The Newcastle upon Tyne Hospitals NHS Foundation Trust

Implementation Policy for NICE Guidelines

<table>
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<tr>
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<th>6.0</th>
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<tr>
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<td>Ratified By:</td>
<td>Clinical Policy Group</td>
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1. Introduction

The Policy sets out the procedures to be followed throughout the Trust to monitor the implementation of guidance published by the National Institute for Health and Care Excellence (NICE).

2. Scope

This policy is intended for all Trust staff involved with the implementation of NICE guidance. It should be read in conjunction with the Introduction and Introduction and Development of New Clinical Interventional Procedures, Clinical Audit Policy and Clinical Practice Guidelines & Protocols policy.

The policy covers all guidelines issued by NICE.

3. Aims

The Policy aims to ensure that all recommendations from NICE are considered by the appropriate area(s) within the Trust and that any mandatory recommendations are implemented in a timely and effective manner. It sets out the processes to be followed, the roles and responsibilities involved and the escalation processes for areas of risk.

4. Roles and Responsibilities

4.1 Medical Director

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

4.2 Clinical Governance and Risk Department

The Department coordinates 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.
4.3 Clinical Effectiveness, Audit and Guidelines Committee (CEAGC)

The Clinical Effectiveness, Audit and Guidelines Committee (CEAGC) considers new guidance issued by NICE, except IPGs (see item 4.4 below and Appendix 3) to ensure:

- effective audit and monitoring arrangements are in place
- effective forward planning occurs and appropriate financial arrangements are in place
- that the Clinical Governance and Quality Committee is notified of any issues concerning non-compliance.

4.4 New Interventions Procedure Committee

- The Committee supports timely and suitably planned innovation.
- Reviews applications to undertake new procedures in the trust, considering the evidence base, whether there are adequate facilities, training for staff and information for patients.
- Makes a recommendation to the Clinical Governance and Quality Committee, which gives the final approval.

4.5 Clinical Governance and Quality Committee

The Clinical Governance and Quality Committee has responsibility for monitoring non-compliant NICE guidelines which are deemed non-compliant and have a risk rating of High or greater.

5. Definitions

5.1 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.

5.2 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.

5.3 CGs and NGs 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.

5.4 PHIs provide guidance on the promotion of good health and the prevention of ill health.

5.5 DTGs are designed to help the NHS adopt efficient and cost effective medical diagnostic technologies more rapidly and consistently.
5.6 MTGs are designed to help the NHS adopt efficient and cost effective medical devices and diagnostics more rapidly and consistently, such as medical devices that deliver treatment such as those implanted during surgical procedures, technologies that give greater independence to patients, and diagnostic devices or tests used to detect or monitor medical conditions.

5.7 **Quality Standards** are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.

5.8 HSTs are recommendations on the use of new and existing highly specialised medicines and treatments. The HST programme only considers drugs for very rare conditions.

5.9 MPGs provide recommendations for good practice for those individuals and organisations involved in governing, commissioning, prescribing and decision-making about medicines.

5.10 SGs provide recommendations for safe staffing including minimum ratios for certain settings.

6. **Implementation of NICE Guidance**

6.1 The Trust approach to the implementation of NICE guidance follows 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.

6.2 **Systematic approach to financial planning**

The Trust recognises the importance of clear financial planning in implementing NICE guidance. This is in accordance with the Audit Commission’s report “Managing the financial implications of NICE guidance” (September 2005). In particular, the implications of Payment by Results on funding of NICE recommendations must be clearly understood.

The CEAGC seek clarification and assurances that appropriate assessments have been made by Directorates.
6.3 Systematic approach to implementing guidance

**TAGs**
- The process for ensuring that recommendations are acted upon throughout the Trust are set out in Appendix 1.
- Appendix 2 details the additional arrangements for drug-related TAGs.

**IPGs**
- Where a Directorate indicates that an IPG is applicable within the Trust, the process for ensuring that recommendations are acted upon throughout the Trust are set out in Appendix 3.
- Any doctor considering use in the NHS of a new interventional procedure which has not been used before, within this Trust, should seek the prior approval of the New Intervventional Procedure Committee using the appropriate form which is available on the Trust intranet. They should state whether the procedure is the subject of NICE guidance as listed on the NICE website.
- If an IPG is not being currently used, but may be used in the future, then at the time of introduction, the lead clinician must ensure that it is discussed at the Clinical Governance and Quality Committee, and thereafter inform the Clinical Governance and Risk Department

**CGs / NGs**
- The implementation process for CGs, NGs, DTGs, MTGs, HSTs, MPGs, PHIs and SGs is identified in Appendix 4.

**Quality Standards**
- The implementation process for Qs is identified in Appendix 4

6.4 Deviance from NICE Guidance

Where the lead clinician(s) for a specific guideline consider 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 deviations will be notified to the Chair, Clinical Governance and Quality Committee through the minutes of the Clinical Effectiveness, Audit and Guidelines Committee and entered on to the Risk Register.

