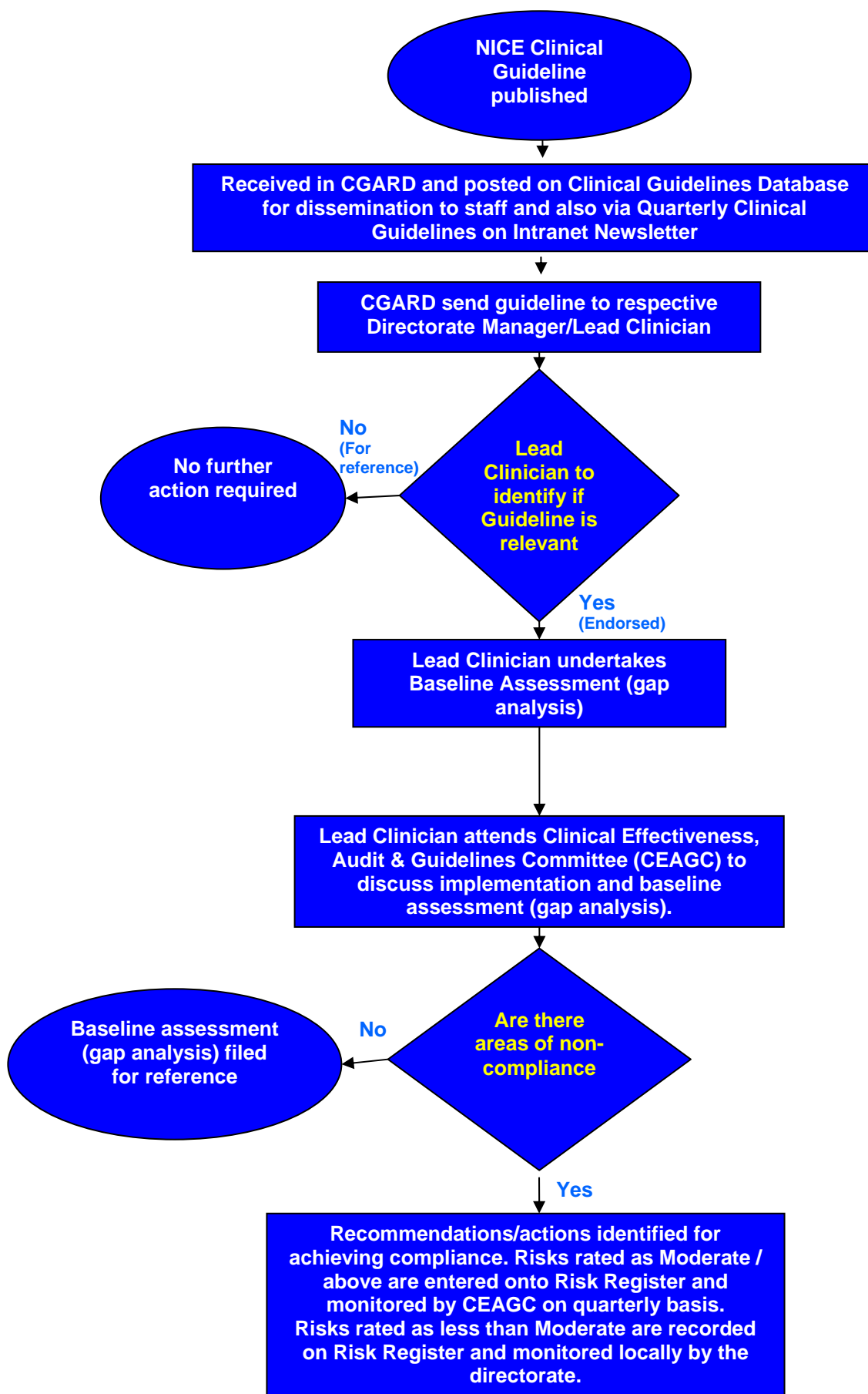




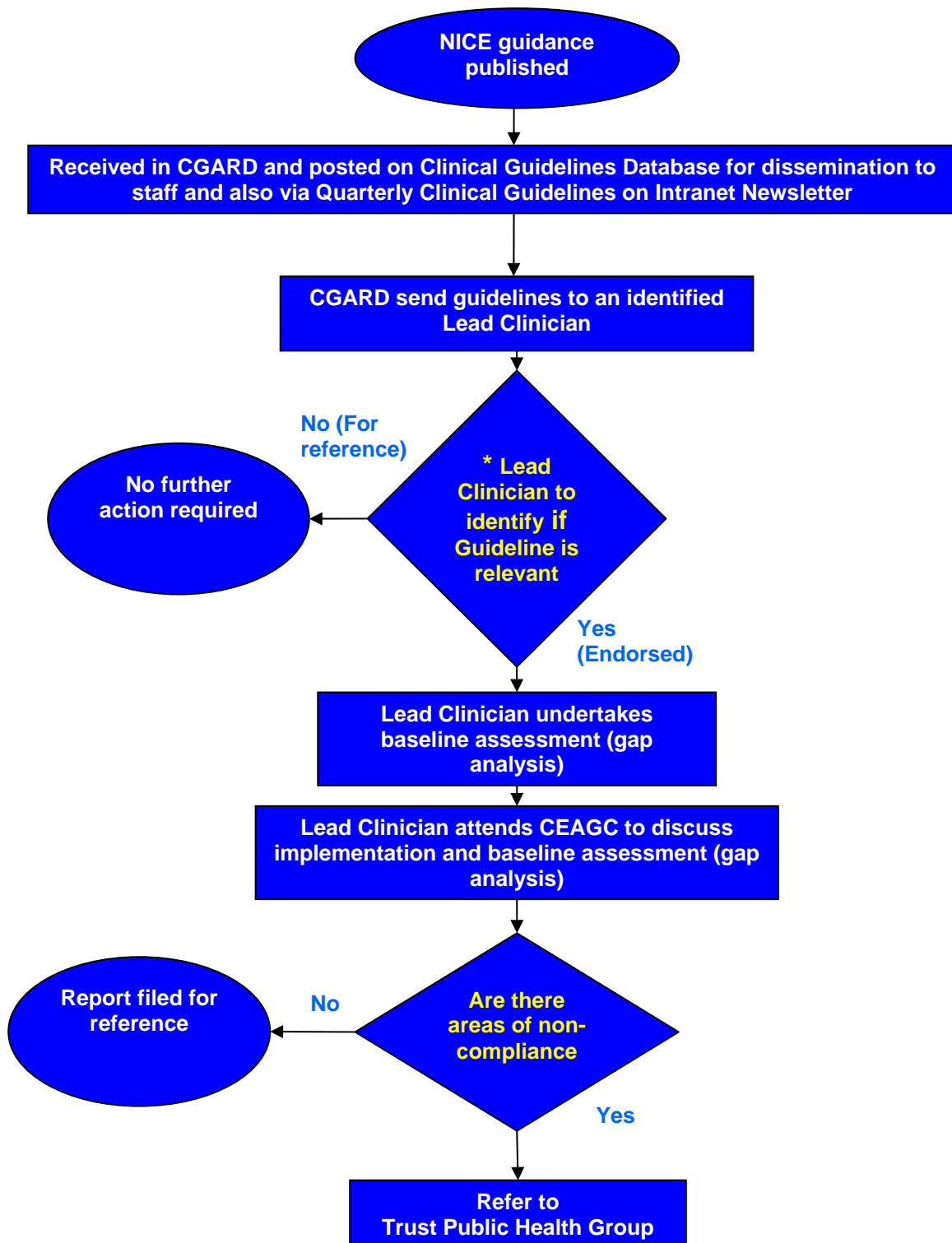
Appendix 3
Flow chart for Implementing Interventional Procedure Guidelines



Appendix 4
Flow chart for Implementing Clinical Guidelines



Appendix 5
Flow chart for Implementing Public Health Interventional Guidelines



THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Implementation of NICE Guidelines	Policy Author:	Clinical Effectiveness Manager
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:	No	This policy does not discriminate on the basis of Race, Ethnicity, Nationality, Gender, Culture, Religion, Sexuality, Age or Disability.
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4(a).	Is the impact of the policy/guidance likely to be negative? <i>(If "yes", please answer sections 4(b) to 4(d)).</i>	N/A	
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
4(d).	Can we reduce the impact by taking different action?	N/A	

Comments:	Action Plan due (or Not Applicable):
	Not applicable

Name and Designation of Person responsible for completion of this form: Mr S Stoker Date: 24 September 2009

Names & Designations of those involved in the impact assessment screening process: Clinical Effectiveness, Audit and Guidelines Committee

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)