6.5 Non-compliant NICE Guidance

If a NICE guideline is assessed as being non-compliant, the appropriate Directorate Manager is asked to record this on the Directorate’s risk register and if the risk is rated as high or greater then it is monitored by the Clinical
Governance and Quality Committee. If the risk is rated as lower than high risk, the risk is monitored by the Directorate through their clinical governance arrangements.

There is a target risk score for all risks, which recognises that almost all risks will never be completely mitigated, but there is a target level where the risk is tolerable. Once the target score is met and the directorate is managing any risk as part of their business as usual the directorate should then be able to close the risk.

7. Training

There are no specific training requirements identified for this policy.

8. Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

9. Monitoring

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
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<tr>
<td></td>
<td>Method</td>
</tr>
<tr>
<td>Audit the process of implementation of the NICE guidelines</td>
<td>Status report</td>
</tr>
<tr>
<td>Any identified deficiencies in gap analysis to be included on the Risk Register</td>
<td>Status Report</td>
</tr>
<tr>
<td>Progress on compliance with non-compliance NICE guidelines</td>
<td>Status Report</td>
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10. Consultation and review

The processes in this policy have been reviewed and agreed by Pharmacy, Finance, Clinicians and the Clinical Effectiveness, Audit and Guidelines Committee.

11. Implementation (including raising awareness)

Information about NICE guidelines, the implementation processes and the forms to be completed are available on the Trust’s intranet pages. All new NICE Guidelines are published in the Quarterly Clinical Guidelines Newsletter produced by CGARD.
12. **References**

13. **Associated Documents**
   - The Newcastle Upon Tyne Hospitals NHS Foundation Trust [Clinical Audit Policy](#)
   - The Newcastle Upon Tyne Hospitals NHS Foundation Trust [Clinical Practice Guidelines & Protocols Policy](#)
   - The Newcastle upon Tyne Hospitals NHS Foundation Trust [Introduction and Development of New Clinical Interventional Procedures](#)
Appendix 1
Flow chart for Implementing Technology Appraisal Guidelines

NICE guidance published monthly

Received in CGARD and posted on Clinical Guidelines Database

CGARD send guidelines to relevant Directorate Manager/Lead Clinician

*Lead Clinician to identify if guidance is relevant

YES (Endorsed)

Drug-related TAG goes to North of Tyne Area Prescribing Committee for ratification see Appendix 2

NO

Documented in CEAGC minutes and no further

* Directorate Manager/Lead Clinician responsible for disseminating the guidelines to colleagues

Non - Drug TAG

Lead Clinician undertakes gap analysis

Review of gap analysis are presented to Clinical Effectiveness, Audit and Guidelines Committee. (CEAGC)

YES

Are there any stated areas of non-compliance?

NO

Report filed for reference and monitoring

YES

All non-compliant guidelines reviewed at monthly directorate clinical governance meetings

Three months to provide funding

Risks should be registered on the Risk Register. Risks rated “high” or greater monitored by Clinical Governance and Quality Committee. Guidelines rated less than “high” risk to be reported in directorate’s annual report to the CEAGC.
Appendix 2
Additional arrangements for drug-related Technology Appraisal Guidelines (TAGs)
Appendix 3
Flow chart for Implementing Interventional Procedure Guidelines

* Directorate Manager/Lead Clinician responsible for disseminating the guidelines to colleagues

NICE guidance published monthly

Received in CGARD and posted on Clinical Guidelines Database

CGARD send guidelines to relevant Directorate Manager/Lead Clinician

Directorate Manager/Lead Clinician to advise whether guideline is undertaken within the Trust

Status reported to New Interventions Procedure Committee and status recorded on Trust Guidelines Database

No further action required

Not undertaken (For reference)

YES already undertaken (Endorsed)

Not undertaken but Lead Clinician wishes to commence undertaking procedure

Lead Clinician applies to New Interventions Procedures Committee to undertake procedure

New Interventions Procedures Committee makes recommendation to Clinical Governance and Quality Committee

Clinical Governance and Quality Committee makes final decision

Lead Clinician informed of Committee decision

CGARD revise status to Endorsed

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Appendix 4
Flow chart for Implementing NICE guidance and Quality Standards
(this does not include TAGs and IPGs)

NICE guidance published

Received in CGARD and posted on Clinical Guidelines Database

CGARD send guidelines to respective Directorate

No further action required

* Lead Clinician to identify if Guideline is relevant

YES (Endorsed)

Lead Clinician undertakes gap analysis

Lead Clinician attends Clinical Effectiveness, Audit & Guidelines Committee (CEAGC) to discuss implementation and gap analysis

Report filed for reference,

Are there any stated areas of non-compliance?

NO

YES

All non-compliant guidelines reviewed at monthly directorate clinical governance meetings

Risks should be registered on the Risk Register. Risks rated “high” or greater by Clinical Governance and Quality Committee. Guidelines rated less than “high” risk to be reported in directorate’s annual report to the CEAGC.

* Directorate Manager/Lead clinical responsible for disseminating the guidelines to colleagues